

Integrative Psychotherapy

Constructing Your Own Integrative Approach to Therapy

INTRODUCTION

A major emphasis of this book has been on helping you construct your own integrated approach to psychotherapy. Research has indicated that psychotherapy is moving toward an integrated approach to therapy (Norcross, 2005b). Throughout the world, when you ask a psychologist or counselor what his or her theoretical orientation is, the most frequently given response is integrative or eclectic. It is highly likely that upon graduation from your training program, you will integrate one or more of the theories presented in this book. In fact, my own professional journey has resulted in my adoption of an integrated psychotherapy framework. This chapter explores in detail the integrative approach to therapy.

The first part of this chapter traces psychology's historical development from emphasizing a single approach to therapy to the current integrative psychotherapy movement. In particular, I direct your attention toward multitheoretical approaches to psychotherapy integration. Jeff Brooks-Harris' (2008) multitheoretical psychotherapy framework is presented as a potential framework you might consider either using or modifying to develop your own integrated approach to therapy.

After providing a foundation for an integrative approach that is multitheoretical, I then move toward helping you construct your own personal

integrative approach to therapy. After studying each of the various theories of psychotherapy presented in this book, it may be difficult for you to decide which approach seems to match best with your own personality, therapeutic style, and your methods of conceptualizing the many different types of life challenges people bring to therapy. How do you go about integrating or combining the best of several counseling theories? To help you with this task, I present a number of questions that you might ask yourself in constructing your own integrated counseling approach.

While constructing your own integrative approach to therapy is a very important professional step, you must also get a vision of what you have to do to become an effective therapist. I believe that every therapist who becomes an effective professional has to learn how to reflect on his or her therapy experiences. It's when we are alone in our offices thinking about a client with whom we been working who appears to be struggling with therapy and himself that we begin to grow and mature as therapists. We reflect on what we did or did not do and what we might do in the next session.

The final section of this chapter contains an integrative psychotherapy plan for Justin, the young student who has served as a case study at the end of each theory chapter. In writing the integrative treatment plan, I use Jeff Brooks-Harris' (2008) multitheoretical framework.

Brief Historical Overview of the Integrative Movement

The movement toward integration of the various schools of psychotherapy has been in the making for decades. On the whole, however, psychotherapy integration has been traditionally hampered by rivalry and competition among the various schools. Such rivalry can be traced to as far back as Freud and the differences that arose between him and his disciples over what was the appropriate framework for conceptualizing clients' problems. From Freud's Wednesday evening meetings on psychoanalysis, a number of theories were created, including Adler's individual psychology. As each therapist claimed that he had found the one best treatment approach, heated battles arose between various therapy systems. When behaviorism was introduced to the field, clashes took place between psychoanalysts and behaviorists.

During the 1940s, 1950s, and 1960s, therapists tended to operate within primarily one theoretical school. Dollard and Miller's (1950) book, *Personality and Therapy*, was one of the first attempts to combine learning theory with psychoanalysis. In 1977, Paul Wachtel published *Psychoanalysis and Behavior Therapy: Toward an Integration*. In 1979, James Prochaska offered a transtheoretical approach to psychotherapy, which was the first attempt to create a broad theoretical framework.

In 1979, Marvin Goldfried, Paul Wachtel, and Hans Strupp (Strupp & Binder, 1984) organized an association, the Society for the Exploration of Psychotherapy Integration (SEPI), for clinicians and academicians interested in integration in psychotherapy (Goldfried, Pachankis, & Bell, 2005). Shortly thereafter in 1982, *The International Journal of Eclectic Psychotherapy* was published, and it later changed its name to the *Journal of Integrative and Eclectic Psychotherapy*. By 1991, it began publishing the *Journal of Psychotherapy Integration*. As the field of psychotherapy has developed over the past several decades, there has been a decline in the ideological cold war among

the various schools of psychotherapy (Goldfried, Pachankis, & Bell, 2005).

Norcross and Newman (1992) have summarized the integrative movement in psychology by identifying eight different variables that promoted the growth of the psychotherapy integration trend in counseling and psychotherapy. **First**, they point out that there was simply a proliferation of separate counseling theories and approaches. The integrative psychotherapy movement represented a shift away from what was the prevailing atmosphere of factionalism and competition amongst the psychotherapies and a step toward dialogue and cooperation. **Second**, they note that practitioners increasingly recognized the inadequacy of a single theory that is responsive to all clients and their varying problems. No single therapy or group of therapies had demonstrated remarkable superior efficacy in comparison to any other theory. **Third**, there was the correlated lack of success of any one theory to explain adequately and predict pathology, personality, or behavioral change.

Fourth, the growth in number and importance of shorter-term, focused psychotherapies was another factor spearheading the integrative psychotherapy movement. **Fifth**, both clinicians and academicians began to engage in greater communication with each other that had the net effect of increasing their willingness to conduct collaborative experiments (Norcross & Newman, 1992). **Sixth**, clinicians had to come to terms with the intrusion into therapy with the realities of limited socioeconomic support by third parties for traditional, long-term psychotherapies. Increasingly, there was a demand for therapist accountability and documentation of the effectiveness of all medical and psychological therapies. Hence, the integration trend in psychotherapy has also been fueled by external realities, such as insurance reimbursement and the popularity of short-term, prescriptive, and problem-focused therapists.

Seventh, researchers' identification of common factors related to successful therapy outcome influenced clinicians' tendency toward psychotherapy integration. Increasingly, therapists began

to recognize there were common factors that cut across the various therapeutic schools. **Eighth**, the development of professional organizations such as SEPI, professional network developments, conferences, and journals dedicated to the discussion and study of psychotherapy integration also contributed to the growth of the movement. The helping profession has definitely moved in the direction of theoretical integration rather than allegiance to a single therapeutic approach. There has been a concerted movement toward integration of the various theories (Prochaska & Norcross, 2010).

Definition of Integrative Psychotherapy

As noted in Chapter 1, integrative psychotherapy is an attempt to combine concepts and counseling interventions from more than one theoretical psychotherapy approach (Stricker, 2001). It is not a particular combination of counseling theories, but rather it consists of a framework for developing an integration of theories that you find most appealing and useful for working with clients. According to Norcross (2005b):

Psychotherapy integration is characterized by dissatisfaction with single-school approaches and a concomitant desire to look across school boundaries to see what can be learned from other ways of conducting psychotherapy. The ultimate outcome of doing so is to enhance the efficacy, efficiency, and applicability of psychotherapy. (pp. 3–4)

PATHWAYS TO PSYCHOTHERAPY INTEGRATION

This section provides an overview of how theorists and practitioners have tried to integrate the various theoretical approaches to therapy. Perhaps in examining how others have integrated their therapy with different concepts and techniques, you might feel more comfortable in thinking about how you might pursue this same avenue. Clinicians have used a number of ways to integrate

the various counseling theories or psychotherapy, including technical eclecticism, theoretical integration, assimilative integration, common factors, multitheoretical psychotherapy, and helping skills integration (Norcross & Goldfried, 2005).

Definition of Eclecticism

Eclecticism may be defined as an approach to thought that does not hold rigidly to any single paradigm or any single set of assumptions, but rather draws upon multiple theories to gain insight into phenomena. Eclectics are sometimes criticized for lack of consistency in their thinking. For instance, many psychologists accept some features of behaviorism, yet they do not attempt to use the theory to explain all aspects of client behavior. Eclecticism in psychology has been caused by the belief that many factors influence human behavior; therefore, it is important to examine a client from a number of theoretical perspectives (Goldfried, Pachankis, & Bell, 2005).

What are some differences between eclecticism and psychotherapy integration? Typically, eclectic therapists do not need or have a theoretical basis for either understanding or using a specific technique. They chose a counseling technique because of its efficacy, because it works. For instance, an eclectic therapist might experience a positive change in a client after using a specified counseling technique, yet not investigate any further why the positive change occurred. In contrast, an integrative therapist would investigate the how and why of client change. Did the client change

Inner Reflections

Key Points in the Integrative Movement

What key developments stand out in your mind about the integrative movement in psychotherapy?

Thoughts about theory integration date back to the 1930s and 1940s. In your opinion, what took so long for the movement to reach its current status?

because she was trying to please the therapist or was she instead becoming more self-directed and empowered?

Integrative and eclectic therapists also differ in the extent to which they adhere to a set of guiding, theoretical principles and view therapy change. Practitioners who call themselves eclectic appear to have little in common, and they do not seem to subscribe to any common set of principles. In contrast, integrationists are concerned not only with what works but why it works. Moreover, clinicians who say they are eclectic tend to be older and more experienced than those who describe themselves as integrationists. This difference is fast disappearing because some graduate schools are beginning to train psychologists to be integrationists (Norcross & Goldfried, 2005). It is noteworthy, however, that practitioners ascribe to eclecticism/integration more frequently than academic and training faculty do (Norcross & Goldfried, 2005). Hence, it may take a while for therapist training programs to move toward integration of theory.

Theoretical Integration

Theoretical integration is perhaps the most difficult and sophisticated of the three types of psychotherapy integration because it involves bringing together theoretical concepts from disparate theoretical approaches, some of which may present contrasting worldviews. The goal is to integrate not just therapy techniques but also the psychotherapeutic theories involved as Dollard and Miller (1950) did with psychoanalysis and behavior therapy. Proponents of theoretical integration maintain that it offers new perspectives at the levels of theory and practice because it entails a synthesis of different models of personality functioning, psychopathology, and psychological change.

Assimilative Integration

The assimilative integration approach to psychotherapy involves grounding oneself in one system

of psychotherapy but with a view toward selectively incorporating (assimilating) practices and views from other systems. Assimilative integrationists use a single, coherent theoretical system as its core, but they borrow from a broad range of technical interventions from multiple systems. Practitioners who have labeled themselves as assimilative integrationists are: (1) Gold (1996), who proposed assimilative psychodynamic therapy; (2) Castonguay et al. (2004), who have advocated cognitive-behavioral assimilative therapy; and (3) Safran, who has proposed interpersonal and cognitive assimilative therapy (Safran & Segal, 1990/1996).

Assimilative integrationists believe integration should take place at the practice level rather than at the theory level. Most therapists have been trained in a single theoretical approach, and over time many gradually incorporate techniques and methods of other approaches (Goldfried, 2001; Dryden & Spurling, 1989). Typically, therapists do not totally eliminate the theoretical framework in which they were trained. Instead, they tend to add techniques and different ways of viewing individuals.

The Common Factor Approach

The common factors approach has been influenced by the research and scholarships of such renowned leaders in psychotherapy as Jerome Frank (1973, 1974) and Carl Rogers (1951, 1957). Clearly, Rogers' contributions to common factors research has become so accepted by clinicians throughout the world that his core conditions (or necessary and sufficient conditions to effect change in clients) have become part of the early training of most helping professionals (Rogers, 1951). Researchers and theorists have transformed Rogers' necessary and sufficient conditions into a broader concept that has become known as "therapeutic alliance" (Hubble, Duncan, & Miller, 1999). The therapeutic alliance is important across the various counseling theory schools; it is the glue that keeps the person coming to therapy week after week. Currently, more than 1,000 studies have been reported on the therapeutic alliance (Hubble, Duncan, & Miller,

1999). In describing the common factor approach, Norcross (2005b, p. 9) has stated:

The common factors approach seeks to determine the core ingredients that different therapies share in common, with the eventual goal of creating more parsimonious and efficacious treatments based on their commonalities. This search is predicated on the belief that commonalities are more important in accounting for therapy outcome than the unique factors that differentiate among them.

MULTITHEORETICAL APPROACHES

Recently, therapists have developed multitheoretical approaches to therapy. Multitheoretical frameworks do not attempt to synthesize two or more theories at the theoretical level. Instead, there is an effort to “bring some order to the chaotic diversity in the field of psychotherapy and “preserve the valuable insights of major systems of psychotherapy” (Prochaska & DiClemente, 2005, p. 148). *The goal of multitheoretical approaches is to provide a framework that one can use for using two or more theories.* Two examples of multitheoretical frameworks are (1) the transtheoretical approach by Prochaska and DiClemente (1984, 2005), and (2) multitheoretical therapy by Brooks-Harris (2008).

The Transtheoretical Model

The most widely recognized model using a multitheoretical framework has been the transtheoretical model developed by Prochaska and DiClemente (1984, 2005). The transtheoretical model is a model of behavioral change, which has been the basis for developing effective interventions to promote healthy behavior change. Key constructs are integrated from other counseling theories. The model describes how clients modify a problem behavior or how they develop a positive behavior. The central organizing construct of the model is the stages of change. The theorists maintain that change takes place through five basic stages: (1) precontemplation,

(2) contemplation, (3) preparation, (4) action, and (5) maintenance.

In the precontemplation stage, people are not intending to take action in the foreseeable future, usually measured as the next 6 months. During the contemplation stage, people are intending to change within the next 6 months. In the preparation stage, clients are intending to take action in the immediate future, usually measured as the next month. Clients in the action stage have made specific overt modifications in their life styles within the past 6 months. During the maintenance stage, clients work to prevent relapse, a stage which is estimated to last from 6 months to about 5 years. The termination stage of change contains clients who have zero temptation and 100% self-efficacy. They are confident they will not return to their old unhealthy habit as a way of coping.

The transtheoretical model also proposes 10 processes of change, which are the covert and overt activities that people use to progress through the stages. The first 5 processes involve experiential processes of change, while the last 5 are labeled behavioral processes, and these are used primarily for later-stage transitions. For instance, during the experiential processes of change, people experience consciousness raising (“I remember information people gave me about how to stop smoking”) and social liberation (“I find society changing in ways that make it easier for me to be a nonsmoker”). The 5 behavioral processes of change range from (6) stimulus control to (8) counterconditioning (“I do other things with my hands to stop smoking”) to (10) self-liberation (“I make commitments not to smoke”).

The transtheoretical model does not make assumptions about how ready clients are for change in their lives. The model proposes that different individuals will be in different stages and that appropriate interventions must be developed for clients based on their stages of development. The transtheoretical model assumes that the different systems of psychotherapy are complementary and that different theories emphasize different stages and levels of change.

Brooks-Harris' Multitheoretical Model

The most recent multitheoretical model for psychotherapy comes from Brooks-Harris, who provides a framework that describes how different psychotherapy systems come together. Brooks-Harris (2008) begins with the premise that thoughts, actions, and feelings interact with one another and that they are influenced by biological, interpersonal, systemic, and cultural contexts.

Given this overarching premise, he integrates the following theoretical approaches: (1) cognitive, (2) behavioral, (3) experiential, (4) biopsychosocial, (5) psychodynamic, (6) systemic, and (7) multicultural. A brief explanation of each of these areas is provided below. His framework emphasizes at what point a therapist might consider using elements of psychodynamic theory or multicultural theory. A major umbrella in multicultural psychotherapy consists of the focal dimensions for therapy and key strategies.

MULTITHEORETICAL PSYCHOTHERAPY

- Cognitive strategies deal with the focal dimension of clients' functional and dysfunctional thoughts.
- Behavioral skills—focal dimension of actions encourage effective client actions to deal with challenges.
- Experiential interventions result in adaptive feelings.
- Biopsychosocial strategies emphasize biology and adaptive health practices.
- Psychodynamic-interpersonal skills are used to explore clients' interpersonal patterns and promote undistorted perceptions.
- Systemic-constructivist interventions examine the impact of social systems and support adaptive personal narratives.
- Multicultural-feminist strategies explore the cultural contexts of clients' issues.

Brooks-Harris (2008) presents five principles for psychotherapy integration, which include (1) intentional integration, (2) multidimensional integration, (3) multitheoretical integration, (4) strategy-based integration, and (5) relational integration. The first principle says that psychotherapy integration should be based on intentional choices. The therapist's intentionality guides his or her focus, conceptualization, and intervention strategies. Principle two (multidimensional) proposes that therapists should recognize the rich interaction between multiple dimensions.

The third principle asserts that therapists take into consideration diverse theories to understand their clients and guide their interventions. The fourth strategy-based principle states that therapists combine specific strategies from different theories.

Strategy-based integration uses a pragmatic philosophy. Underlying theories do not have to be reconciled. The fifth or relational principle proposes that the first four principles must be enacted within an effective therapeutic relationship.

Brooks-Harris' (2008) model offers a good plan for therapists seeking to implement an integrative multitheoretical approach. He outlines strategies for each of the seven core areas. For instance, cognitive strategies should encourage functional thoughts that are rational and that promote healthy adaptation to the environment. In addition, he enumerates a catalog of 15 key cognitive strategies, which include identifying thoughts, clarifying the impact of thoughts, challenging irrational thoughts, providing psychoeducation, and supporting bibliotherapy. To integrate behavioral

Inner Reflections

Pathways to Psychotherapy Integration

Which pathway to psychotherapy integration do you choose—eclecticism, assimilative integration, theoretical integration, multitheoretical framework?

Do you have any particular reasons for choosing your designated pathway to psychotherapy integration?

therapy into one's practice, he suggests some of the following catalog of key strategies: assigning homework, constructing a hierarchy, providing training and rehearsal, determining baselines, and schedules of reinforcement.

Integrative treatment planning. The multitheoretical psychotherapy (MTP) model offers a step-by-step method to engage in **integrative treat-**

ment planning. The first three steps emphasize using the multidimensional manner and the therapist's need to make intentional choices about the use of multitheoretical strategies. The last two steps emphasize using the catalog of key strategies during the psychotherapy process. **Step one** involves watching for multidimensional focus markers. As clients tell their stories and describe their concerns, therapists listen for markers that reveal clients' areas of concerns. The therapist uses the Focus Marker Checklist, which is available on the web in the treatment resources section of <http://www.multitheoretical.com>.

Step two involves conducting a multidimensional survey to explore the seven dimensions in a structured manner: (1) thoughts, (2) actions, (3) feelings, (4) biology, (5) interpersonal patterns, (6) social systems, and (7) cultural contexts. Brooks-Harris (2008) suggests that the therapist conduct a multidimensional survey (examine the seven areas to determine which area is of most concern to the client). **Step three** emphasizes establishing an interactive focus on two or three dimensions. After the therapist surveys the client's problems in terms of all seven dimensions, the therapist and client collaboratively identify two or three salient dimensions that will form

the initial focus of therapy. **Step four** entails formulating a multitheoretical conceptualization of the client's problem. A summary of multitheoretical conceptualization is provided on the web in the treatment resources section of <http://www.multitheoretical.com>. **Step five** involves choosing interventions from a catalog of key strategies for each of the seven areas of client functioning. A summary of the catalog of key strategies is also found on the theory's website.

The multitheoretical model of psychotherapy gives the example of Claire, a Japanese-American female in her 50s who is experiencing symptoms of depression after the death of her mother, a little over a year ago. The client is the oldest of three daughters; she has never married, lived with her mother, and was the primary caretaker while her mother was dying. Claire's multidimensional survey will examine the seven core areas Brooks-Harris outlines. Claire's:

Thoughts: "I am having difficulty going on without my mother."

Actions: Withdrawal and social isolation from family and friends

Feelings: Despair, hopelessness, numbing sense of being

Biology: Decreased appetite and trouble sleeping

Interpersonal: Claire's focus on being her mother's favorite child

Social: Claire competed with her sisters growing up. Her father was emotionally distant.

Cultural: In the Japanese-American tradition, the eldest takes care of her parents.

After surveying all seven dimensions of the multitheoretical model, the therapist selects two or three that will function as the initial focus for psychotherapy. He or she consults with Claire to determine the two dimensions on which she would like to work. Claire chooses her feelings of hopelessness and despair and her interpersonal patterns—the fact that her close relationship with

her mother got in the way of her developing other sources of social support. For each focal dimension, the therapist chooses an existing theoretical school. For instance, to deal with the feeling conceptualization of Claire's issue, the therapist selects emotion-focused therapy. The therapeutic goal is to help Claire explore and express her sadness in more adaptive ways. To deal with her core conflictual relationship theme, the therapist uses psychodynamic conceptualizations. The therapist identifies relationship themes with Claire by exploring childhood experiences and her adaptations to interpersonal losses. The therapist uses the Key Strategies information provided on the website <http://www.multitheoretical.com>.

Evidence-Based Therapy and Integrative Practice

Regardless of whether a therapist uses an integrative approach or one based on a single therapy school, he or she will have to take into consideration whether or not empirical support exists for a chosen treatment approach (American Psychological Association, 2006). Evidence-based practice (EBP) is a combination of learning what treatments work based on the best available research and taking into account clients' culture and treatment issues. The American Psychological Association (2006, p. 273) conceptualizes evidence-based practice as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences." Evidence-based practice emphasizes the results of experimental comparisons to document the efficacy of treatments against untreated control groups, against other treatments, or both.

The arguments in favor of EBP are reasonable. First, clients have a right to treatments that have been proven to be effective (Gibbs, 2003). Second, managed care requires counselor accountability in choosing a method of treatment. Increasingly, counselors may have to consult with research studies to determine which approach is the most efficacious with what mental health disorder (Gibbs, 2003). Helping

professionals may be required to answer for using a therapeutic approach with a specific disorder.

Twenty years ago, few therapists would have been concerned about whether or not their theoretical approach had accumulated much research evidence to support treatment of a particular disorder. However, conditions have changed in the world of therapy. Therapists must now

be able to not only articulate a psychotherapeutic orientation, but ethical issues are now also being raised about one's choice of orientation for specific mental disorders.

Evidence-based treatment presents several ethical issues to clinicians. First, do you know what evidence exists to support your psychotherapeutic treatment of clients? What research evidence exists to demonstrate that your theoretical perspective and interventions actually do work and help clients recover from their disorders? Are you familiar with the treatments that have been found to be empirically supported in the psychotherapeutic literature? Or, do you use the same theoretical approach, regardless of the client's presenting problem or disorder? How ethical is it for you to use your theoretical approach when one examines it in terms of its treatment efficacy?

How does a therapist implement EBP in practice? The therapist must gather research that informs him or her about what works in psychotherapy. Such information should be obtained *before treatment is begun*. There are several major resources for evidence-based practice. For instance, the Cochrane Collaboration (<http://www.cochrane.org>) sets

Inner Reflections

Theories You Want to Integrate

Have you given any thought to the counseling theories you might want to integrate in your approach to therapy?

Is there any particular school of therapy—psychodynamic, existential-humanistic, cognitive-behavioral, or constructivist—that you feel resonates with you?

standards for reviews of medical, health, and mental health treatments and provides “systematic reviews” of related research by disorder. The Cochrane Collaboration is an international, independent, not-for-profit organization of over 28,000 contributors from more than 100 countries, dedicated to making up-to-date, accurate information about the effects of health care readily available worldwide. The Cochrane Reviews contain systematic health care interventions that are published online in The Cochrane Library. Cochrane Reviews are designed to help providers, practitioners, and patients make informed decisions about health care and are the most comprehensive, reliable, and relevant source of evidence on which to base these decisions. Moreover, the United States government also offers treatment guidelines based on EBP principles at the National Guideline Clearinghouse (<http://www.guideline.gov/>). This site contains very good information on medication.

Other online resources for EBP and treatment guidelines include the American Psychiatric Association (APA), which offers practice guidelines for mental health (http://www.psych.org/psych_pract/treatg/pg.prac_guide.cfm). Another way of accessing practice guidelines is to go to the American Psychiatric Association website and type in the words “Practice Guidelines.” This page links to the complete text of all APA practice guidelines published on PsychiatryOnline, which gives additional resources for each guideline. Evidence-based practice guidelines are available for the following mental health disorders: Acute stress disorder and posttraumatic stress disorder, Alzheimer’s disease and other dementias, bipolar disorder, borderline personality disorder, eating disorders, major depressive disorder, obsessive-compulsive disorder, panic disorder, and suicidal behaviors. Part A of every APA practice guideline is initially published as a supplement to the *American Journal of Psychiatry*. For the treatment of children and adolescents with mental health disorders, practice parameters may be obtained from the American Academy of Child and Adolescent Psychiatry.

Helping Skills Approach to Integration

Clara Hill (2004) has provided a helping skills model to therapy integration. Her model describes three stages of the helping process that are based on different therapy schools. For instance, the first stage of helping is labeled *exploration*. Using Rogers’ client-centered therapy as the therapy school of choice, Hill (2004) emphasizes the counseling skills of attending, listening, and reflection of feelings. The second stage is termed *insight*, and this stage is based on psychoanalytic theory; therefore, such skills as interpreting and dealing with transference are stressed. The third stage is termed the *action stage*, and this stage is based largely on cognitive-behavioral techniques. Using the helping skills model, training would focus on teaching graduate students techniques associated with each of these three therapeutic schools.

The Outlook for Psychotherapy Schools and Therapy Integration

What does the future look like for psychotherapy schools that have been presented in this book? Norcross, Hedges, and Prochaska (2002) and Norcross, Hedges, and Castle (2002) used a Delphi poll to predict the future of psychotherapy over the next decade. The experts who served as participants in the poll predicted that the following theoretical schools would increase the most: cognitive-behavior therapy, culture-sensitive multicultural counseling, Beck’s cognitive therapy, interpersonal therapy, family systems therapy, behavior therapy, technical eclecticism, solution-focused therapy, and exposure therapies. Therapy orientations that were predicted to decrease the most included classical psychoanalysis, implosive therapy, Jungian therapy, transactional analysis, humanistic therapies, and Adlerian therapy. The poll also showed how psychotherapy is changing:

The consensus is that psychotherapy will become more directive, psychoeducational, technological, problem-focused, and briefer in the next decade. Concomitantly, relatively unstructured, historically oriented, and long-term approaches are predicted to decrease . . . Short term is in, and long term on its way out. (Prochaska & Norcross, 2003, p. 545)

The movement toward short-term therapy is one that was fairly easy to predict. Insurance companies will not pay for long-term treatment. Therefore, therapists have had to change their treatment focus and their estimate of the amount of time necessary to bring about client improvement. Moreover, long-term therapy focuses on fundamental change in a person's overall functioning. In contrast, short-term therapy seeks small change that is pragmatic to help clients deal with a presenting issue—it does not focus on “curing” a client. Whereas long-term therapy views the presenting problem as reflecting more basic client pathology, short-term therapy emphasizes clients' strengths and resources. Insurance companies are not interested in having a therapist to be there for clients while they make significant changes in their lives. On the contrary, they accept the reality that many changes will take place after therapy and will not be observable to the therapist.

In addition, insurance companies' demand for evidence-based practice is likely to increase, and therapeutic approaches that lack a sufficient evidence-based record will not be reimbursed. Psychoanalytically oriented and existential-humanistic approaches have a very limited evidence-based record upon which to build. I predict there will increasingly be a focus on manualized therapy. Therapists will be able to purchase books or manuals that describe the steps to take for a specific problem, life challenge, or disorder. Manualized treatment will most likely be evidence-based or empirically supported treatment. Therefore, it is important for beginning therapists to become aware of evidence-based, manualized treatment for specific mental disorders. A failure

to use such treatment approaches could possibly lead to law suits centering on “failure to provide a basic standard of care.”

I disagree that there will be an increasing emphasis on problem-focused therapy. Both strengths-based and positive psychology have spread throughout the world. Many federally supported programs for youth and their families are requiring a strengths-based rather than a problem-focused orientation. Much of this shift is being caused by recent empirical studies showing the value and importance of positive emotions. If researchers develop a diagnostic manual that is based on positive client emotions, there will most likely be a decrease in clinicians' emphasis on problem-focused disorders. It is clear, however, that psychotherapy integration will become the most frequently cited approach to therapy. The cognitive-behavioral school will continue to be the most dominant because it has provided the most empirically supported evidence for its effectiveness.

Toward Developing Your Own Approach to Integrative Psychotherapy

Yalom (1989) has pointed out that theories of psychotherapy are developed to reduce the counselor's anxiety in dealing with the complexities and the uncertainties of the therapeutic process. The theories discussed in this book are designed to help you view how others have conceptualized the therapeutic situation. Only you can decide how you will go about constructing your own personal, integrative approach to therapy.

Constructing your own approach to psychotherapy is a lifelong process, one that is begun in graduate school and continued throughout your professional career. It is my strong belief that graduate training is only the first step in becoming a therapist. It takes a certain amount of experience for you to truly develop your own integrative approach to therapy.

You begin the journey toward developing your own integrative therapy approach in graduate school when you are faced with trying to read and understand the various major systems of psychotherapy. As Yalom (1989) so aptly pointed out, having a theory helps to quiet our own anxiety. I also believe that having our own integrated theory of therapy helps the client who seeks our assistance.

For the most part, I concur with Brooks-Harris' multitheoretical framework for developing an integrative approach to therapy. Movement toward your own integrative theory should be intentional

rather than haphazard—guided by forethought and completed with client consultation. Your integrative approach to therapy should be informed by your training, clinical experience, and research. In contrast to the multitheoretical therapy framework, I propose five additional categories: (1) spiritual, (2) relational (similar to Brooks-Harris' interpersonal), (3) strengths—internal and external, (4) evidence-based research, and (5) change process. More specifically, my own personal multitheoretical framework takes into account the following conceptual areas to form an integrative therapy approach.

ANOTHER MULTITHEORETICAL FRAMEWORK FOR INTEGRATIVE TREATMENT

- Cognitive conceptualizations or the role of cognitions with clients
- Affect or the influence of clients' feelings on issues
- Body—energy and health issues—holistic nature of mind and body
- Relational—all living is relational and most problems have a relational component
- Spiritual—we do not live by bread alone, influence of religion. There is increasing empirical evidence that our spiritual values and behaviors can promote physical and psychological well-being (Richards & Bergin, 1997; Richards, Rector, & Tjelveit, 1999).
- Multicultural—we live within a cultural context
- Systemic influences (political system, economic system, racism, sexism)
- Evidence-based research or empirical support for counseling interventions
- Change process—how clients are motivated to change and the change process

Guideline Questions to Help You in Choosing a Therapy Orientation

What are some guidelines for constructing an integrative theory of counseling and psychotherapy? First, you should be able to have a working knowledge of the particular theories from which you will draw and a basic description of why each theory is important and relevant to you as a mental health

counselor or therapist. It helps to write out your own integrated approach to counseling. You should demonstrate a balance between your knowledge of the particular theories from which you select and a genuine description of why each theory is important and relevant to you as a clinician or therapist. It is important that you examine in depth your reasons for choosing each theory. The following questions are designed to help you think about the core counseling theory that you are initially adopting.

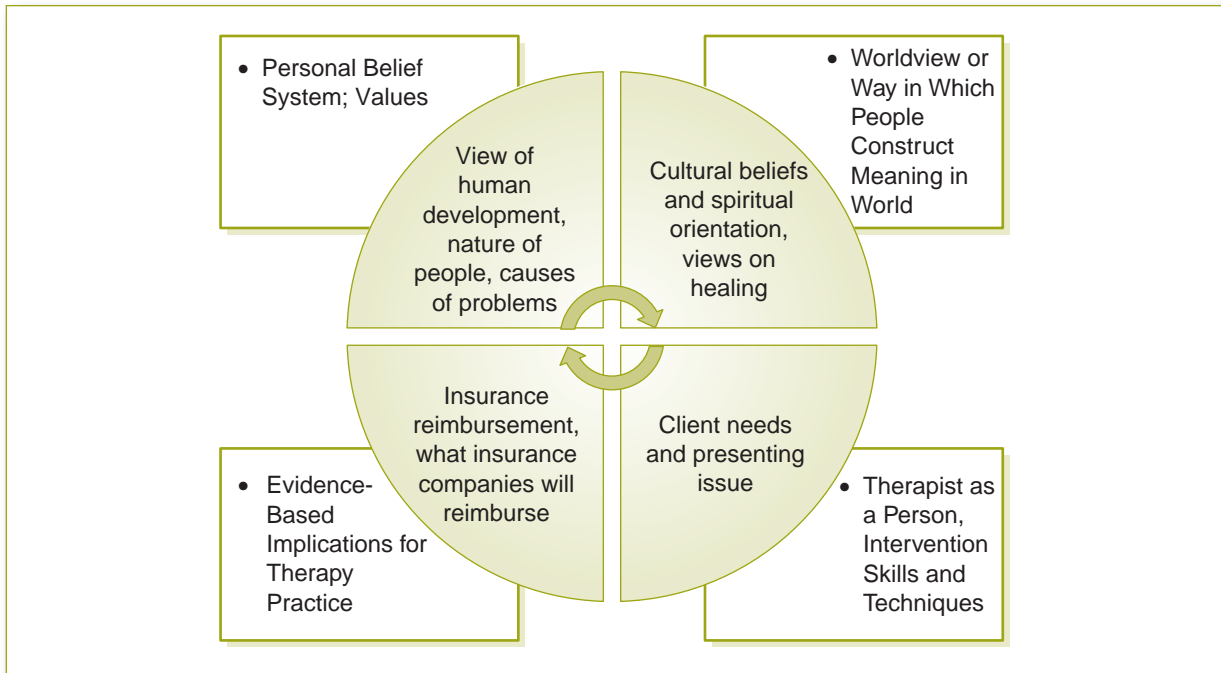
YOUR KNOWLEDGE OF PSYCHOTHERAPY THEORIES

1. What are four basic concepts from the theory you are adopting as your core or base theory?
2. What constitutes a problem in your core counseling theory?
3. What are the goals of counseling for the theoretical approach you have chosen?
4. Who establishes the goals in counseling?
5. What is the nature of the relationship between you and the client?
6. What competencies must you have to carry out your role as therapist/counselor?
7. What are the responsibilities of clients during counseling? What is expected of clients?
8. What can the client expect from the therapist—from you?
9. What is your position on therapist self-disclosure?
10. What are some of the main values held by a counselor with your theoretical approach?
11. Using the theories you have selected to be integrated in your therapy approach, how do you want to be as a clinician?
12. How comfortable are you in expressing your emotions during counseling?
13. What is it about your personality and your personal history that leads you to believe that a particular theory or group of theories form a goodness of fit for you?
14. How have your personal ground, personal attributes, and life experiences affected your choice of a personal theory of counseling?
15. What techniques will you use from your chosen theory or group of theories?
16. How does your theory take into account diverse cultural groups?
17. How does your theory take into consideration political, social, and economic factors that lie outside the client—external factors?

Second, after you have developed a working knowledge of the particular counseling theories from which you will select, take into account your worldview or your basic way of understanding the world. I offer the following as a beginning framework (Smith © 2010) for incorporating your worldview, personal

values, and therapeutic intervention skills into your personal, integrative approach to counseling.

Your worldview will have a significant impact on how you conduct counseling. The following contains some questions to help you sort out your worldview.



(© Elsie Jones-Smith, 2012)

WORLDVIEW OR WAY OF UNDERSTANDING CLIENTS AND THE WORLD

18. What is your view of human nature? Which counseling theory best suits your view of human nature?
19. In the area of free will/determinism, to what extent do people direct their own actions, or are we governed by other forces outside of our awareness or control?
20. Nature/nurture: To what degree are people influenced by heredity (nature) and/or by their environment (nurture)?
21. Past/present orientation: To what degree are people controlled by early events in their lives and/or affected by later life experiences? What is the significance of the past, present, and future in governing human behaviors? Are we prisoners of our past, or can we work to free ourselves from our past?
22. What are some of the basic assumptions you have about people, and what theoretical approach to therapy best deals with your views on this topic?

Therapy deals with clients' thoughts, feelings, and behaviors. The next group of questions you might ask yourself in formulating an integrative approach to therapy deals with the relationship between cognition, affect, and behavior. Which counseling theory has a goodness of fit with your

views on the role of cognition, affect, and behavior? This group of questions also focuses on change, especially as it relates to the therapeutic process. How is behavior changed in the therapy session? Some questions that deal with these issues are presented in the table below.

COGNITION, AFFECT, AND BEHAVIOR

23. How do people's thoughts (cognitions) and affect (feelings) influence their behavior? Which counseling theories best reflect your views on the role of cognitions and affect on clients' behavior?
24. How are these three dimensions interrelated?
25. What motivates people?
26. What cognitive strategies do you use to encourage functional or positive thoughts with your clients?
27. What kinds of experiential interventions do you feel comfortable in using with clients to explore their feelings?
28. Where do clients' maladaptive thoughts, feelings, or behaviors come from?
29. What are some basic assumptions/beliefs about change underlying your approach?

Another set of variables includes personality development, maladaptive and adaptive behavior, and mental disorders. What counseling theories support your ideas regarding these variables? It might be helpful for you

to write out simple statements. "I believe that maladaptive behavior is caused by [blank], and I choose [blank] theory as my frame of reference on personality development or maladaptive behavior."

VIEWS OF DEVELOPMENTAL PERIODS, ADAPTIVE AND MALADAPTIVE BEHAVIOR

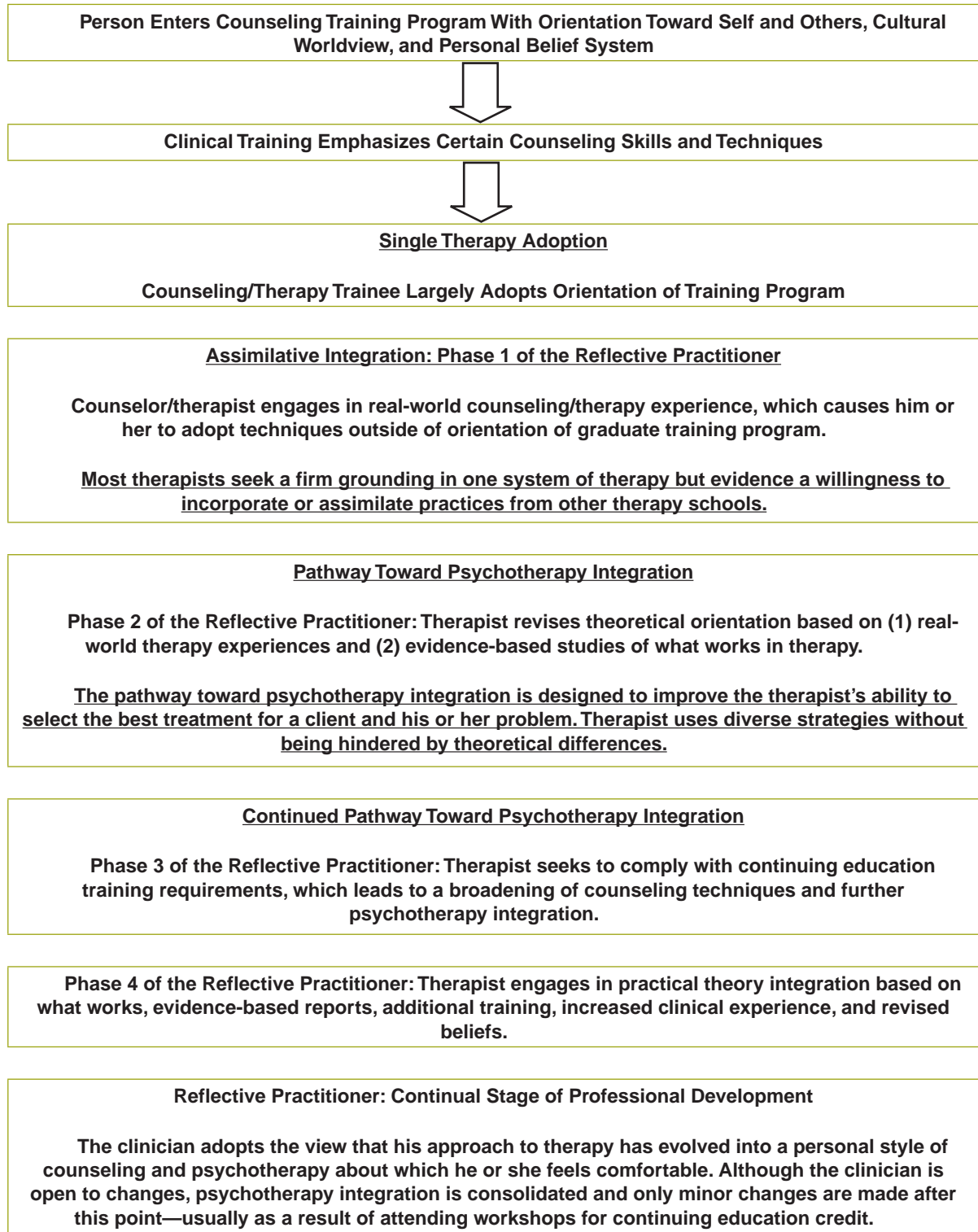
30. Are there critical periods in a person's life development? If so, what are they?
31. How do individuals develop mental or emotional disorders?
32. What causes mental or emotional disorders and healthy development?
33. Using your current theoretical approach, what constitutes a problem for clients?

Stages in Developing an Integrated Theory of Counseling

The questions presented in the foregoing section are not exhaustive. Rather, they represent a beginning point for you to think about yourself as a therapist. Becoming a therapist is not an easy journey. There is

a great deal of work involved, including much self-introspection, experience, and training. Sometimes it is helpful to understand what the journey might look like in becoming a therapist or a counselor. Therefore, I have outlined the following stages that the typical therapist goes through in developing his or her own integrated approach to therapy.

STAGES OF PROFESSIONAL DEVELOPMENT AS A THERAPIST _____



The Reflective Practitioner and Therapist Effectiveness

One of the goals of this chapter is to help you start the process of becoming a reflective practitioner. I maintain that an effective therapist is essentially a reflective therapist in the tradition described by (Schon, 1983, 1987). In his seminal work, Schon (1983) emphasized the role of self-reflection in the training of professional practitioners. He proposed that the knowledge needed for competence in the professions is twofold: (1) technical-rational knowledge (e.g., the learning of counseling theories, the learning of treatment protocols), and (2) professional artistry (e.g., sensitivity to the dynamics of the therapeutic relationship, timing of interventions, and the instillation of hope). Schon maintained that while technical-rational knowledge can be (and typically is) conveyed by didactic procedures, the knowledge required for professional artistry is often tacit, the product of experience, and is best assessed by practitioner self-reflection. Schon's ideas regarding the value of self-reflection have been used in a number of fields, including medicine, social work, counseling, and teaching (Fook, 1996; Kressel, 1997; Niemi, 1997; Schon, 1987).

Schon's reflective practitioner model presents a framework for decision making and problem solving. A Harvard-educated man, Schon was critical of the traditional teaching methods adopted in many universities. From his perspective, universities used the technical-rational approach, in which students first studied basic science, then the relevant applied science, before finally applying their learning to real-life problems. Schon believed this approach bore little resemblance to reality and did not equip professionals with the training needed to solve the practical problems they encountered in their daily practice.

In contrast to the rationality approach, Schon discovered that when effective practitioners were confronted with a problem in their practice, they instinctively worked through it, drawing upon previous similar experiences. Using a mixture of knowing and doing, practitioners tended to try

out various solutions until they resolved the issue. Schon labeled this process *reflection in action* and coined the term *theory in use* to describe the nature of the reflective activity in which the practitioner was engaged. According to Schon (1983, 1987), this type of practitioner problem-solving was an intuitive rejection of the textbook that effective practitioners had been taught during their professional training. Schon labeled this formalized approach *the practitioner's espoused theory*. He argued that it was the practitioner's ability to reflect, both in and on action, that separated the effective practitioner from less effective professionals.

Undoubtedly, Schon left an enduring legacy that has had a major impact on professional education and training programs. One of his accomplishments was that he highlighted the importance of the practical experience in the learning process. Another major contribution was that he challenged the view that theory is a privileged form of knowledge. Each one of us constructs on a daily basis our theories of the world and of the people with whom we work. Each therapist goes through a process of continually constructing his or her own theory of counseling or psychotherapy, and perhaps that is one reason a number of studies have reported that the average American therapist is an eclectic or an integrative therapist rather than a therapist of a single theoretical school. A third major contribution of Schon was that he recognized the difference between a practitioner's formal theory and his espoused theory. Much more will be said about this point in an ensuing section.

Schon's reflective practitioner model has implications for both therapist training and practice. Self-reflection produces a deeper sense of knowing than traditional didactic teaching. I recommend that practicum and training courses for counselors and psychologists contain a self-reflection component to increase therapists' therapeutic artistry. Training programs that do not include a self-reflection component tend to be more logical, evidential, and analytical. Training from such programs appeals predominantly to students' rational systems, and information learned may be less deeply embedded than experiential learning.

Conversely, if programs include a self-reflection component, students may be exposed to greater emotion (both within themselves and from other students undergoing the same training) that triggers their experiential system, and hence, a deeper level of encoding and realization. Self-reflective practitioners are usually effective therapists because they take time to integrate their knowledge with therapeutic experiences. Their self-reflection allows them to weed out techniques and approaches that have not worked for them and include those that have.

The Therapist's Implicit Theory as Opposed to Explicit or Formal Theory

Schon's (1983, 1987) work on formal and espoused theory has helped pave the way for current conceptualizations in psychology involving a therapist's implicit and explicit theory (Najavits, 1997). Lambert (1989) has pointed out that although the single most predominant way to define therapists is by their theoretical orientation, such orientations have been found unusually limited in their capacity to predict outcomes of treatment for clients. This finding is further supported by studies that show that therapists of the same orientation differ widely in their processes and impact on clients (Luborsky et al., 1986; Najavits & Strupp, 1994), while on the other hand, therapists of different theoretical orientations have been found highly similar in their therapeutic styles and outcomes (Smith, Glass, & Miller, 1980).

The concept of therapists' "implicit theories of psychotherapy" is important to consider in a course on theories of psychotherapy, because as pointed out in the section on the reflective practitioner, therapists construct their own theories of counseling as they develop their clinical skills and practices. Researchers have observed many times that therapists develop "implicit theories" in addition to the explicit theories to which they subscribe (Burrell, 1987; Kottler, 1986; Schon, 1983). An explicit theory

usually represents a theoretical orientation of some school of thought.

Therapists' implicit theories may be conscious, preconscious, or unconscious. Implicit theories refer to the therapist's tacit assumptions. They can be distinguished from the formal propositions of the various psychotherapy schools—psychoanalytic, Gestalt, psychodynamic, cognitive-behaviorist. According to Sternberg (1985), "Implicit theories are constructions by people . . . that reside in the minds of these individuals. Such theories need to be discovered rather than invented because they already exist in some form, in people's heads" (p. 448). Likewise, Kottler (1986) has suggested implicit theories are a part of all therapists, whether we like it or not. From his view:

All therapists are theoreticians. We harbor our own unique ideas about how the world works and how therapy ought to be conducted. No matter what school of thought we align ourselves with, we have our own individual notions about how . . . to work. (p. 137)

Scholars have offered various definitions of implicit theories. Najavits (1997, p. 4) has defined a therapist's implicit theory "as therapists' private assumptions or 'working model' about how to conduct psychotherapy that is distinct from, but coexists with, formal theoretical orientations." An implicit theory of psychotherapy is that the assumptions the therapist subscribes to about therapy are distinct from any formal therapy theoretical orientation. A therapist's implicit theory might include personal strategies on what to do during therapy sessions, such as Reik's (1956) emphasis on listening with the third ear for elements of surprise in the client's report, or Kottler's (1986) statement on taking risks in therapy.

Moreover, a therapist's implicit theory might consist of his or her views on what to do or what not to do in therapy, such as "I try not to push my clients too hard; they will tell me what's wrong when they are ready." A therapist's implicit theory might contain personal axioms that one has learned growing up, or it might contain what

to do when particular problems arise, or the subjective criteria that one uses to measure the success or failure of therapy. Dolliver (1991), for instance, described his selection of parts of formal theories, plus his own unique views, in an article titled “The Eighteen Ideas Which Most Influence My Therapy.”

As one of the pioneers on therapists’ implicit theory of psychotherapy, Shoben (1962) labeled the therapist’s theory a “personal trait” composed of both explicit theoretical positions (e.g., client centered, behavioral) and implicit assumptions about their therapy. From his perspective, the everyday practitioner developed implicit theories because explicit theories are all too often phrased as abstractions that do not specify how to act in particular cases, or that may even contradict one’s own therapeutic experience. Shoben proposed that therapists differ in the degree to which they rely on their explicit versus implicit therapy theories; and that further, they choose an explicit theory based in part on how well it corresponds with implicit theories about human personality and development. Shoben (1962, pp. 620–621) has admonished that it is important for therapists to become aware of their own implicit theories for therapy.

Since theories are inescapable in the ordering of the data with which we work as counselors, it would seem important to hold them as explicitly as possible and to examine their influence on our judgment and on our professional conduct with . . . unsparing honesty. . . . The counselor who achieves this kind of honesty in dealing with his cognitive self is likely to enjoy a sense of personal growth in his professional life that is denied to others. (pp. 620–621)

Therapists develop implicit theories for various reasons. Sandler (1983) has suggested that therapists develop their own implicit theories of psychotherapy because the formal or explicit theories sometimes are not concerned with the practical problems therapists encounter. He has asserted that

the therapist’s implicit theories may sometimes be superior to the formal or explicit theory for a particular case. In addition, he states that implicit theories give birth to explicit theories. Explicit theories arose because of weaknesses in the available theories and the gradual elucidation of the “partial theories” to complement them. Examples of this phenomena might be the therapists who developed their own theories after disagreeing with Sigmund Freud—Adler, Horney, Sullivan, and so on. In agreement with Sandler, Sternberg (1985) has also indicated that implicit theories are the beginning points for the development of explicit theories. Sandler, an analyst, has written about the conflict some therapists would feel if the world knew about their “real theories.” Commenting on the fact that some therapists attempt to hide their implicit theories, Sandler (1983, pp. 36–37) has stated:

The conscious or unconscious conclusion of many analysts [is] that they do not do “proper” analysis . . . [a] conviction that what is actually done in the consulting room is not “kosher,” that colleagues would criticize it if they knew about it . . . At times he may have to depart quite far from the “standard” technique. He may be very comfortable with this as long as it is private rather than public.

Although psychology originated the concept of implicit theory, there has only been limited research on this topic as it relates to therapists’ theoretical orientations. For example, Deutsch (1984) surveyed 264 therapists on a questionnaire of “irrational beliefs” about conducting therapy (e.g., “I should be able to help every client,” and “I should always work at my peak level of enthusiasm and competence.”). She related these irrational beliefs to stresses that therapists face in their practice, and hypothesized that therapists’ irrational beliefs would contribute to their reported stress. Deutsch found that 40% of the sample rated three specific beliefs (all on perfectionism as a therapist) moderately stressful or higher. In addition, she found significant differences between therapists’ degrees of endorsement of beliefs, and she reported

that some participants spontaneously added their own beliefs to her questionnaire.

Orlinsky (1993) studied the development of therapists over their career spans and found that the greater the discrepancy between therapists' actual versus ideal views of themselves as therapists, the greater was the therapists' subjective experience of difficulties in therapy and the lower their subjective rating of their own skillful performance as a clinician.

Clearly, therapists do develop an implicit theory, perhaps beginning as early as their days of graduate training. The question remains, however: Can the implicit theory concept be used to improve a therapist's effectiveness or create research that would help us understand the variability amongst therapists? It would seem that understanding the therapist's implicit theory is important from several standpoints. First, implicit theories are not simply noise getting in the way of the real, formal or explicit theory. The study of implicit therapist theories may shed some light on therapist variability that may exist either independently of theoretical orientation or alongside it. There may be great similarity between therapists regardless of their theoretical orientation because all share a common implicit theory system that interacts with the explicit theory. In terms of a research study, therapists might be assessed (or they might engage in a process of self-reflection) on what is required to build an alliance with clients and what benchmarks

they personally use to monitor their level of alliance with a client. How are their implicit theories of psychotherapy different from their espoused or explicit theory?

The implicit theory approach also has some training implications. Najavits (1997) has suggested that the theory proposed in a therapy manual may be competing against unspoken, alternative, contradictory beliefs that the therapists already has—namely, the therapist's implicit theory. Perhaps it might be helpful to have therapists in training list their implicit theory first and then to see how it meshes, or enlarges, their explicit theory.

Training programs might consider developing more formal models of examining therapists' implicit beliefs as well as creating methods to assess them. To what extent, for example, do implicit theories of psychotherapy interfere with the material that training programs seek to elucidate? It might be helpful for counselor and therapist trainees to examine their implicit theories about forming relationships and therapeutic alliances, about the role of hope in therapy. Studies might also investigate the relationship of therapists' implicit theories to their counseling outcomes. In other words, the journey toward psychotherapy integration should encompass integrating both therapists' implicit and explicit theories into a coherent framework and not just integrating their explicit psychotherapy theories that they have learned through didactic methods.

CASE STUDY: JUSTIN AND INTEGRATIVE TREATMENT PLANNING

This section provides a general outline of integrative treatment planning with Justin. An in-depth treatment plan is not provided because Justin has already been examined from the perspective of each of the major counseling theories. In most private practices, Justin and his mother would be given an intake form, a professional disclosure statement for his mother, Sandy, to sign because Justin is a minor, and an intake form for Sandy to complete. This section is designed to give you a realistic view of the information that would be required in an intake or initial interview with Justin and his mother. Below is a copy of such an intake form that might be used with Justin.

(Continued)

(Continued)

CHILD AND ADOLESCENT INTAKE FORM

To be filled out by parent or guardian requesting services for a minor child. This information will help your therapist understand your child. This statement will be kept confidential to the extent to which state law permits.

BACKGROUND INFORMATION

Child's name _____ Date of Birth ____/____/____ Age _____

School attending and grade level (if applicable): _____

Child lives with (check one): both biological parents ____ mother ____ father ____ other _____

If parents are divorced, describe custody arrangements: _____

Child's address _____

Emergency contact person (other than parent) _____

Phone number _____ - _____ - _____

Custodial parent's contact information:

Phone _____ (Home) _____ (Cell) _____ (Work) _____ E-mail: _____

INFORMATION ABOUT CHILD'S MOTHER

Mother's name _____ Age _____ Race _____

Employer _____

Occupation _____

Hrs./wk. _____ Can you be contacted at work by phone? Yes No

Circle the best way to contact you:

Phone: _____ / (Home) _____ (Cell) _____ (Work) _____

E-mail _____

Denomination _____ Church _____ Active? Yes

No

INFORMATION ABOUT CHILD'S FATHER

Father's name _____ Age _____

Race _____

Employer _____

Occupation _____

Hrs./wk. _____ Can you be contacted at work by phone? Yes No

Circle the best way to contact:

Phone _____

(Home) (Cell) (Work)

E-mail _____

Denomination _____ Church _____ Active? Yes No

Please list others living in custodian parent's home, including names, ages, and relationship to child:

Legal Issues

Is there any legal involvement with your child? Yes _____ No _____ If so, please describe: _____

Please bring copies of any court orders that are related to your child to our next session.

Has the court ordered that your child seek counseling?

Presenting Problem: Describe the issue your child is having.

Briefly state the problem that brought you here:

How long has this situation been in existence?

Problem Areas: From the following list, please prioritize each item that identifies an area of concern to you that you have for your child. For example, the number 1 would be placed by the item that concerns you the most today.

(Continued)

- | | |
|---|--|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Shyness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Feels hopeless |
| <input type="checkbox"/> Grades, academic performance | <input type="checkbox"/> Fidgety, unable to sit still |
| <input type="checkbox"/> Court trouble, legal issues | <input type="checkbox"/> Daydreams too much |
| <input type="checkbox"/> Inability to get along with other children | <input type="checkbox"/> Takes unnecessary risk |
| <input type="checkbox"/> Bullying—being bullied by other children | <input type="checkbox"/> Blames others for his or her troubles |
| <input type="checkbox"/> Bullying, threatening other children | <input type="checkbox"/> Takes things that do not belong to him or her |
| <input type="checkbox"/> Religious/spiritual concerns | <input type="checkbox"/> School grades dropping |
| <input type="checkbox"/> Developmental issues | <input type="checkbox"/> Distracted easily |
| <input type="checkbox"/> Fights with other children in school | <input type="checkbox"/> Has trouble with his teacher(s) |

How were you referred? _____

What are your reason(s) for seeking therapy? _____

What goals do you have for therapy for your child? _____

Have you sought mental health treatment before for your child? _____ Yes _____ No _____

If so, when and with whom? _____

Current medical doctor/family physician: _____ Phone number: _____

Is your child under medical care for any ailment? Is he or she on any medications? If so, please indicate current medications (type and dosage): _____

Have there been any suicide attempts? (If so, explain) _____

In case of emergency, please notify :

Name: _____ Phone: _____ Relationship: _____

Insurance (The following questions are about the policy holder.)

Policyholder's name: _____ SSN: _____ DOB: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home phone: _____ Cell: _____ Work: _____

Insurance company: _____

Authorization #: _____ Number of sessions authorized: _____ Co-pay: _____

Employer: _____

Job title: _____

Form completed by: _____ Date: _____

Signature: _____

(© Elsie Jones-Smith, 2012)

Information gathered from this form is typically reviewed prior to meeting with clients, although some therapists prefer to see clients immediately after they have completed an intake form. Typically, Sandy would be required to attend the initial counseling session in order to obtain informed consent. The initial counseling session would be used to focus on Justin's presenting problem from an integrative perspective.

Using the Multitheoretical Framework With Justin

After talking with Sandy and Justin, the therapist would use Brooks-Harris' Multitheoretical Dimensional Survey to explore the various dimensions of Justin's issues. For instance, the therapist would search the following seven dimensions to determine where his presenting issue(s) are located: (1) thoughts, (2) actions, and (3) feelings, and the contextual dimensions of (4) biology, (5) interpersonal patterns, (6) social systems, and (7) cultural contexts. Justin's multidimensional survey might reveal that his presenting problem has concurrent dimensions:

Thoughts: "I don't want to be placed in the residential treatment home, 100 or so miles from my mother and brother. (The therapist uses cognitive therapy to conceptualize one dimension of his current issue.)

"It's not my fault I get into fights at school. Kids make smart remarks about me so that I can hear them."

Actions: Social isolation at school because of fighting and inability to control his anger. (Behavior techniques might be appropriate—anger management training.)

Feelings: Low self-esteem. When the therapist asked Justin how he felt about the kids making fun of him in school, Justin responded "sad," "angry, and "hurt." The therapist might consider using concepts from existential-humanistic therapy.

The therapist would also examine the contextual dimensions of Justin's presenting problem, meaning the role of biology, interpersonal relations, systemic issues, and cultural issues. Justin's mother is on welfare, and the family lives in a neighborhood that has a great deal of crime (i.e., gangs, etc.).

Biology—Justin has complained of headaches and trouble sleeping because of his fears of being placed in residential treatment. Because he has trouble sleeping, he overslept twice and was late for his court appointment. It also might be wise to have Justin examined for an attention deficit disorder because he frequently gets out of his seat in school and has difficulty concentrating.

(Continued)

(Continued)

Interpersonal: Justin has made a poor choice of friends outside of school. He hangs around boys much older than he and boys who have gotten into trouble with the law. Justin's brother is in a gang. (Psychodynamic therapy concepts could possibly shed light on Justin's development, especially Erickson's work on psychosocial stages of development.)

Social: Justin tries to hide his feelings of low self-esteem that are fueled by his family's poverty and his feelings that his father abandoned him. (Perhaps concepts from psychodynamic therapy might be useful to deal with issues regarding his mother, Sandy [the "good enough" mother?].)

Cultural: Justin has experienced difficulty with his mixed racial/ethnic heritage—White mother and African American father. (Multicultural counseling theory might prove useful in helping him resolve his personal identity and his ethnic identity in predominantly White Utah.)

After surveying all seven dimensions described above, the therapist chooses two to three areas that will serve as the initial focus for psychotherapy with Justin. The therapist selects the focal dimensions in collaboration with Justin. The therapist asks Justin to notice what takes place in his life regarding the two to three focal dimensions selected for psychotherapy. In addition, the therapist writes down initial hypotheses that are taken from the corresponding theoretical school.

The next step involves choosing interventions from a catalog of key strategies from theories that address the selected focal dimensions. For instance, to address Justin's feelings about his situation, the therapist chooses experiential strategies from the Multitheoretical Therapy website (<http://www.multitheoretical.com>). The catalog of Key Strategies under the experiential theoretical school lists such strategies as exp-10-creating experiments and exp-11, accepting freedom and responsibility. The therapist and Justin collaborate on the effectiveness of therapy and then move to the next focal dimensions for work in psychotherapy. The Multitheoretical Therapy Model offers a useful method for treatment planning from an integrative perspective.

SUMMARY

A major theme was that counseling and psychotherapy are moving toward an integrative approach to psychotherapy. The days of adopting one singular therapy approach and using it for the rest of one's professional development seem to be coming to an end. Psychotherapy integration has become intertwined with the evidence-based movement in stressing that various client problems necessitate that the therapist use different solutions. Moreover, increasingly these solutions can be chosen on the basis of empirical outcome research—what is known as evidence-based studies. One advantage of integrative therapies is that they allow therapists the flexibility to meet the needs of clients who have different presenting issues and who come from a range of cultural contexts.

Psychotherapy integration can take several different paths including assimilative integration,

technical eclecticism, common factors integration, and theoretical integration. Clearly, over the past four to five decades, therapists and researchers have stressed therapy that goes beyond the limited confines of one theoretical school. The movement toward psychotherapy integration encourages therapists to take into consideration the benefits of individual therapeutic approaches. Integrative psychotherapy posits that many treatment methods can be helpful in working with different clients. It is predicted that evidence-based studies will have an important influence on psychotherapy theory integration.

Therapists must understand not only the individual theories so that they can decide for themselves what they feel is appropriate for them, but they also need to establish a multitheoretical or integrative framework from which they can integrate the theories they choose. The framework by Brooks-Harris (2008) offers the simplest route

to developing your own integrative approach. My own preference is to modify his framework to include the spiritual area as well as several mind-body approaches.

Currently, there are few graduate schools that offer an integrative approach to counseling and psychotherapy. Within the next couple of decades, it is predicted that graduate schools will adopt an integrative approach to psychotherapy training because such programs themselves will come under increasing pressure to equip their graduates with therapeutic skills that cross theoretical lines. Ethical guidelines for counselors and psychologists appear to be headed in the direction of requiring therapists to know evidence-based research (what techniques actually work with what clients with what problems) if they are to exercise an appropriate standard of care for their clients.

The effective therapist is a reflective practitioner—one who looks inward to discover who he or she is becoming as a therapist. Theories should guide your therapy practice. Good luck on your journey to becoming a professional counselor/therapist/social worker or mental health worker.

DISCUSSION QUESTIONS AND EXERCISES

Your Personal Journey Toward Psychotherapy Integration

- a. Can you think of any developments in your own life that have led you to choose one theoretical approach over another?
- b. Review the chapters on different approaches to psychotherapy. What therapy schools did you feel closest to?
- c. Have any of your life experiences had an influence on your choice of a therapy school?
- d. What theories are you considering integrating into your own personal approach to psychotherapy? Explain why.

1. Number of Theories to Integrate Into Your Theoretical Approach. How many theories

do you feel comfortable using to conceptualize clients' issues or to guide your therapeutic interventions?

2. The Reflective Practitioner. Reflect back on your own life, with an emphasis on reviewing the various issues and difficulties you have had throughout your life. How might you present yourself as a client? What would you be looking for in your therapist? What therapeutic goals might you establish if you were a client? For what issues might you consider personal counseling prior to engaging in the formal practice of psychotherapy?

3. Disagreements Between the Various Theories of Psychotherapy. In your opinion, what are the various schools of therapy really disagreeing about? Are they describing different features of the same phenomena, disagreeing about the very nature of those phenomena, or discussing completely different phenomena? Are the disagreements in psychotherapy approaches mainly differences in terminology? Choose a theory of psychotherapy with which you disagree. Role-play your arguing for the basic tenets of a theory with which you disagree.

4. Reflection on Therapist Qualities. The purpose of this exercise is to help you identify and assess your own strengths and weaknesses as future therapists and encourage self-reflection and openness in your group. Identify three things about yourself that you believe will assist you in becoming a good therapist. Record these things in your journal.

5. Qualities for Effective Therapists. Create your own list of qualities for the effective therapist. Review that list and discuss them with the people in your small group.

6. Create a Timeline for Your Own Professional Development. Indicate on this timeline what you want (hope to achieve) and when, throughout your expected lifetime. What do you see yourself doing 10 years from now in the helping professions? If you could be the type of person that you wish you could be, what kind of

person would you be? What might you be doing if you were living as you dreamed or wanted to live?

GLOSSARY OF KEY TERMS

assimilative integration An approach to psychotherapy integration that involves having a strong grounding in one system of psychotherapy and a willingness to select (assimilate) practices and views from other systems.

manual-based treatments Involve the use of standardized, manual-based treatments. Proponents of evidence-based treatments often advocate the use of manual-based treatments.

multitheoretical psychotherapy (MTP) Maintains that thoughts, actions, and feelings interact with one another and are shaped by biological, interpersonal, systemic, and cultural contexts. This simple foundation is used to organize seven theoretical models that can be used to conceptualize clients and guide interventions, resulting in a sophisticated and integrated approach to psychotherapy.

stages of change A psychotherapy model developed by Prochaska and DiClemente that matches a therapist's approach to a client's readiness to change. The model proposes five stages: precontemplation, contemplation, preparation, action, and maintenance.

technical eclecticism An integrative approach that advocates using multiple procedures taken from various therapeutic approaches without specific concern from which theories they come.

theoretical integration Involves the integration of two or more therapies with an emphasis on integrating the underlying constructs associated with each therapeutic system.

WEBSITES

American Psychiatric Association. Practice guidelines: This website gives practice guidelines for a number of mental disorders. It is highly

recommended that therapists review this website to see what evidence-based treatment has been established for working with clients who have specific, diagnosed disorders. This website should be useful in insurance reimbursement because it indicates the appropriate standard of care for specific mental disorders.

Website: http://www.psych.org/psych_pract/treat/pg/prac_guide.cfm

Inner Life. Selective Treatment: This website provides online assessment and treatment matching based on 30 years of research on systematic treatment. It generates an individualized, yet comprehensive report for treatment plans. *Selective treatment* provides you with a simple, yet comprehensive, snapshot of your mental health profile or that for a family member's current mental health profile.

Website: <http://www.innerlife.com/>

Multitheoretical Therapy. This website is the official homepage for Brooks-Harris' (2008) Multitheoretical Therapy. I recommend this approach to psychotherapy integration because the model is an easy one to follow and offers great promise. Multitheoretical Psychotherapy (MTP) provides a way to understand the relationship between psychotherapy theories based on the way these approaches focus on different dimensions.

- MTP describes a catalog of key strategies that counselors can learn over time.
- MTP describes a method of integrative treatment planning based on collaborative dialogue with individual clients.
- MTP uses the following focal dimensions for theory integration: thoughts, actions, feelings, biology, interpersonal patterns, social systems, and cultural contexts.

Website: <http://www.multitheoretical.com>

Society for the Exploration of Psychotherapy Integration: This website contains the homepage of SEPI, the foremost integration organization. It gives information on professional membership, conferences, the *Journal of Psychotherapy Integration*, and training opportunities.

Website: <http://www.sepiweb.com/>

Transtheoretical Model: This is the homepage of the transtheoretical model. It gives publications, measures, and research studies on the stages of change.

Website: http://www.uri.edu/research/cprc/trans_theoretical_model.html

ANNOTATED BIBLIOGRAPHY _____

Brooks-Harris, J. (2008). *Integrative multitheoretical psychotherapy*. Boston: Houghton-Mifflin.

This book asserts that thoughts, actions, and feelings interact with one another and are shaped by biological, interpersonal, systemic, and cultural contexts. From this foundation, Brooks-Harris organizes seven theoretical models that can be used to conceptualize clients and guide interventions, resulting in a sophis-

ticated and integrated approach to psychotherapy. The text begins by reviewing psychotherapy and integration and introducing a new approach. The second part of the book describes almost 100 key strategies drawn from seven theoretical approaches. The book's final section applies the multitheoretical approach to both treatment and training.

Norcross, J. S., & Goldfried, M. R. (Eds.), (2005). *Handbook of psychotherapy integration* (2nd ed.). New York: Oxford University Press.

This book is an authoritative resource on the psychotherapy movement. It is a state-of-the-art comprehensive description of psychotherapy integration and its clinical practice by some of the leading proponents in the field.