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Models of Integration

After a brief historical perspective, we first compare a number of different approaches to integration before discussing the ‘approach, method and technique’ framework. Next we define our own stance on integration and discuss current methods of training.

BRIEF HISTORICAL PERSPECTIVE ON INTEGRATION

When we have a problem or are feeling unhappy, some of us like to talk with a person who is not a friend or part of our family. In the past that was often someone respected in the community: a wise woman, a doctor or a spiritual leader such as a priest or shaman. These days that individual is often a counsellor or psychotherapist. It was not until the beginning of the last century, however, that therapy became a profession and developed its own body of knowledge and methodology.

Theories generally do not appear in a vacuum, but in relation to other developments. Freud, regarded as the founder of the ‘talking cure’, was influenced by the philosophy, literature and medical science of his time. This is not to deny Freud’s brilliance; he was a truly original thinker. However, ideas about the unconscious, for example, were also being discussed by thinkers such as the Danish philosopher Harald Hoffding (Hoffding and Lowndes, [1881] 2004) and Carl Jung, whose conception of the unconscious differed significantly from Freud’s view.

Freud’s views were taken up, criticised, modified and developed further by others, a process that still continues; indeed, this is what happens with theories in all disciplines. Having just developed a groundbreaking theory of inner dynamics that may go on inside human beings, however, it was not easy for Freud to acknowledge that others might have ideas that contradicted some of his own. His falling out with, for example, Jung and Reich mark the beginning of the many ‘turf wars’ that have plagued the field from the beginning, such as ‘Freudians’ vs ‘Jungians’, followers of Melanie Klein vs those of Anna Freud or classical analysis vs attachment theory. Currently, we have disputes between those for and against cognitive behavioural therapy, and between the relational psychoanalytic movement and those favouring a classical psychoanalytic approach. While some of these divisions may be

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characterised as acrimonious, others have maintained a healthy dialogue of difference and innovation on a theme.

As early as the 1930s, French (1933) attempted to integrate aspects of psychoanalysis and Pavlovian conditioning. Reactions were mixed, with some rejecting the idea outright, while others thought it a potentially fruitful line of inquiry. A few years later Rosenzweig (1936) wrote an article with the now famous title, 'At last the Dodo said, "Everybody has won and all must have prizes"'. This quote from Lewis Carroll's *Alice's Adventures in Wonderland* ([1865] 1962, chapter 3) is referenced in current debates on psychotherapy's effectiveness, where the term 'Dodo Effect' is used as shorthand for a lack of evidence for any difference between approaches. Rosenzweig claimed that effectiveness was attributable to elements all therapies have in common, rather than with differences. He identified three factors:

- Effectiveness is related to therapists' personalities, rather than their theoretical approach.
- All therapies tend to help people see their problems differently.
- Although therapies differ in focus, all are likely to be helpful as change in one area will also affect other areas (Rosenzweig, 1936). (This claim seems to anticipate some principles within a systems approach, which we will discuss further in the next chapter.)

Many subsequent writers have been more interested in the similarities between therapeutic approaches than their differences. Until relatively recently, however, they were in the minority, perhaps because psychotherapy was still young and the zeitgeist was not yet ready to accept an integrative view. This began to change in the 1960s with Frank and Frank ([1961] 1993) discussing commonalities between psychotherapy and other forms of healing and Carl Rogers (1963) claiming that the traditional borders between the various therapeutic approaches were beginning to disintegrate. Interestingly the third edition of Frank and Frank's book *Persuasion and Healing* was reprinted in 1993, which seems to indicate that integrative ideas emerging in the 1950s and 1960s formed the roots of a general movement towards integration as a mainstream approach in therapy.

From the late 1980s onwards there has been increasing emphasis on the importance of the therapeutic relationship, irrespective of theoretical approach. Lazarus (1981) took a pragmatic view and saw no problem with therapists borrowing techniques from other modalities, without necessarily taking on board the theory upon which these techniques were based. Lazarus coined the term 'technical eclecticism' for this practice and later developed his ideas further into 'multimodal therapy' (Lazarus, 1981). The 1980s saw an explosion of publications and conference presentations and integration came to be regarded as a significant movement.¹

In recent years we have observed two distinct phenomena. On the one hand, as mentioned earlier, there are ongoing disagreements between the proponents of a number of different theoretical approaches. On the other hand there appears to be a general growing together in the theory and practice of approaches hitherto regarded as distinct. We will discuss these phenomena in more detail in chapter 2.

¹For a detailed history of psychotherapy see Goldfried, et al. (2005).

CURRENT APPROACHES TO INTEGRATION

Since the early founders of the ‘talking cure’, the body of therapeutic knowledge has increased dramatically, giving rise to many different models within three broad categories of approach: psychodynamic, humanistic and cognitive-based. Integrative approaches, which constitute a combination of two or more models within the above approaches, might be seen as a fourth category. We say ‘might’ as there is always the danger of setting any approach in concrete. Even within the three main categories, there are many new models that are influenced by several others. The fact that there are so many variations in theoretical approach indicates that the field is very ‘alive’ and developing in response to the complexity of human circumstances and the evolving nature of knowledge.

Re-invention of Wheels?

Our Western society appears to lend itself to pluralism and competition (O’Brien and Houston, 2007). Practitioners within one approach may be ignorant of other theories, resulting in duplication and ‘re-invention of wheels’. For example, there is a current movement within the psychoanalytic world towards a more relational (Mitchell and Aron, 1999; Mitchell, 2000) and intersubjective approach (Stolorow et al., 2002; Stern, 2009). At the same time this does appear to be a (re)discovering of many beliefs and practices that have always been a part of therapies based on a humanistic philosophy. It is not always clear whether these are true ‘discoveries’ or whether people are using work from other fields without acknowledging that they are doing so. For example, despite a great deal of overlap with the humanistic-existential field, Carl Rogers is never mentioned in psychoanalytic literature (O’Brien and Houston, 2007: 4).

Jungian psychology appears rather on the sidelines in the official psychoanalytic literature and is rarely included in training. At the same time, Jungian concepts such as ‘complexes’, or intro- and extraversion have filtered through into everyday language. The literary and artistic fields have been widely influenced by Jungian psychology. For example *Women Who Run with the Wolves*, by the Jungian analyst Clarissa Pinkola Estes (1997) became a bestseller, and the science fiction series *Dune* by Frank Herbert had the ‘collective unconscious’ as its main concept. Other artists influenced by Jungian ideas include Italian filmmaker Federico Fellini, the painter Jackson Pollock and the singer-songwriter Peter Gabriel. The Myers-Briggs personality test (Briggs Myers, 1962), which is widely used within the business world, is based on Jungian typology and Jung’s ideas also indirectly influenced the twelve-step programme of addiction recovery.²

²After meeting Rowland H, one of Jung’s patients, Bob Wilson, one of the founders of Alcoholics Anonymous, became interested in Jungian psychology. Wilson later had a spiritual experience, which convinced him of the importance of change at a deep level. In a letter to Wilson Jung made a link between ‘the craving for alcohol’ and ‘the spiritual thirst of our being for wholeness...’ (C. G. Jung, letter to W. G. Wilson, Alcoholics Anonymous, Box 459 Grand Central Station, New York 17, 30 January 1961. In www.barefootworld.net/jungletter.html (accessed 30 December 2010). See also Kurtz (1979).

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Often, however, borrowing and sharing of ideas is acknowledged. Schema-based cognitive therapy, for example, acknowledges its use of Gestalt theory (Young et al, 2006). Overall it seems that the zeitgeist³ is moving towards a more integrative stance, which (as we will discuss in chapter 2) is in line with postmodern philosophy. It may be that commentaries and critiques of therapeutic approaches recognise that the field is as subject to conceptual cross-fertilisation, analysis and synthesis as other fields of intellectual and scientific endeavour. The conditional nature of knowledge is well recognised in the so-called hard sciences (Kuhn, 1962; Popper, 2002). Therapy, which spans sciences, humanities and the arts is subject to similar social and theoretical evolution and integration. The challenge is to conceptualise such integration as a synthesis rather than a cacophony of jarring concepts thrown together randomly. At the same time – who is to judge?

This may also be a result of the field of counselling and psychotherapy beginning to mature (O'Brien and Houston, 2007).

KEY CONCEPTS OF INTEGRATION

The key concepts of psychotherapeutic integration are set out in the box below.

Key Concepts of Integration

Theoretical and practical limitations of single theory approaches.
Wide range of methods, tools and interventions.
Flexibility to meet individual clients' needs.
Lack of demonstrated effectiveness of any single theory for all clients.
Identification of common factors that facilitate efficiency and effectiveness.
Generic, rather than specific factors believed to facilitate change.

A Metaphor

This is an experience one of us had recently:

My partner and I had been invited to a dinner party out in the countryside. Although we had been there before, we could not remember the exact route. My partner decided to get directions from a travel site on the Internet and off we went. At first everything was fine. We followed the instructions and made good progress. But after a while things became unclear. 'Was that the second or the third turning? Did we miss one? Why is there a second roundabout when according to the directions

³'Spirit of the time' (German).

there should be only one?’ We were lost, so retraced our steps to a point where things had still made sense and realised that we had taken a wrong turning. According to our directions we should be just outside the town of our destination, but we knew from previous experience that we still had a long way to go. Eventually, after another forty-five minutes of driving involving many turnings and roundabouts, our printout suddenly made sense again and we were indeed entering the town.

The above experience may be seen as a metaphor for different types of theory. Some may focus on one aspect of human experience, some on another, but none are likely to be able to encompass the entire richness of life. If we rely on just one theory, or only one set of instructions as in the above example, we might miss something important or lose our way. We believe that every theory offers useful reference points, which may be a reason why many practitioners are attracted to integration.

Typically integrative therapy involves combining different theoretical approaches and accompanying methods. As there are many models within the main theoretical approaches, it follows that there are also many different ‘integrations’, depending on which models or part models are being integrated. McLeod (2003b) fears that the proliferation of integrative models may add to the fragmentation of the field of counselling and psychotherapy. We do not share this fear and agree with O’Brien and Houston (2007: 4) who take the opposite view and regard integration as ‘a corrective tendency in an over-fragmented field’.

The Happy Eclecticist

‘As long as it works, I’m happy’, said Sally. ‘I really do not care whether a new technique such as EMDR or whatever fits with my original model. For me the main issue is – does it help this client at this moment?’ Sally is a well-respected practitioner with a full practice and many satisfied clients. Clearly what she is doing works for her and her clients. We suspect that it is ‘who she is’ rather than the techniques she is using that makes Sally successful. She ‘integrates’ new techniques and experiences and makes them ‘hers’ and part of her professional repertoire.

The Eclectic–Integration Continuum

According to McLeod (2003b: 64) the world of counselling and psychotherapy is involved in an ‘important debate over the relative merits of theoretical purity as against integrationism or eclecticism’. However, eclecticism, within which a practitioner may employ a wide range of techniques without a unifying theory, seems less popular than integrationism, which does attempt to unify different theories.

Mahrer (1989) identified six methods of integration comprising: the development of a new grand theory capable of encompassing all existing theories; using one theory

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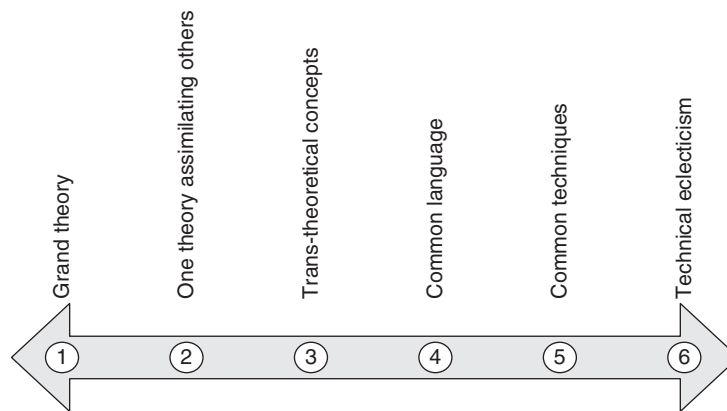


Figure 1 The Eclectic – Integration Continuum

to assimilate others; developing a common language, trans-theoretical concepts or techniques; and technical eclecticism – evidence-based approaches that marry specific problems with particular techniques (Dryden, 1984). The six approaches may be mapped onto a continuum with integration through a unifying theory at one end and the eclectic approach, focusing only on techniques, at the other.

According to Cooper and McLeod (2007) the ‘grand theory’ as well as some trans-theoretical attempts at integration may end up as unitary or purist rather than integrative models. We agree with Mahrer (1989) and Lapworth et al. (2001) that the trans-theoretical and technical eclecticist approaches seem the most viable options. What these approaches have in common is that, despite being placed in different positions on the continuum, each constitutes a partial rather than a complete integration. We see this as an advantage rather than a limitation (McLeod, 2003b: 69), as complete integration seems neither possible nor desirable. This is because each core theoretical approach is characterised by numerous sub-sections, which often do not see eye-to-eye. Also, we suspect that a grand theory that aims to contain all other approaches would be so general as to become meaningless.

Trans-theoretical Approaches Currently in Use

A trans-theoretical approach, which attempts to integrate theories through the identification of unifying concepts, seems to us the most fruitful. Well-established models such as Egan’s ([1975] 1994) three-stage problem solving model, Andrews’ (1991) self-confirmation model and Ryle’s (1990) cognitive analytic (CAT) approach are said to fall into this category (McLeod, 2003b: 68–9).⁴ Recent models include Cooper and McLeod’s (2007) pluralistic framework, structured around the domains of ‘goals, tasks and methods’. These domains operate as a meta-heuristic or meta-frame,

⁴Scott sees CAT as an integration of two models to make a third (Scott, 2004: 38), which would make it a unitary rather than a trans-theoretical model.

enabling therapists to select ‘concepts, strategies and interventions from a range of therapeutic orientations’ (Cooper and McLeod, 2007: 135). The authors see this framework as postmodern⁵ in that it allows for the existence of conflicting but equally effective ways of working, and is respectful and inclusive towards ‘otherness’.

Lapworth, Sills and Fish’s multidimensional integrative framework has three dimensions: a core based on ‘aspects of self experience’ (2001: 43); context and relationship; and a larger frame of ‘past, present and future’ that surrounds the other two dimensions. This model helps therapists to assess clients’ current needs, problems and deficits, thus serving as a useful guide to practice. Like Cooper and McLeod’s pluralist model it allows the practitioner to choose strategies and ways of working from a wide range of theories.

Evans and Gilbert’s relational–developmental model (2005: 3) uses the concept of the ‘developing self’ as a ‘super-ordinate organising principle’ that forms a bridge to others and the rest of the world. They take a ‘two-person view of the therapeutic process’ (2005: 2) in which what happens is co-constructed⁶ between client and therapist and requires therapists’ willingness to tolerate ‘uncertainty, ambiguity and not knowing’ (2005: 63).

O’Brien and Houston’s (2007) model of integration is firmly focused on practice. Its nine components range from assessment and contracting to theoretical understanding and the use of codes of ethics, together forming a comprehensive framework.

APPROACH, METHOD AND TECHNIQUE – A FRAMEWORK FOR THINKING ABOUT INTEGRATION

What is it that attracts us to one type of therapy rather than another? Each of us brings a set of beliefs and theories, which form a system of thinking about human nature. These include ideas about the nature of mind, what constitutes mental health and wellbeing, how problems and difficulties arise and what mechanisms and processes bring about change. These personal maps or epistemologies determine which specific concepts we draw on from any psychological and therapeutic theory. This in turn will influence how we interpret information in the therapy session and how we choose to act. The actions we take include decisions about the therapeutic ‘frame’ (Gray, 1994): how and where we meet clients, the frequency and length of sessions, arrangements around breaks, our choices about how and what we communicate, and how we behave generally.

According to Burnham (1992), psychotherapeutic models comprise the three levels of approach, method and technique. ‘Approach’ is defined as the assumptions, values, theories and working ideas or epistemologies of a particular orientation; ‘method’ includes both the organisational patterns or frameworks and structures of practice and ways of working; ‘technique’ involves all the activities that take place

⁵We discuss postmodernism in more detail in chapter 2.

⁶Within the RIM we also take the view that whatever happens between client and therapist is co-constructed.

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within actual practice. We use this framework to organise and conceptualise the different therapies that are included in our relational integrative model. In the next few chapters we will begin by exploring each theory at a level of approach and then go on to examine in detail the method and techniques that grow out of them.

Approach

Why Do We Do What We Do?

This is the theoretical store we draw upon to guide how we work with our clients, how we may understand and conceptualise our clients' experience and actions, and the processes that occur in the therapeutic encounter.

Method

How Do We Do What We Do?

This concerns whether the work is with individuals, couples, families, groups, etc; the length of sessions; whether the clients lie on a couch or sit facing us; whether there is a co-counsellor or a team behind a screen, as may be the case in family therapy; the length of the work, for example whether it is brief and time-limited or long-term and open-ended.

Technique

What Do We Do?

Technique constitutes the actions and behaviours we engage in when practising therapy. In other words, they are the skills, interventions and techniques underpinned by the approach, such as, for example, Socratic questioning, reflecting, active listening or setting homework tasks.

THE INTEGRATED PRACTITIONER

Most of the integrative models we discussed earlier share a focus on the 'client' and their needs. Rowan and Jacobs (2002), however, see integration differently and suggest that, rather than focusing on the practitioner's school or integration, it may be more fruitful to look at the therapist herself and the position she takes vis-à-vis her work. They outline three broad positions, constituting an 'actualisation hierarchy', a term taken from Eisler (1987) who sees it as analogous to the organisation of living organisms ranging from a single cell to a complex interlinked system of organs and processes.⁷ The three positions

⁷See chapter 2 for a discussion of a systems approach.

(‘instrumental’, ‘authentic’ and ‘transpersonal’) are created through an interaction of the ‘confidence and development’ of the therapist, the needs of the client and the ‘place where the client currently is’ (Rowan and Jacobs, 2002: 5). An advantage of focusing on the practitioner rather than the theory is that it allows for continuous growth and development of the individual. Perhaps inevitably there will be as many manifestations of a given integrative approach as there are practitioners using it.

The Instrumental Position

According to Rowan and Jacobs (2002) therapists occupying an ‘instrumental position’ are more likely to be in an ‘I-it’ (Buber [1923] 1958) relation to clients, and have curing the client of their problems or difficulties as their goal. Technical ability as well as evidence-based practice and manualisation are likely to be of great interest, although working with unconscious processes is also possible. Rowan and Jacobs (2002) claim that some cognitive behavioural approaches, neuro-linguistic programming and eclectic approaches without an integrating framework are examples of an instrumental position. It could be argued that they are jumping to unwarranted conclusions here, as it is not clear why wishing to cure, or evidence-based practice should preclude therapists from being in an I-thou or authentic (see below) relationship with their clients.

The Authentic Position

A therapist with an ‘authentic’ way of being is likely to be more occupied with the ‘person-to-person’ therapeutic relationship (Clarkson, 2003) than with specific techniques. Rowan and Jacobs (2002) see most humanistic therapists as coming under this umbrella, as well as Jungians, post-Jungians and many psychoanalytic therapists. The language used to denote what is valued in this position varies according to the theoretical approach, such as the more contemporary understanding of countertransference, authenticity or ‘healing through meeting’ (Rowan and Jacobs, 2002: 6). This position may also be seen as a level of psycho-spiritual development (Wilber, 2000: 152). It is not entirely clear, however, on what basis Rowan and Jacobs (2002) include some approaches here and not others.

The Transpersonal Position

With a ‘transpersonal’ position or way of being, therapist and client may connect at a soul or heart level, in which the boundaries between them ‘may fall away’ and they let go of ‘all aims and assumptions’ (Rowan and Jacobs, 2002: 6). According to Rowan and Jacobs (2002) this level is the least well understood of the three and may involve much struggle and self-searching.

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Therapist Rather than Therapy

The three positions identified by Rowan and Jacobs (2002) are helpful as they recognise that it is the therapist and who she is that is important, rather than the theoretical approach. However, their reasoning is inconsistent as they then group all therapists who practise within a certain approach as belonging to a particular position, although they might argue that it is the therapist's personal philosophy and position that leads her to choose a particular approach. Wilber's (2000) concept of 'transcend and include' that values rather than denigrates what has gone before may be helpful here. It provides a way to think about the three positions, in that each level is useful and therefore included, rather than negated or superseded by the next. This concept may also be applied to personal development generally. Whatever we have done, learnt or experienced becomes part of us; we do not discard, but continue building on and transcending, i.e. integrating, what we have learnt before. Although Wilber's concept of transcend and include does imply a hierarchy, it does not follow that we see the relational integrative model as better; it is just different. For example, Einstein's theory of relativity transcends Newton's theory and includes it when it is applicable (e.g. when bodies, such as satellites, move very slowly). It does not apply when bodies are moving extremely fast, or are very massive (e.g. black holes). Although Einstein's theory is 'better' in terms of its range of applicability, Newton's theory is 'better' as it is much easier to use and therefore better when it applies. Another example: the body includes organs, organs include tissues, tissues include cells – but we need them all. None are 'better' than the other.

THE RELATIONAL INTEGRATIVE MODEL'S DEFINITION OF INTEGRATION

'When I use a word,' Humpty Dumpty said, in rather a scornful tone, 'it means just what I choose it to mean – neither more nor less.'

'The question is,' said Alice, 'whether you can make words mean so many different things.' (Carroll, 1872: 72).

The word 'integration' is often used in a Humpty Dumpty kind of way with many practitioners professing to be 'integrative' without a shared understanding of what that means. What does 'integration' actually signify? According to the Collins English Dictionary (2000) 'to integrate' means 'to make or to be made into a whole, to incorporate or be incorporated, to amalgamate or mix, or to make up of parts'. Although subtly different, all four definitions involve a bringing together of different elements and creating something new. Scott (2004: 38) suggests four types of integration:

- Integration of a number of psychotherapeutic theories.
- Mental, physical, emotional and spiritual experience within the client.
- Integration of other disciplines such as philosophy or poetry.
- The use of humour or metaphor in the therapist's way of working.

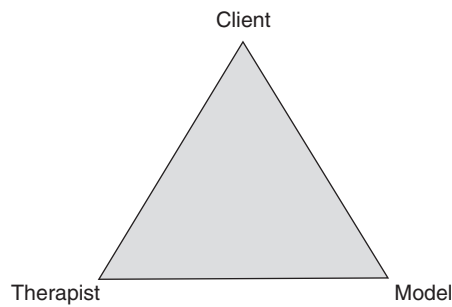


Figure 2 The Three Aspects of Our Relational Integrative Approach

Our view of integration is influenced by Scott (2004) as well as Rowan and Jacobs's (2002) views as discussed above, in that we see integration as a continuous, holistic process involving the client, the therapist and the therapeutic model or theory. Different approaches to integration may vary, some emphasising theory and others being more concerned with the client's experience or the actual methods used by the therapist.

THE CLIENT

We see the purpose of therapy as helping clients come to terms with, digest or 'integrate' difficult experiences or aspects of their lives and relationships. Often someone comes to therapy because they feel that they are 'falling apart', are suffering and want to be healed and made 'whole'. This may involve an integration of different parts of herself, different experiences or sets of processes that may not sit easily together or the learning and integration of new strategies and ways of being. This is a dynamic process, and may involve the letting go of unhelpful habits (cognitive, behavioural, interpersonal), withdrawal of projections and re-integration of split-off parts, or the creation of new narratives.

The word 'heal' is from the Old English word 'hal', meaning 'whole'. It is also related to the word 'hale' and the Old English toast 'Wassail' meaning 'Be Healthy'. The Middle English 'hool' meant healthy, unhurt or entire. So it seems that 'healing' implies the restoration of the whole. As such it offers a description not only of psychotherapy, but also of other traditions and ways of helping people with problems in living found in other cultures throughout the world.

THE PRACTITIONER

We aim to be and work with clients in a way that helps make their integrating process possible. As each person is unique, the relationship and the way we work with

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each individual is also unique.⁸ The client–therapist relationship, or how we relate as two beings together, is not static but will also shift from moment to moment. This means that both of us (client and therapist) need to integrate what occurs between us. So the therapist’s task involves allowing herself to notice what is happening, voice it and together with the client make sense of it, so that it can be digested, i.e. integrated psychically.

However, the client is not the only person who seeks internal integration. The practitioner also needs to be committed to a process of continuing integration, both personal and professional. This involves an intention or a continuous striving, rather than an actual achievement. This is not unlike Rogers’s ‘core conditions’ (1957), which many of us aim to embody but rarely achieve fully. The minute we think we have ‘achieved’ full integration we are in trouble as it is a process and not a final state. Seeing integration as a finite state is likely to result in arrogance and a loss of openness. There is a danger of falling in love with our own approach and seeing it as superior to others.

Being committed to continuous integration can be challenging. In order to do this we need a secure base or framework that incorporates our values and beliefs. At the same time, however, it is important to hold theories lightly, and remember that they are metaphors, hypotheses or tools. We need to retain a stance of interest and curiosity and remain open to new knowledge and experience, even if these appear to invalidate some of our earlier beliefs, which is, after all, what we encourage our clients to do.

THE THEORY

We discuss our approach in more detail in the following chapters, but for now agree with Wahl according to whom therapeutic integration is:

the discovery of an overarching concept or principle that reconciles apparently contradictory features of two or more therapeutic models. It is a way of saying: hey, if you look at things in this manner, what looked contradictory or irreconcilable no longer is. (2001: 7).

We prefer to talk of integrating rather than integration, as this expresses more clearly the continuing willingness of the therapist to learn and develop. Perhaps there is a difference between the therapist who, having been trained in a particular model, whether purist or integrative, is happy to stay within it, and the one who is curious to find out what else there might be. The latter is more likely to go on integrating continuously. McLeod (2003a: 72) suggests that the move away from pure theories, which are based on the ideas of their founders, towards a ‘more sceptical stance’ is characteristic of a postmodern way of thinking. A stance of continuously integrating therefore seems in line with this. We do not wish to imply a hierarchical relationship between a ‘one model’ therapy and a position of continuously integrating. If the position is right for

⁸This ‘intersubjective’ approach will be discussed further in chapter 2.

the therapist, who is thus able to practise congruently with her philosophical assumptions, it is likely that her clients will benefit. We therefore agree with O'Brien and Houston (2007: 16) who say that, 'the root to integration may lie in the therapist's careful monitoring of her subjective experience in the moment-to-moment interaction with the client followed by reflection on what she did and why'.

METHODS OF TRAINING INTEGRATIVE PRACTITIONERS

The Importance of Congruence between Training Method and Training Model

If there is no congruence between the values and philosophies of a therapeutic approach and how it is taught, the students will experience their trainers as 'do as I say, don't do as I do'. It is a fact of life that teachers are always in the 'gaze' of the students and often seen as embodying the particular approach they teach. As trainers we need to be aware that we are engaging with students' strongly held core beliefs, predispositions and assumptions, and will receive all kinds of projections from them, positive as well as negative.⁹ For the teacher, being the recipient of a positive transference can be very seductive. However, most of us get our share of both types of projections, which helps keep us grounded, provided we acknowledge, name and work with them. Psychodynamic theory is helpful here as it provides a means of thinking and talking about these phenomena. If one's theoretical model does not include a means of working with transference and relational patterns then there may be a tendency to ignore what happens, which may result in unconscious acting out, both by trainers and trainees. Many trainers like to have supervision for their training work, either from their therapy supervisor or from someone who specialises in training supervision.

Ideally there would also be a consultation group within the training organisation, where people can support and challenge each other on their teaching practice. We see such a group as essential for trainers, to help them reflect on what happens in their groups and on themselves within the group and what actions might need to be taken. This would be an example of the organisation holding the trainers, so that the trainers can hold the students, which in turn will contribute towards the students being able to hold their clients. Trainers also need to be supported with administration, sufficient manpower so that the teaching groups do not get too large, a manageable workload and a say in how the organisation is run. If, however, there are problems within the larger organisation, this is likely to have a destabilising effect on the training team and will affect the students' experience negatively.¹⁰ When, as is almost inevitable, problems do occur, it is essential that they are recognised, discussed and dealt with. This is not always easy; in some organisations, there

⁹The concepts of transference, countertransference, projection and projective identification originated in psychoanalysis.

¹⁰All parts of a system mutually influence each other.

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can be a tendency to focus on the positive, but deny or ignore the negative. Reflexive processes, however, can help us to integrate the shadow¹¹ and pay attention to issues of power, thus avoiding the possibility of ‘acting out’, not just by the students, but also by the trainers or the organisation. Sometimes a training climate can be experienced as persecutory: as one therapist put it to us recently, ‘some training organisations eat their young’.

Training: Single Model or Pluralist Approach

Despite the plethora of therapeutic approaches, training in a single approach is often advocated, as it is claimed to give trainees a good grounding in one model, upon which they can always build later. We feel that although this is certainly possible, it does very much depend on *how* that single model is taught. According to Summers and Barber (2010: 7), for example, ‘traditional psychodynamic teaching methods can be more like catechism than intellectual exploration’. It seems likely that such methods, where what is taught is presented as ‘the one and only true model’, result in students being less open to looking at other models or ways of working. In other words, it could lead to Balkanisation, where the model’s ‘hypotheses’ become reified and other approaches are treated with suspicion and hostility. Indeed the history of the therapy field is full of battles and conflicts. Training in a single approach may arguably make it more difficult to integrate new learning, so that something new may be at best ‘bolted on’ rather than integrated.

We see training integrative practitioners as helping trainees to engage critically with a number of ideas and open themselves up to the experiences offered. It may be wise to be suspicious of definite and simple answers, of people who claim to know the ‘truth’ or adhere to a reified truth as if it were doctrine. Truth is an elusive concept that often depends on ‘whose’ truth we are talking about. An integration of a number of approaches requires a clear understanding and knowledge of the premises behind each of them individually and a rigorous yet flexible stance, where the trainee is invited to entertain a number of ideas simultaneously holding all as *contextually* true.

Some training organisations prefer to teach a number of theories separately, and expect students to create their own integration. This can be challenging for students, particularly when on shorter (two or three year) counselling courses. This may result in confusion and the adoption of just one model, the one students like or find easiest, and a rejection of the others. Alternatively students may engage with each discrete model a little and say things such as, ‘well first I worked psychodynamically by asking her about her childhood, then we did CBT because I asked what she was thinking, and then I worked in a person centred way and just listened’. This demonstrates not only a misunderstanding of what it means to work integratively, but also of the models mentioned, as what is said of each one of them sounds like a parody.

Students may be able to create their own integration, provided the training is long enough for this process to happen. In this case there needs to be clarity regarding the

¹¹The shadow is a concept from Jungian psychology and denotes everything that we are not aware of, deny or reject. The shadow is often regarded as negative, but it can contain positive elements too.

organisation's underlying values and philosophies as well as a rationale for the teaching of particular theories and the exclusion of others. Lack of such clarity may leave students confused, particularly if there is also a lack of agreement between individual trainers regarding the usefulness of various therapeutic approaches.

INTEGRATION OF THEORY AND PRACTICE

We believe that successful training involves an integrative approach to three main areas: theory, practice and personal development. A typical training day might include sessions on theory, skills practice and personal development. During skills practice students take turns in functioning as client and therapist for each other. We find that theory is best introduced through inviting the students to actively participate in debate and discussion. Also, having been introduced to a particular aspect of theory, trainees are then asked to work with the new material in their skills practice, and reflect on what this means to them personally. This means that theory is not something dry and abstract, but comes alive through direct experience and practice.

TEACHING STYLES AND METHODS

Trainees are not the trainers' clients, but they are not their friends either. No matter how egalitarian therapy teachers try to be, the power differential cannot be denied. We are mindful of the fact that as trainers we are the people who mark trainees' work, observe their practice sessions, and will be influenced by our observations of them. As far as the course and their plans for the future are concerned, it may feel to trainees that their fate is in our hands, and to some extent it is. Training to be a therapist is not an easy experience. Not only do we ask people to learn a great deal of new material, they are also required to implement what they learn in their practice. We find that students are often very anxious, particularly when assessment looms near, and may need a great deal of support.

Although by definition everyone who trains as a therapist is an adult, the training itself can be curiously infantilising. So rather than a 'pedagogical' teaching style, which is based on the teaching of children, we advocate a stance of 'relational andragogy',¹² where students are treated as adults and therefore our equals. Within such an approach students are encouraged to take responsibility for their learning and are more likely to take an active part in the life of the training organisation. Feedback from students and ideas for improvement are actively sought and taken on board. How we like to be with clients – open, available, collaborative, invitational and creative – is how we like to be in our relationship with students.

¹²Andragogy is Greek meaning 'man-leading'. The term was first coined by the German teacher Alexander Kapp in 1833, and used by Knowles to develop a theory of adult learning. Andragogy emphasises 'process', not just content, and students' active involvement in their learning. Teachers act as facilitators rather than instructors. See Carlson (1989).

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THE ROLE OF PERSONAL DEVELOPMENT

Personal and professional development is widely regarded as essential for all practitioners, whether qualified or in training, and an important aspect of our continuing integration of theory, practice and experience. As trainers we aim to help students become integrative practitioners through the integration of theory and practice, as well as the development of self-knowledge and self-awareness. There are at least three means by which trainees' self-knowledge and awareness may be facilitated: personal therapy, a personal development group and supervision.

Personal Therapy

Regarding the necessity of personal therapy, opinions appear divided, with many regarding it as absolutely essential throughout training, and others seeing it as an unnecessary expense, the value of which cannot be demonstrated. Interestingly, the writers of this book do not share the same opinion on the subject either. One author regards personal therapy as useful, though not essential, and one of several methods for gaining self-awareness. She questions how we can differentiate between models of training that pathologise their students, by defining their experience of the training process as one in which they are made aware of their deficits (which might then be 'cured' by their training therapists in mandated therapy), and those approaches that provide a resource to trainees, by recognising that an opportunity for reflection and personal development is a necessary component of the learning experience. However, the other author finds it hard to see how practitioners can help their clients go to places where they may not be prepared to go themselves and regards personal therapy as an essential part of training. This difference of opinion between us regarding mandatory therapy in therapy training is also reflected in debates in the field and different course requirements.

An argument in favour of therapy for trainees is that therapy training often shakes people's views and beliefs about themselves. This goes for every part of the course, even seemingly straightforward bits of theory. As discussed above, theory is best taught integratively, through asking students to check in with their own experience, observe their responses to theory, and ask themselves 'do I have strong reactions against anything?' A strong reaction is often a sign that there is something going on inside. It is therefore good to encourage students not to reject anything, but to be interested in their own wish to reject and reflect on what might lie underneath that wish. So therapy training involves helping students become interested in their own process and their own internal world and to develop a stance of curiosity.

Personal therapy can be hugely supportive and may provide excellent learning regarding 'how it is done'. A study by Rake and Paley (2009) reports how personal therapy helped people in three ways: it showed how to do therapy, developed their self-knowledge and helped to dissolve difficult personal issues. Congruence with the approach being learnt is therefore crucial. Practitioners who have had helpful therapy themselves are much more likely to have confidence in the therapeutic process than if they haven't, and their clients will sense that confidence.

Studies that attempt to link personal therapy to patient outcomes have so far been inconclusive (Beutler et al., 2004). This may be due to methodological problems, or the general difficulty of attributing single factors to client outcome, given the complexity and multidimensional nature of therapeutic work.

Personal therapy can also help trainees to learn the skills of being present with clients (such as developing attunement and advanced empathic responding) as well as learning to recognise and manage their own emotional responses. Some of the reasons for personal therapy during training may include: to provide the space to explore one's own inner world in order to help clients to do so, to gain support and help with processing of difficult experiences, to help with recognising blind spots and developing a stance of curiosity in self and others, and to learn to be with clients' as well as one's own emotional responses, and to learn to do therapy itself.

Reasons for Personal Therapy During Training

- Explore own inner world in order to help clients do so too.
- Support and help with processing of difficult experiences.
- Help with recognition and integration of blind spots.
- Help develop a stance of curiosity in self and others.
- Learn to be with clients' as well as own emotional responses.
- Learn how to do therapy.

The Personal Development Group

Many integrative courses include a personal development group where students can talk about and help each other to process their emotional responses to the course. For the successful functioning of a group, its members need to feel safe, so its first task is the development of a clear contract, which should include agreement on confidentiality. Personal development groups offer an excellent learning opportunity for students, provided certain parameters are adhered to: they should not be too large (no more than twelve people);¹³ facilitators should not be involved in teaching or assessing the same group of students; and contracts should be clear.

Not all organisations are able to satisfy the first two criteria and run large personal development groups of around twenty people. A large group may leave some of its members too intimidated to speak, resulting in a few people actively participating while the others watch. If the group's facilitators also teach and assess, people may not feel safe and the group may function at a superficial level only. This would be unfortunate as in our experience personal development groups can be very supportive (as well as challenging) and offer fantastic personal learning opportunities for all concerned. The issue of personal development will be discussed further in chapter 5.

¹³See Johns (1996) on optimum group size.

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Supervision of Practice with Clients

Supervision of practice is an important aspect of therapist development (Mehr et al., 2010). Supervisors can help trainees to talk about and integrate what they are learning and experiencing, and help them to 'be with' and engage with clients. Supervisors can also help trainees to notice their emotional responses to clients and reflect on what this might mean while, at the same time, listening to the client. Even though supervision is focused on practice, it has the potential to foster practitioners' personal awareness and development immensely.

Supervision of Skills Practice with Fellow Trainees

Trainees may also learn a great deal through observed work with each other – in vivo or recorded. We particularly like the use of audio/video recordings where trainees function as client or therapist for each other, which can then be shown and processed in small groups. This can be very revealing, so it is important for the facilitator or supervisor to hold the group and their anxiety, and ensure that the group reflection and discussions are respectful and supportive, so that all can learn.

The Value of Mindfulness

Both of us have integrated mindfulness practice into our daily life and in our work with clients.¹⁴ It can also play an important part in the self-development of trainee practitioners (Chambers and Maris, 2010). In addition to teaching sessions on the use of mindfulness with clients, we therefore also like to include a brief period of mindfulness practice at the beginning of every training day.

SUMMARY

In this chapter we have discussed the history of psychotherapy integration as well as a number of different views of the subject. We concluded that a trans-theoretical approach seems the most fruitful and suggested the framework of 'approach, method and technique' as a useful way to think about integration. However, rather than seeing integration or an integrative model as static, we argued that it may be useful to think about integration as an activity. So instead of calling ourselves 'integrative' practitioners, we describe ourselves as engaged in a process of continuously integrating our relevant personal and professional experiences.

¹⁴The value of mindfulness in therapy and its practice has been adopted in humanistic approaches, contemplative and transpersonal therapies (Rowan 2005; Wellings and McCormick 2005) and integrated with a cognitive behavioural approach in the form of mindfulness-based cognitive therapy (Segal et al., 2002).

The remainder of the book will be devoted to all aspects of the relational integrative model and in the next chapter we introduce the theoretical ideas that form its basis.

QUESTIONS FOR FURTHER REFLECTION AND DISCUSSION

- How would you integrate concepts and methods from seemingly incompatible approaches?
- What do you think of the various types of integration? Are you attracted more to one type of integration than another? If so, what are your reasons for your preference?
- Is there a type of integration you would never contemplate using? If so, what are your reasons for its rejection?
- What do you think of Rowan and Jacobs's (2002) distinctions between therapists and therapies?
- What are your views on the various methods of personal development? What is your experience? What would you recommend to a new trainee practitioner?

FURTHER READING

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