AN APPRAISAL OF INTEGRATED APPROACHES TO PSYCHOTHERAPY

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Norcross and Beutler (2014) and Norcross (2005) agree there is a need to integrate various schools of psychotherapy. According to Norcross and Beutler clinicians admit that there are limitations in all of the approaches used at present and that there is a need to integrate them. Norcoss lists eight reasons integration has been important over the last two decades. These include the inadequacies of current treatment, the need in this era for short-term treatment, and the fact that there are numerous common elements in various approaches. The most important reason is that different conditions seem to respond more favorably to different techniques.

A continuing theme throughout Wedding and Corsini (2014) is that ultimately the relationship between the therapist and client is more important that any specific technique. This does not mean techniques are irrelevant. I believe that part of the reason for the effectiveness of the relationship between therapist and client stems from the fundamental philosophical and theoretical orientation of the therapist and the client's compatibility with it.

Norcross (2005) and Norcross and Beutler (2014) identify four major approaches to integration that are currently used. The terminology is somewhat different but the descriptions show they are similar. The four approaches are divided into two major types, eclectic and integrative.

Norcross (2005) refers to one eclectic approach. He calls it *technical eclecticism.* Lazarus developed it. Those who embrace *technical eclecticism* use therapeutic techniques with no regard to their underlying theories. Techniques are chosen based on perceived efficacy when used to treat a particular condition. Norcross and Beutler (2014) note that ultimately all therapy involves some form of learning and therefore can be said to use elements of cognitive theory. This may be stretching the meaning of integration. However most therapists use simple

behavioral conditioning techniques when they are appropriate without accepting the basic theory of behaviorism that only behavior matters. Richer forms of *technical eclecticism* such as Lazarus' use a larger collection of therapeutic tools.

Norcross (2005) identifies a *common factors* method as one of his integrative approaches. The goal is to integrate common successful elements that occur in many therapies into one comprehensive therapeutic model. The words integrate and comprehensive differentiate *common factors* from *technical eclecticism*. To use an analogy, *common factors* integration resembles a mechanic who assembles a collection of tools into a toolkit deliberately selected in advance to use in his work. On the other hand *technical eclecticism* is more like a mechanic who assembles his tools as needed.

Another form of integration is *assimilative integration* (Norcross, 2005). The therapist's approach is built on one fundamental school of psychotherapy but the therapist is willing to incorporate both techniques and views from other approaches. A distinction between *assimilative integration* and *common factors* is that the latter uses techniques from more than one school without necessarily accepting the underlying rationale. *Assimilative integration* incorporates it. Advocates believe this has the advantages of a single approach combined with the flexibility of embracing innovations from other systems. Critics say it is an effort for clinicians to avoid adopting an empirically based *technical eclecticism.* I opine that 'empirically based' connotes a specific philosophical approach. If so an 'empirically based' *technical eclecticism* becomes a contradiction. In other words, 'empirically based' is fundamental philosophy for many clinicians.

The last approach is called *theoretical integration* (Norcross, 2005). This approach blends two or more approaches into one new approach. By melding elements from the schools a

new integrated school results. This involves reconciling and integrating the philosophical premises as well as merging techniques from the schools into new techniques. In psychotherapy the equivalent of the Grand Unification Theory in physics is the *theoretical integration* of all major schools into one comprehensive model. Most feel this is impossible. However there have been attempts to merge two or more schools. There have also been a few attempts to merge most major systems into one integrated model. James Prochaska and Carlo Di Clemente have crafted one such *theoretical integration* model (2005). This paper will describe it, comment on it, and suggest ways it might be improved.

Prochaska and Di Clemente's (2005) call their theoretical integrated theoretical integrated model the Transtheoretical Approach (TA). They believe individual therapy systems are focused more on psychopathology rather than therapy. Their approach is centered on the therapeutic processes of change. They arrived at this by studying 24 of the most common theories of psychotherapy. They concluded change was a common dimension in all. Having devised the model they have empirically tested and validated it in a variety of environments. Because of this empirical support it merits serious consideration.

The TA has four goals, to retain insights from other systems, to provide practical approaches to therapists, to bring some sense of order among disparate techniques, and to produce a comprehensive model that incorporates all crucial approaches to psychotherapy (Prochaska & Di Clemente, 2005). The model is built on a matrix that consists of processes, stages, and levels.

The first component of the matrix is the processes of change. They identify ten. They are, raising consciousness, the liberation of self, counterconditioning, controlling stimuli, reevaluation of self, reevaluation of environment, managing contingencies, helping relationships,

and dramatic relief. They believe that these ten processes delineate the ways people change in their natural environment. In their opinion most therapeutic approaches only use two or three. The TA employs all ten based on which is expected to be most beneficial in a given circumstance.

The next element in the matrix is the stages of change (Prochaska & Di Clemente, 2005). Stages of change incorporate two ideas in the therapeutic process. First is a period of time within the stage. Second is the work needed to move from one stage to another. This could be compared to the sequential nature found in stage theories of development. The distinction is that TA deals with stages based on a relationship to the therapeutic process rather than the life span. The analogy continues as the TA assumes that the tasks needed to move from one stage to the next do not vary. However in the TA the time needed to move from one to another does. The TA identifies five major stages in the therapeutic process: precontemplation, contemplation, preparation, action and maintenance. Each stage is associated with one or more of the ten processes. The TA says that once a therapist has discerned which stage a client is in, the therapist will then know what process or processes need to be activated in order to move the client to the next stage or in the event the client has reached the maintenance stage to sustain the therapeutic changes. In Prochaska and Di Clemente's view this is an important guide for therapists. I would say that most therapists are generally aware of the idea that clients move through stages in their therapy, but for at least some having it defined and clarified is definitely helpful.

When clients are in the precontemplative stage they are less prone to change (Prochaska & Di Clemente, 2005). They tend to ignore the emotionally negative aspects of their problems. Generally they change less in their natural environment than individuals in later stages. They

tend to be less open with others about their problems. They resist therapy. Remembering the goal is to move the client to the next stage, the TA proposes three processes to use with precontemplative clients. The first necessity is to raise the client's consciousness about their situation. Often they first must be made aware they are not aware. Techniques that offer dramatic insight or relief are often used. Psychodrama and the empty chair from Gestalt therapy are commonly employed. The client may be led to revelations about the impact they are having in their environment. Someone who smokes heavily but has no desire to quit may see the negative health effect their smoking has on others in their household. At this point the goal is not to get the client to stop smoking but to consider it, to contemplate it. I would not disagree with Prochaska and Di Clemente's opinion that the precontemplative client may be the most difficult to work with. It is often said these clients are in denial. In one of their studies Prochaska and Di Clemente found that over 90% of those who terminated therapy prematurely were in the precontemplation phrase. Therefore dropout prevention is a critical part of the goal for those in precontemplation. Focusing on making the client aware of the problem, creating a goal that will address the problem and motivating the client to contemplate the problem need to be done reasonably rapidly to prevent drop out. My sense is the therapist must quickly reach a point where the process of liberation enables the client to move past this stage.

In Prochaska and Di Clemente's (2005) TA self-reevaluation is the process that needs to be activated to move the client through the contemplative stage. Using both cognitive and affective methods the client needs to reflect about how they think and feel about their behaviors. They need to realize problems that are buried in their lifestyle. As the client moves to a stage of preparedness, he or she prepares a plan of action. The problem or problems have been identified. Now they are prioritized and based on priorities, the steps needed for change are planned.

According to the TA the goal in the preparation stage is to employ the liberation process. The critical element is that the client perceives the plan as one that will result in liberation from the problems. The process of liberation is implemented in the action stage. Both stages employ the same processes.

The TA also suggests that preparation is a component for the maintenance stage (Prochaska & Di Clemente, 2005). This final stage implements three processes, planning for contingencies, counterconditioning, and controlling stimuli. All three may also be part of the action stage. Clients need to continually assess their alternatives to perceive areas of cognition and affect that threaten their liberation. Maintenance is life long.

Throughout the stages clients continually consider the pros and cons of change Prochaska & Di Clemente, 2005). What are the benefits of change to the client and to others? How will the change benefit the client's self-worth, and increase esteem from others. Each of these benefits will be evaluated against an equivalent cost. While clients may not distinguish the four types they definitely weigh the overall pros and cons. A meta-analysis of 60,000 people using 43 behaviors showed that the cons outweighed the pros for clients in the precontemplation stage. The reverse was true for those in the maintenance stage. They are equal in the contemplation stage. Those contemplating change are ambivalent. Pros begin to outweigh cons as a client moves into the preparation stage. These ratios account for the reason those in the precontemplation phase are far more likely to discontinue treatment prematurely. At that point the cons outweigh the pros.

The last element is levels of change (Prochaska & Di Clemente, 2005). The levels conceptually group disorders into five broad categories. Individual diagnoses in terms of the medical model are not used. The five categories are symptom and situation problems,

maladaptive cognitive problems, interpersonal conflicts, family and system conflicts, and intrapersonal conflicts. Prochaska and Di Clemente consider the levels both hierarchical and interrelated. They criticize traditional methods asserting they focus on only one or two levels rather than all. I would note that broad levels of understanding are far more useful than the rigid diagnostic approach generally required for third party reimbursement. Further, Prochaska and Di Clemente acknowledge that many clients have problems in several areas and that these are intrinsically related in the client. In addition as the levels move from problems relating to symptoms and situations to intrapersonal conflicts the problems become deeper and more difficult to reach. They believe that deeper problems require longer terms of therapy. I believe the TA's articulation of a highly fluid and interactive understanding of the client's problems is one of its most important features.

Prochaska and Di Clemente (2005) suggest implementing therapy at the symptom and situation level because it generally includes the reason the client sought help, it is the easiest to deal with, and hence treatment can quickly show the client the benefits of therapy. Typically the deeper the level the less aware the client is of the problem(s). As each level is treated the client will become aware of the deeper problems. It is imperative there is complete agreement between the therapist and the client about the treatment priorities. It may seem obvious but clients are not likely to agree to treatment for problems they are not aware of.

The last task for the therapist using the TA (Prochaska and Di Clemente, 2005) is to integrate the stages, processes, and levels into a comprehensive whole. Even in the precontemplation stage the therapist is beginning to use techniques based on identified levels and the specific problems in that level. In the case study they cite process of change techniques are

used in the first session. The client related the problem and the therapist quickly moved toward suggesting actions the client might consider.

Another element in the TA (Prochaska & Di Clemente) is to find the core level of the client's problem. Treating this level as rapidly as possible minimizes the time needed to move to the maintenance stage. However especially in the earlier stages of therapy the need to treat the key level must be balanced against the need to treat the level where the greatest change can be achieved rapidly.

Traditional assessment techniques need to be adapted in order to be used in the TA model (Prochaska and Di Clemente, 2005). Generally the client has arrived with some kind of problem. Assessment needs to find our what steps the client has already taken about dealing with the problem. Equally important is why the client took these particular steps. What were the client's motives? They give an example of a man who stopped drinking when his wife left him. Did he stop because he wanted to or did he stop to get his wife back? It is also important to know how much time and effort the client has spent in making changes. If the client has not changed, why is the client coming for therapy. Has the client already reached the contemplative stage? In my experience many clients arrive because Judge *fill-in-the-blank* gave them a choice of treatment or prison. Some took weeks to decide between the two. Less obvious are clients who arrive as if they are at the contemplative stage. Then, for example, assessment finds out they really came because the spouse has said that the choice for the client is treatment or divorce. The therapist must be attuned to these issues. Assessment in the TA models must also address the levels of change. Whatever stage the client is in, the level of the problem or problems must be identified. Last if the client is already doing something about the problem the therapist must find out what processes the client is using. To quickly accomplish assessment Prochaska and Di Clemente

have developed a University of Rhode Island Change Assessment Scale (URICA) and a Stages of Change Questionnaire. Other questionnaires are also used.

Prochaska and Di Clemente (2005) offer a matrix that relates therapeutic techniques to stages and levels. These include most major schools of individual therapy. Among them are psychoanalytic, existential, Adlerian, Gestalt, Cognitive Behavioral Therapy (CBT) and Rational Emotive Therapy (RET). Bowian therapy and strategic therapy are included from family therapy. Techniques like motivational interviewing that do not qualify as complete theories are also employed. Prochaska and Di Clemente include a table clearly showing the matrix. As examples, the level of symptoms and situational problems begins with motivational interviewing in the precontemplation and contemplation stages moving to behavioral and exposure therapy in the action and maintenance stages. At the bottom level, intrapersonal conflicts begin with psychoanalytic therapy in the precontemplative stage, existential therapy in the contemplative stage and Gestalt therapy in the preparation stage onward.

In the TA model (Prochaska & Di Clemente, 2005) the relationship between therapist and client is built on interactive rapport. However the role of the therapist and the nature of the relationship change with the stage and level of therapy. Therapists are reminded resistance is not to the therapist but grows out of the fear of change. Patience on the part of the therapist is crucial in the early stages, especially the contemplative stage. At the same time contemplation cannot be allowed to continue indefinitely. In the early stages the therapist must assume the role of an ally. Over time the therapist evolves into a teacher and the relationship becomes more formal in the action stage. This furthers the goal of having the client gain confidence. Finally in the maintenance stage the therapist becomes a consultant to a client who now owns their condition.

The TA model is not simple (Prochaska & Di Clemente, 2005). It places a huge responsibility on the therapist. However the authors believe that simple often leads to mediocre. I believe that being a therapist always requires a major commitment. Medical doctors have the lesser obligation of extending life while the therapeutic goal is to make an individual's life worth living. The TA model also requires the therapist be trained and knowledgeable in an extraordinary range of schools and techniques. The quantity and quality of the empirical evidence Prochaska and Di Clemente (2005) present showing the effectiveness of the model indicate the effort is worth it.

However, there are some issues that might be raised about it. How much consideration does the model give to the context of the world of the client? Is there an encompassing understanding of the nature of a human being? In other words is there one uniting philosophy? While techniques ranging from psychoanalysis to pure behaviorism are used, is the underling philosophy of any of them considered or are they merely tools in the sense found in *technical eclecticism*?

Despite the fact the TA (Prochaska and Di Clemente, 2005) has levels of change that include interpersonal, family, and systems conflicts, I believe that therapy must always view the client in the context of the client's world and the important elements in it. I would not go so far as to say that all therapy is family therapy, but all therapy is systems therapy. Who are the important people in the world of the client? The family remains the primary system but in our culture other people such as close friends, religious advisors, and mentors may be a vital part of the system. I would incorporate this and even suggest that a genogram including significant outsiders be part of the initial assessment. The genogram may be changed and enhanced through the course of therapy. Even in individual therapy I feel it would be advisable to try to have

major people in the client's world come to one session. I do not question that the world of the client is absolutely real to the client. However in all interpersonal relationships there are at least two views. The case study from which Irving Yalom took the book title Love's Executioner (1989) is a perfect example. Without going into detail, Yalom's understanding of his client was revolutionized when he met his client's former therapist and then her husband. Yalom's assessment was that the therapy failed in great part due to lack of knowledge about those two key people in the client's world. Knowledge of the family and other members of the client's system is crucial.

Prochaska and Di Clemente (2005) do not seem to have an all-encompassing philosophy of therapy. They employ many techniques. In this they are like Gestalt therapy in using anything that works (Wedding & Corsini, 2014). At the same time how do they reconcile their approach with the fundamental rejection of reductionism and the goal of symptom removal that is philosophically at the heart of Gestalt therapy (2014)? What happens to the I-Thou nature of the therapeutic relationship? Compared to Gestalt therapy, TA could easily be charged with reductionism. Moving on, Adlerian therapy has many outstanding features in the way it deals with interpersonal relationships and in many ways presages family therapy, but where in the TA is the holistic concern for the physical health of the client (2014)? When the TA incorporates psychotherapy is the model truly embracing the underlying drive theory so central in Freud's work (2014)? As a last example the TA uses existential therapy. The existential model really does not really incorporate therapy (2014). In the TA what is meant by existential therapy?

I would suggest that the existential approach to therapy could easily be extended to provide a philosophical umbrella incorporating the elements of the TA and moving closer to a truly integrated model. I would extend the existential model by adding a concept that is summed

up in one word, *Dasein*, Being-in-the-World. If we include the core phenomenological thinking of Martin Heidegger (1927) I believe we can create a far more comprehensive model that can reconcile many conflicts. First, the client is always viewed in the context of his or her experience in the world. This includes the physical world, the physical environment, and the relatedness to others. Looking at Wedding and Corsini (2014) Freud's drives and Rogers' fundamental human goodness are both possible. They can both exist in the same client. One or the other may dominate. Adler's holistic view including the physical condition and his thoughts on human interaction pose no problem. Gestalt therapy is already rooted in existentialism. The essence of instrumental conditioning can be seen as part of Freud's pleasure principle.

Undoubtedly there will be remaining conflicts and difficulties. A primary conflict among therapeutic schools is the relationship between therapist and client. A phenomenological approach implicitly rejects Freud's detached approach to the client (Wedding & Corsini, 2014). Some conflicts can be resolved. Is therapy designed to alter the fundamental philosophy of the client as Ellis supposes? Is it merely there to alter thinking and behavior as Beck and the pure behaviorists suggests? Questions such as this can be answered with a bit of humility in acknowledging that Rogers was right in saying that therapy is client centered. We hide behind a great deal of obfuscation. In most endeavors the client would clearly be acknowledged as the customer. Further, going back to the TA (Prochaska & Di Clemente, 2005) in the matrix of stages and levels the client may move from simple changes in behavior to seeking for more fundamental transformations.

The work needed to identify the ways different approaches can truly be reconciled is daunting. Why bother? My sense is the effort is worth it as it could retain the fundamental

strengths in the TA (Prochaska & Di Clemente, 2005) while removing the reductionism I see presently limiting it.

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