11 Integrative Approaches

Integration might be more appropriately seen as a movement than an approach; a movement that has involved the development of myriad ways of ‘doing’ integration. Integrative working has been borne from the explosive proliferation of, and resulting heterogeneity in, psychotherapy approaches, and it is clear to us that there is little value in attempting to convey any myth of uniformity in this chapter. To suggest that there is a single integrative approach that can be learnt and followed would be misleading: integrative working draws on the full range of possible theories about human distress and psychological routes to change and wellbeing, and therefore the possible combinations and permutations within integrative working are limitless.

Integrative working has evolved under a range of favourable conditions. Without doubt, one such condition has been an increasingly widespread recognition that no single theoretical model or approach to psychotherapy has all of the answers, for all of the people, all of the time. This, alongside a drive to constantly improve the efficiency, efficacy, and acceptability of psychotherapy, has led clinicians, academics, and researchers alike to look across the range of psychotherapy approaches in order to refine, elaborate, and improve the way we work. To that end, integrative working aims to be flexible and responsive to the needs and competence of both client and therapist, with the goal of improving outcomes.

In this chapter, we have been asked to consider what is unique about integrative working. This is a tricky question to answer. In one sense, nothing is unique about integrative working because it rests entirely on the foundations built by ‘pure-form’ models and approaches: the process of integrating individual approaches is (and we argue, should be) based on the evidence-base for each approach being drawn upon. We appreciate a specific point of wisdom from John Norcross in his book on the subject (2005) that “one cannot integrate what one does not know” (p.14). We note also that the approaches considered in other chapters of this text are, in many cases, works of integration themselves. Our sense is that perhaps what is unique about integrative working is the opportunity to refrain from repeatedly redefining and ‘re-badging’ through the demarcation of new boundaries; rather, integrative working might be seen as a ‘meta-approach’ in which all approaches are held in mind and applied dynamically. More generally though, we wish to communicate that integrative working is a natural extension and evolution of pure-form working, rather than a theoretical opponent to it.
11.1 The Origins of Integrative Working

The origins of integrative working offer much by way of explanation of its philosophy. In the 1950s and 1960s key psychotherapeutic ‘camps’ (psychoanalysis, behaviourism, cognitivism) were engaged competitively with each other to prove the value of their respective approaches. This is described by some authors as akin to an ‘ideological cold war’ (Norcross, 2005) and the difficulty we have today in imagining this level of furious duelling is perhaps testament to the impact that the integrative movement has had in the last forty years. Ultimately, they were all shown to be effective for some people and the differences between them were judged to be small and unreliable (Wampold, 2001; Wampold et al., 1997). The resulting ‘all have won and all shall have prizes’ conclusion (the ‘Dodo verdict’; Rosenzweig, 1936), when combined with findings that a larger portion of change could be attributed to client variables and common factors than to the specific model itself, led to something of a revolution.

The first identifiably integrative publication came in 1950 (Dollard & Miller, Personality and Psychotherapy) but it took until the 1970s for the movement towards integrative working to gather any significant pace (Prochaska, 1979; Wachtel, 1977). The conditions were right for integration, not simply by virtue of outcome-related dissatisfaction with any single-model approach; short-term approaches to psychotherapy became more numerous and credible, and alongside this the financial and organisational support for traditional long-term approaches began to dwindle. Therapists were asked anew to demonstrate and document the efficacy of their approach, leading to a favouring of more easily-evidenced, problem-focussed ways of working with clients. There was an additional sense of theoretical dissatisfaction that no single theory could fully explain or predict the development of core concepts like personality, or the aetiology of clinical problems and why they change. Academics began peering over the fences to see what neighbouring theories could offer and a timely increase in collaboration between academics and clinicians saw this translate into the approaches used in clinical services. Ultimately the movement gathered enough momentum to see the launch of the first journal dedicated to the integrative cause (The International Journal of Eclectic Psychotherapy) in 1982, and professional bodies committed to furthering integrative working followed.

As it stands today, it seems fair to say that a significant move towards integrative working has taken place and is continuing (Prochaska & Norcross, 2010) to the point that most practitioners would identify themselves as either explicitly integrative or at least influenced by more than one theoretical approach (McLeod, 2009). This prompts us to question what the logical end point of this movement might be: Will we arrive at theoretical unification, whereby an ultimate integration of theory and approach is agreed upon as the most effective or universally applicable? We find this almost as difficult to imagine as the ‘cold war’ described by Norcross. Our sense is that we may instead be experiencing a new proliferation of standardised integrative approaches,
for example: Cognitive Behavioural Therapy; Cognitive Analytic Therapy (Ryle, 1995); and Schema therapy (Young, Klosko, & Weishaar, 2003) to name just a few.

11.2 Approaches to Integrative Working

Different forms of integrative working have been defined as ways of classifying approaches. These are briefly discussed to provide context for the approach we intend to take. One factor upon which these ways of integrating vary is the level at which integration occurs: technique, theory, or somewhere between the two.

At the level of technique, ‘technical eclecticism’ involves the collation of therapy techniques that ‘work’ without necessarily blending the theoretical assumptions underpinning those techniques. An eclectic therapist would not be held to one set of assumptions about how clinical problems operate and they may be less concerned with ‘why’ something works than the fact that it does work. Technical eclecticism is criticised for inconsistency and potential theoretical muddlement. However Norcross (2005) argues that successful technical eclecticism should involve the systematic selection of techniques on the basis of both outcome research and patient need. Furthermore, to do this he suggests a sound knowledge and experience of several therapeutic approaches is needed.

At the level of practice, ‘assimilative integration’ might be seen as a step towards integration of theory, whilst remaining essentially at the level of practice. This approach begins with a grounding in one ‘home’ theoretical position and works towards selectively incorporating practices and views from other theories in a process of reworking, augmenting, and casting in new form the ideas from the home theory. Without the demand for full theoretical synthesis, a perspective on theoretical congruence can be adopted. It might be thought of as the way in which therapists naturally expand their clinical repertoire upon recognising the limitations of their home theory.

At the level of theory, ‘theoretical integration’ aims to synthesise different theories that may hold differing world views and underpinning assumptions. Such synthesis offers the potential for new perspectives at a theory level, although the barriers to synthesis should not be underestimated; how do we rationalise assumptions that appear to sit at odds with each other and fundamental epistemological contrasts? A simple example might be the challenge of identifying the aim of therapy; differing theories would support differing objectives, with possible focal outcomes including: the promotion of self-actualisation, the relief of symptoms, the restructuring of relationships, the development of insight, and the modification of overt behaviours. Theoretical integration might seem therefore to present the greatest challenge to a therapist working integratively.

In our view at least, the ‘common factors’ approach to psychotherapy integration is located somewhere to the side of the ‘technique – theory’ continuum described above. It has developed from the search for the key ingredients that different therapies
share, given the acknowledgment that theoretical nuances do not produce significant variance in efficacy. The process of identifying these common factors has, more recently, included empirical (as well as rational) methods (Grencavage & Norcross, 1990; Tracey, Lichtenberg, Goodyear, Claiborn, & Wampold, 2003). Factors shared across successful therapies are thought to include concepts like alliance; empathy; positive regard; client feedback and preferences; and acknowledgement of culture (Norcross, 2011). Whilst identifying the ingredients of good therapy is undoubtedly valuable, it does not offer an approach for case formulation. We see the common factors approach as a meta-approach: a clinical strategy or arrangement of ideas that guides the efforts of therapists. It does not dictate how theory is to be arranged within that structure and this falls, as it does with other integrative approaches, to the individual therapist to negotiate according to their own preferences, experiences, and resources.

Perhaps in response to this, some ‘framework’ approaches have offered conceptual maps that organise elements of a clinical case and link these to appropriate theoretical approaches. Jeff Brook-Harris’ (2008) Multitheoretical psychotherapy (MTP) approach suggests that ‘thoughts’, ‘actions’, and ‘feelings’, as primary dimensions of human functioning, are influenced by contextual dimensions of ‘biology’, ‘interpersonal patterns’, ‘social systems’, and ‘cultural contexts’. MTP goes on to suggest that multiple theories should be considered: e.g., cognitive theory for ‘thoughts’; experiential theory for feelings; psychodynamic theory for interpersonal patterns; and so forth. This clearly moves towards an approach for case formulation and the same may be said for other frameworks (Ingram, 2006; Weerasekera, 1996). Ingram’s work in particular offers a highly prescriptive approach to the building of a case formulation from individual hypotheses situated within a range of theoretical perspectives. Our sense is that, whilst these frameworks acknowledge the need for some level of theoretical integration, they give little sense of how this might be done.

Our aim in this chapter is to offer an example of the approach we feel most closely represents ‘normal integrative practice’ for clinicians: assimilative integration. The process we went through to arrive at and execute this is described in more detail in the ‘Formulation in Action’ section below. Central to our rationale for this decision are two considerations: firstly, what merit is there in reorganising (already frequently reorganised) concepts to produce another framework approach? Secondly, the significant challenges to full theoretical integration mean that this does not reflect real-life practice as we know it. We settled on the notion that producing something with clear relevance for practice was a more pragmatic and useful endeavour.
11.3 What Evidence is There for Integrative Working?

We hope to have ultimately made clear that uniformity within integrative working is indeed a myth. Working integratively can be approached in a number of ways, each of which comes with inherent strengths and limitations.

The evidence-base for integrative working therefore mirrors this lack of uniformity. The evidence specific to each ‘branded’ theoretically integrated model (e.g., Schema Therapy, Cognitive Analytic Therapy, Cognitive-Behavioural Therapy, and Compassion Focused Therapy) is variously developed and a fuller account of three such models (Schema Therapy, Compassion-Focused Therapy, and Cognitive-Behavioural Therapy) can be seen in previous chapters. Other approaches to working integratively depend on the evidence-base of each model being drawn upon and this extends to the evidence for specific techniques that may exist. In a sense, therefore, many ways of working integratively are difficult to test, given that each is developed in response to a specific problem, for a specific client, by a specific therapist. This affords opportunity for sweeping criticisms of integrative working: that it is untestable and therefore unsound, or lacking in depth, clarity, coherence, and focus (Gilbert & Orlans, 2011).

These criticisms are entirely appropriate when levelled at poor quality integrative working – i.e., unsystematic, ‘pick-n-mix’ therapy that gives little consideration to congruence, efficacy, or competence. We would argue therefore that integrative working must involve the following:

- A thorough and detailed understanding of each theoretical model that is being drawn upon, its evidence-base, and translation to clinical practice.
- Consideration of the idea of theoretical congruence so that the overall message communicated to the client, by the therapy, is coherent.
- As clear a focus on the clinical problem as would be taken by a single-model approach.
- A clear sense, for each therapist, of their own fields of competence and an acceptance that only what is fully understood should be used.

11.4 Formulation in Action

Originally, in thinking about Molly we attempted to develop a novel conceptual model of case formulation, rather like a ‘framework’ approach. However, it became apparent that this is not how we work with real clients; therefore, we should do as we would in actual practice. This shift allowed us to lose the constraints of trying to produce an all-encompassing, yet clinically usable model of functioning, and indeed also of the challenge of synthesising theory to the point of providing new perspectives. Instead we could work intuitively, starting from a Cognitive-Behavioural Therapy
(CBT) outline. This matched our clinical expertise and was congruent with Molly’s tendency to prominently articulate her thoughts and feelings.

The process of assimilative integration allowed us to take note of, and respond to, ‘gaps’ left by the CBT model. We felt that there were significant systemic and relational aspects to her experience; hence, we augmented our initial CBT formulation with ideas from systemic and psychodynamic approaches. At each stage we considered the theoretical congruence to ensure that the ideas we were using could sit sensibly alongside each other. For the sake of clarity, we will demonstrate our formulation in three stages.

11.4.1 Initial Formulation

11.4.1.1 Stage 1: CBT Model
Figure 11.1 shows application of a Beckian longitudinal CBT model. This model explains the influence of life experiences via the development of core beliefs and rules for living, which are activated and/or violated by more recent trigger events. The model captures Molly’s articulation of her self-concept (as ‘weak and useless’) and is helpful in identifying the connections between longstanding ways of coping and current patterns of thinking, feeling, and behaving. Molly wishes to ‘sort (herself) out’ and locates her problems internally, which is congruent with CBT assumptions about internal processes driving distress. Please refer to Figure 11.1.

This model is not as useful when it comes to explaining the influence of her family interactions on her current distress, or indeed why, in new situations, she finds similar forms of emotional distress.

11.4.1.2 Stage 2: Addition of Systemic Ideas
As Chapter 8 explains, systemic approaches are informed by systems theory and the notion that the behaviour of a system can be understood by considering the characteristics of each element within the system and the relationship between these elements. Although there is limited information about the wider culture that influences Molly, a system of primary importance in her life is family; there may therefore be value in conceptualising how Molly and her family communicate with each other and the interpersonal aspects of her distress.

Molly’s account suggests that her family may have been invested in a system of beliefs around the importance of achievement and of self-reliance (that she should be able to achieve without relying on help from others) and these beliefs seem to have been communicated within the family system through both the language used and in non-verbal communications (her Mother’s ‘looks’). The family system also seems to favour the non-expression of emotion as part of its overall pattern of communication. As a part of the family system, Molly is likely to have been influenced to
maintain these values in her own patterns of communication and behaviour, perhaps to the point that she ‘owns’ them as her own values. She attempts to contain her emotions (‘you just have to get on with it’) but struggles to sustain this and is inevitably overwhelmed, leading to an intensified expression of emotional distress, which the system receives with difficulty.

Interactional patterns within the family system appear to discourage and even punish emotional expression, and this can be observed in the family’s response to Molly’s hospitalisation and in their descriptions of Molly as “overly emotional” and “dramatic”. It is plausible that the family are invested in a wider social discourse about mental health problems reflecting weakness (Molly certainly perceives that they felt stigmatised by having a daughter “in the nuthouse”) as congruent with their own belief system about self-reliance/resilience. This might complement a strategic perspective in proposing that the family’s responses to her distress are, in fact, attempts to encourage resilience in Molly. However, she reports distress resulting from these interactions, which suggests they are ineffective solutions that require disruption.

Molly describes a lack of warmth and an atmosphere of ‘separateness’ within the family system. It may be that when combined with a pattern of communication that discourages expression of emotional distress, this maintains a sense that the system would not receive well any news of traumatic events. Molly chose not to disclose the sexual abuse she suffered, perhaps fearing her account would be understood through the existing family story, in which she is “dramatic” and disclosure would “wreck the family”. This supports the notion that she strived to maintain stability within the system, even though her own need for support was unmet.

Molly has tried to achieve self-reliance, autonomy, and success in a series of transitions (leaving home for university, commencing a relationship, taking a job at the library) that see her joining new systems. Unfortunately this seems to have brought her into contact with some overwhelmingly challenging interactions that have resulted ultimately in a retreat from autonomy (leaving the family system undisrupted). Her distress within these new systems seems to arise from an interaction between her own expectations (that she would be exposed and would fail at university; that she may be rejected in relationships) and the system’s expectations and responses to her behaviour. We hypothesise that a university class culture that expects members to join in and work together may not respond well to increased withdrawal; likewise, a student culture with expectations of casual relationships may not receive well intense attachment behaviours. Hence, Molly finds herself failing to meet others’ expectations, ‘rejected’, and needing to retreat to a position of relative safety. The sense overall is one of repeating patterns within new systems, and the advantage of a systemic understanding is that it facilitates causation and maintenance to be viewed as circular, rather than linear, and solely internally located in Molly.

The augmentation of the CBT formulation with systemic ideas contributes an interpersonal and interactional understanding of Molly’s experience of distress. The CBT formulation acknowledges her tendency to be self-critical of her distress and
we feel that a balance needs to be struck between identifying internally-held beliefs and expectations, and recognising the influence of others around her. This offers an alternative perspective on the causation and maintenance of Molly’s distress, and in therapy will give us an effective way of dealing with the idea that she is the sole source of her own distress. It is important to state (although this should be obvious) that systemic thinking does not simply transfer responsibility for Molly’s distress to people around her; rather, it suggests that systems respond in order to try and achieve stability, purpose, or indeed to solve problems. Molly’s distress is understood as arising from these interactions.

11.4.1.3 Stage 3: Addition of Relational Psychodynamic Ideas
The final stage of formulation considers how a relational psychodynamic perspective can add to our understanding of how the systems that Molly grew up in can become internalised and influence her responses to others in the present. Whilst the field of psychodynamic theories is more complex and multifaceted than we have space to explore here, drawing on some essential concepts can usefully add to our developing understanding of Molly. Whereas CBT and systemic approaches tend to address aspects of Molly’s experience that she is at least somewhat conscious of, psychodynamic theorising highlights the role of her unconscious in shaping the experience and expression of her difficulties.

Attachment theory and research (Bowlby, 1969, 1973) suggest that a mother’s empathic responding to her infant is crucial to the child’s development. A caregiver’s attunement to their child’s experience is regarded as enabling the infant to integrate and organise their experience, later supporting the development of memory, emotion regulation abilities, and a sense of self (Stern, 1985). Given the discouragement of emotional expression within Molly’s family, it is likely that her early development was lacking in this vital emotional responsiveness, with consequent effects upon her implicit abilities and her Internal Working Models (IWM; Bowlby, 1969, 1973) of relating to others. Whilst a CBT perspective highlights Molly’s ‘core beliefs’, the IWM concept offers a similar but more dynamic interpersonal understanding of Molly’s expectations in relationships, and ways of being with others and the world. The advantage of including a psychodynamic perspective is to support a clearer understanding of how she might shift and change in her thoughts, feelings, and behaviours with others.

Consider, for example, Molly’s behaviour in her first therapeutic session: fluctuating between angry criticism of the therapist and apologetic frustration with herself. Such behaviour can be understood as mirroring the conflict experienced by an infant whose mother is unresponsive to their needs. The unmet need creates a sense of angry frustration in the child that they struggle to manage without support, but to survive they still require proximity, and whatever support and safety their caregiver can offer. Consequently, the child is understood to become rejecting of their own needs in order
Figure 11.1: CBT diagrammatic formulation
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to limit frustration with the caregiver and maintain a compromised relationship. Returning to Molly in the session, we can see this conflict between frustrated needs for emotional support being expressed in her anger, but to guard against the therapist rejecting her, she resorts to criticising herself for not being able to contain the feeling. Unconsciously, Molly’s IWM of others as failing to provide for her ‘excessive’ emotional needs is reconfirmed.

From a relational psychodynamic perspective, Molly could be seen as consciously seeking change, but unconsciously she might feel threatened by insights that undermine her IWMs because they have helped her to maintain a degree of security. Molly may defend against the threat of change in many ways that she could gain insight into, but the risk of her rejecting the therapy and/or therapy relationship is one potential defence that seems crucial to attend to.

We note that the tasks of therapy, such as self-reflection and emotional expression, will be at odds with Molly’s usual ways of being in the world. Consequently, maintaining sensitive awareness of Molly’s experience of the therapy could provide an opportunity to learn about her relational difficulties, as well as help to guard against a premature ending to the work. The simplified but main tenets of these and the systemic ideas are highlighted in Figure 11.2.

11.4.2 Theoretical Congruence

We have advocated the importance of considering the congruence of the underpinning theories that an integrative formulation may draw upon. This is driven primarily by the need to create a coherent sense of the therapy experience for the client. One area for consideration is the extent to which our models understand ‘problems’ to be internally or externally located, because this poses a potential conflict of basic assumptions. Our understanding is that Molly’s difficulties exist both internally and externally; in fact, to suggest that a raft of life struggles such as those Molly presents with, might have a single location or source, seems unfeasibly simplistic. Put simplistically, CBT understands problems as arising from maladaptive internal processes, whilst systemic theory would identify problems as arising within interactions or relationships. The psychodynamic concept of an IWM offers us a way of bridging this potential divide; suggesting that perhaps the interactions within a family system are formative of an IWM, which comprises internalised processes like emotional regulation and beliefs about the self. Essentially, the ideas and interactions of her family system become Molly’s own ideas about herself and the world. Thus her difficulties ‘exist’ in her interactions with systems, and within her own conscious and unconscious internal experience.

The CBT model offers Molly a way of gaining a sense of conscious control, and therefore hopefully choice, over her experience. It offers a way of capturing and conceptualising her current talk about herself (as core beliefs or rules for living) and
the therapy techniques that spring from the model will offer practical challenges to that talk and tools with which to manage her distress. However, our formulation acknowledges aspects of Molly’s experience that, realistically, she has little control, or perhaps even conscious awareness, of: the influence of systems around her and the implicit structuring of her emotional experience that have developed through her life. We understand the concept of repeating patterns to be common to all three models to varying degrees. Where the CBT model might describe the activation of core beliefs and implementation of maladaptive coping strategies, systemic theory would see the interaction of one’s expectations and that of the system as eliciting ineffective and repetitive attempts to solve and rebalance. Lastly, psychodynamic theory might describe the replication of unconscious relational structures in the present. Across these conceptualisations lies a similar goal and point of core congruence: to identify core beliefs and schemas, observe interactional patterns in systems, or bring the unconscious into conscious awareness. Integrating three theoretical positions is helpful here in reminding us (as Molly’s hypothetical therapists) that to imply that complete control over one’s experience can ever be gained would be unrealistic and unhelpful.

11.4.3 Meaning in Practice

In practice, by helping Molly to understand and manage these somewhat less directly controllable influences on her mental health, at the same time as directly targeting distress through CBT techniques, we would support her to consider what is and is not within her control to change. Steele, van der Hart, and Nijenhuis (2001) suggest that mental health is associated with an individual’s capacity to integrate events, as this enables distributed attention and the possibility of reflective thought and action. Our understanding of integrating these different theories for clients with complex problems – like Molly – would mirror Steele et al.’s (2001) suggestion that a broader appreciation of the factors influencing behaviour and change will be supportive of personal integration and mental health.

11.4.4 Intervention Objectives

Intervention using an integrative approach requires integration of techniques reflecting models used in the formulation; in this case, cognitive, behavioural, systemic, and psychodynamic. There is no one way of organising and delivering the techniques, just as there was no one way of integrating and building the formulation. However, there are empirically supported approaches to draw upon as described in previous chapters, and, of particular relevance to integration, within the ‘common factors’ literature. The primary focus of ‘common factors’ based efficacy research has been
to specify empirically supported aspects of the therapeutic relationship (e.g., Hardy, Cahill, & Barkham, 2007; Norcross, 2011).

Although empirically supported aspects of the therapeutic relationship are too wide-ranging to fully consider here, we highlight a few key objectives for establishing an effective alliance with Molly. Better outcomes have been associated with clients understanding their role and that of the therapist in the work, as well as clients and therapists having hopeful expectations of achieving success (Hardy et al., 2007). Clients’ intentions and motivation for change have also been linked to more positive results (Hardy et al., 2007). Hence our initial approach to working with Molly would focus on developing an effective therapeutic relationship in which we could agree on goals for change that seem desirable, meaningful, and manageable to both Molly and us.

### 11.4.5 Intervention Plan

Whilst ‘pure-form’ theoretical approaches point in particular directions to define appropriate goals, the flexibility of our integrative approach would draw on responsiveness from Molly and aspects of the formulation that fit with her perspectives to facilitate closer collaboration. As agreement about goals and collaborating in an alliance to achieve these has been linked to positive therapeutic outcomes (Norcross, 2011), psychoeducation about the process of therapy and relevant aspects of the formulation could help Molly understand what to expect and how this might be achieved. We know that Molly wants to feel “better”, “more confident” and the “opposite” of how she currently feels. Once more clearly specified, these goals might be achievable through developing alternative coping skills – enhancing her abilities to challenge unhelpful thinking patterns, and to choose less damaging behaviours when she is struggling. Through initial attempts to directly target her immediate distress, we might both try to address issues of risk inherent in her presentation, as well as begin to gauge the extent of her ability to respond to CBT-type interventions.

One of Molly’s stated goals is to “make everyone proud”, but this needs exploration as her history suggests she might be overly focused on pleasing others at personal cost. Our formulation has also highlighted a repeated pattern of failing to ‘achieve’ to the level expected by those around her, so a CBT skills focus in the work has the potential to evoke a familiar story of failure within the therapy. Our understanding of the systemic aspects of this case would become particularly relevant in such circumstances and we might aim to help Molly to understand the influence of the systems around her in developing this narrative. If it was possible to help Molly to distinguish her systems’ goals from more personal goals, this might usefully support her motivation for and expectancies of change. She might choose to adjust her narrative about her needs and abilities, rather than simply aiming to directly change problematic thoughts and behaviours.
Figure 11.2: Diagrammatic integrative formulation
Empathy, positive regard, and affirmation are also associated with therapeutic success, although therapists’ expressions of these need adjustment to fit particular clients’ needs (Norcross, 2011). As Molly is used to keeping others at a distance and her home life ‘lacked warmth’, we expect she will not be able to receive warmth and empathy without a degree of internal conflict. Receiving something so needed but lacking in her life could serve as a painful reminder of what she missed and stimulate a greater sense of neediness, which she ‘hates’ in herself already. Gentle enquiry into how Molly experiences small offerings of attuned care could facilitate exploration of the significance of her unmet needs in her experience of relationships generally. Additionally, findings from neuroscience suggest that adult experiences of empathic responding in the therapeutic relationship can foster trust and promote implicit emotion regulation abilities (Wilkinson, 2010). Such work could become more of a focus if Molly struggles to take conscious control of creating change.

In summary then, we would plan to start work with Molly by building the relationship, being aware of the attachment issues and potential conflict highlighted throughout. Realistically, this development of attachment and modelling by the therapist, as well as the provision of safety, will need to run throughout the therapy. CBT tools will be utilised, including shared building of her formulation, before moving to consider use of techniques like cognitive restructuring and behavioural experiments, some of which would test the system (family and workplace) in which Molly resides. These in turn will help begin to challenge Molly’s IWM. The last phase of work would probably focus on the system, predominantly the family. Educating Molly and refining our shared understanding of her behaviours and attempts to maintain the stability of the system will allow her to build more functional strategies of responding in the future. In actuality, the therapist and Molly will consider the best steps to take at each point through the therapeutic journey.

11.4.6 Effectiveness

Measuring effectiveness in this case is open to many possibilities and it is important to consider in an ongoing manner, so that the therapist can respond to and adjust strategies or techniques that are not working. Within the CBT aspects of the work, one might consider effectiveness as a shift in long held cognitions (that cause distress) and use of new behaviours. Given we believe that the system impacts upon Molly’s belief systems, changing some of these beliefs will be unlikely to happen if the system is not considered or challenged. CBT will also provide Molly with cognitive skills she can use to better manage the scenarios that she faces; such as appropriate emotional expression, practiced and not rejected throughout therapy. Thus we could note the number of new skills Molly develops. We could also consider effectiveness through Molly’s attendance or contributions in sessions, completion of tasks outside of the session, or a growth in confidence. We could notice the negative language about self
that Molly uses and how this changes over the course of therapy and/or gather weekly ratings of mood or therapeutic alliance. Ultimately, however, all three models would allow consideration of Molly’s goals and how far she has achieved them as a sensible way of considering outcome. Perhaps most telling will be change in the levels of distress Molly reports over time, as well as whether she feels “different” to how she felt at the beginning of her journey. We must of course consider the possibility that her original goals may change throughout therapy, thus her goal to “make everyone proud” may come to reflect a more flexible and achievable goal.

David M Gresswell

11.5 Integrative Formulation: Critical Commentary

Helpfully, this chapter not only illustrates the shortcomings of an “integrative approach” but also the shortcomings of CBT, “systemic”, and psychodynamic approaches. As the authors indicate, the evidence-base for integrative approaches (as opposed to the individual components of relationships, techniques, and so forth) is weak. However, putting that issue to one side, the approach also invites a somewhat uncommitted and undisciplined approach to formulation – specifically: When the going gets tough, switch models.

To begin with the CBT model that the authors open with, the longitudinal approach to formulation illustrated in Figure 11.1 falls into several “post-Beckian” traps: including lack of internal consistency, lack of nuance, an incoherent model of emotion, and overlooking the contingencies that maintain the behaviour. Examining the so-called “core beliefs”, these are clearly inconsistent with the conditional assumptions and behaviour – if Molly truly believes she is useless how can she also believe that she must (can) please others and that she can avoid criticism? Why does she seek employment and so forth? The issue here is partly one of nuance: Surely Molly’s “belief” that she is useless varies according to context and could be rephrased into something more consistent with the rest of the formulation and her actual behaviour?

Turning to the conceptualisation of emotion, Beck started off by attempting to explain depression; however, in the approach illustrated in this chapter, we can see the same core beliefs, conditional assumptions, triggers, etc. being used to explain five emotions (specifically: shame, anger, self-loathing, miserableness, and stress) all at the same time – clearly this isn’t going to work. The problem is compounded by the theoretical incoherence of the model of emotion: In this formulation the five emotions listed in the “Emotions” box are separate from, but interact with, physiology, behaviour, and cognition. If emotion is independent of cognition, behaviour, and physiology then, phenomenologically, what is it?

Finally the formulation model does not consider the external variables (contingencies) that maintain the behaviours in question – e.g., if you are prone to emotional
outbursts you will get different responses from someone who is generally reserved. This is a fundamental flaw in the CBT approach to an A:B:C formulation. Beck and colleagues effectively changed it from an operant Stimulus:Response:Stimulus (S:R:S) model – in which “A” is a Stimulus (the trigger for a behavioural sequence), “B” is a Response (everything the person does), and “C” is another Stimulus (the consequences contingent on the behaviour that influence it in some way) – to, in effect, an incomplete S:R1:R2 model – in which “A” is still a trigger, but the “B” (R1) now represents some cognitive processing (typically called “beliefs” in many CBT texts), and the “C” (R2) represents some form of additional “emotional” response to R1. The contingencies which follow on from R1 and R2 have been unhelpfully dropped from the analysis. Rather than address these issues in a disciplined fashion, the archetypal integrative psychologist merely stumbles, half acknowledges the problem, and flips models – in this case, the authors shift to a so-called “systemic approach”.

At the risk of sounding like a psychological Margaret Thatcher, there is no “system”; but, as is well illustrated here, simply a number of individuals (family members, fellow students, colleagues) reinforcing and punishing each other’s behaviour. There is no “systemic theory” illustrated in the chapter; but merely a description of the probable ways (based on history) in which Molly’s mother will, for example, punish some of Molly’s behaviours (thereby causing anxiety and suppressing the behaviour), ignore some other behaviours (contributing to extinction), and intermittently reinforce still others (thereby strengthening them). A thorough behavioural functional analysis would focus on these issues, consider who is influencing who through reciprocal reinforcement and on what schedules, and thereby actually inform the intervention.

Despite two attempts, the authors still consider the formulation incomplete because it does not consider the “unconscious...” In attempting to add an attachment-based interpretation of these unconscious processes, what is highlighted is that Molly’s expressions of anger have probably been punished in the past, and so she acts to suppress angry behaviour now to avoid expected punishment. It would seem highly unlikely that Molly is unaware of these processes given her description of her family life. The result of all this model changing and “integration” is the even more complicated “diagrammatic integrative formulation” illustrated in Figure 11.2, in which the inconsistencies and anomalies evident in the first formulation are not only perpetuated but are now supported by additional boxes: one on the left, with the term “family system” emboldened (which presumably describes how Molly’s family punish and reward her behaviour); and another on the right, which primarily contains “needs” and “Psychodynamic/attachment” issues. These boxes are attached to the initial Beckian formulation with broken lines and arrows – thereby adding the circular links beloved of systemic theorists. Nevertheless these circular links fail to show how the different components of the formulation actually and specifically interact with each other.
Although the authors make the point that they “cannot imagine the ‘cold war’ (between competing ideologies) as described by Norcross”, we think their chapter (inadvertently) makes an argument for a return to those days and to the disciplined thinking of the advocates of the different ideologies. For us, the chapter affirms the need to teach trainee psychological practitioners a holistic model of human behaviour (such as radical behaviourism) and then train them to develop, apply, and rigorously test a comprehensive and theoretically-informed functional analysis in a disciplined and committed fashion. The alternative would seem to be to create a generation of psychological practitioners who are ‘jacks of several trades and masters of none’ – surely the rational thing to do when things go wrong is not to change models at the first opportunity, but to really think about the new data gained, question why the initial formulation hypotheses have been disproved, re-work the formulation, and then test it again?

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11.6 Author Response

There appears to be an essential difference in philosophy underpinning an Integrative perspective and this critique’s perspective. Where we see drawing on a variety of explanatory models as an aid to appreciating the complexity of factors shaping Molly’s distress, this critique characterises her experience as reducible to stimuli and responses. We reject the notion that an Integrative approach advocates switching models when one gets stuck. The approach advocates a systematic choosing of aspects of models that allow integration and the development of a fuller picture of a range of mechanisms contributing to an individual’s psychological life. Integration should be a well-considered process informed by reflection on theory, literature, the client, and their experience.

Given the complexity of human beings generally and Molly’s difficulties specifically, we accept that the diagrammatic formulation and verbal account in this chapter were necessarily heavily summarised and consequently limited in their precision. However, in practice, a more nuanced formulation could be generated through collaboration with Molly and focusing on specific goals.

The critical commentary authors highlight that Molly’s belief about being useless is inconsistent with a belief that she must and can please others. Whilst it might appear inconsistent, as humans are complex organisms they are able to hold more than one view or belief, even those that seem contradictory. In this case, the beliefs are opposite ends of the same continuum, so moving between ‘useless’ and ‘pleasing’ (i.e., being useful to others) is part of Molly’s struggle and distress. Equally, although it is complicated to account for multiple emotional experiences, distress is rarely (if
ever) one-dimensional and emotion labels can encapsulate experiences in a way that is ideally both meaningful and containing for clients.

What Molly might be aware of or not is another question raised by this critique and we accept the concept of ‘the unconscious’ as potentially problematic. We appreciate having the space here to highlight ‘mentalization’ (e.g., Fonagy, Gergely, Jurist, & Target, 2004), a concept that fits better with our intersubjective stance. Whilst ‘the unconscious’ implies awareness is simply not present, accounts of mentalization suggest individuals’ reflective abilities are not constant but fluctuate according to context. Particularly for people considered ‘personality disordered’, non-reflective functioning is thought to dominate behaviour when there is conflict in relationships.

The critique offered is little more than a criticism of something that is not ‘behavioural’. Potentially, our formulation could be broadened to include a behavioural perspective, but we wonder how Molly might receive such an account. Another apparently fundamental difference between the critical commentary and our Integrative perspective concerns the position of the client in relation to formulation. Rather than privileging an account that we regard as technically ‘the correct one’, we aim to use formulations that are meaningful and engaging for our clients, as well as theoretically coherent. We believe that psychological practitioners should be trained in a number of theories and models (in a pure way) so they can ultimately utilise skills of analysis and integration to make models that fit individual clients.

References


