

Integrating approaches

By combining the compatible aspects of humanistic, psychodynamic and CBT theory, *Ariana Faris* and *Els van Ooijen* have created a new teaching model that is applicable to brief counselling and long-term work

As trainers of counsellors and psychotherapists we have an ethical responsibility to help our students to become the best practitioners they can be, but what should guide us in this endeavour? Currently there is much emphasis on concepts such as 'evidence based practice' and 'effectiveness'. As a consequence there is a tendency to find reductionist solutions, such as practising within the NICE (National Institute for Health and Clinical Excellence) guidelines only or concentrating on teaching those approaches that appear to have an evidence base.

At the same time, as Cooper¹ states, relational factors are far more important to the outcome of therapy than instrumental elements or the practitioner's theoretical approach. So how should we train new practitioners? Our employing university's solution to this dilemma was not to narrow choice to perhaps cognitive behavioural therapy (CBT) only, but to also offer a course combining the three main theoretical approaches: humanistic, psychodynamic and CBT.

When the two of us came on board the outline of the course had been established, but the nitty-gritty of its content and delivery was up to us. At first we taught the three approaches discretely, expecting students to create their own integration, but many found this difficult and perplexing. Integration tends to happen over the course of development of the individual practitioner, so we took a good look at our own integration.

Both of us originally trained as integrative counsellors. Ariana then became a family therapist with an interest in systems, and Els trained as an integrative psychotherapist, with a relational/intersubjective way of working. Both of us also had knowledge and experience of meditation and mindfulness and were keen to include it in the training. We combined our two stances into a teaching model, which comprises a synthesis of the three main approaches, with relationship and relational processes at its centre. Now in its fifth year, the course evaluations are positive, with students valuing the model's clear framework, wide therapeutic palette and practical application.

Developing the model

As we come from different theoretical traditions, we each used different language to describe our approach and explain our beliefs about therapy. Before we could develop a shared language from which to begin to form a coherent integrative model, we needed to discover our shared assumptions and presuppositions about the nature of human beings, consciousness, and relational processes which make up our worldview. This process required some element of translation and the negotiation of previously held misconceptions about each other's approaches. We ultimately found lenses we could both subscribe to and through which we could consider the person as well as the therapeutic process and relationship.

Shared assumptions

We drew on the epistemological premises of social constructionism as well as systemic and intersubjective theory that influence both our thinking. These theories imply the relational and mutually dependent nature of human existence. We see the self as constructed through interactional processes via responses to internal and external feedback, and human nature as dependent on the process of being seen and acknowledged by another. The main principles/assumptions that underpin what we have called the Relational Integrative Model are as follows:

- Interdependence and intersubjectivity – people mutually influence one another and human beings are dependent on each other for survival
- Reality is subjective, objectivity can only be approximated, and truth is provisional
- Meaning and behaviour are products of interactional as well as intra-psychic processes
- Human beings are social beings – existing and embedded in socio/cultural/historical/political/language systems
- Wholism – the whole is more than the sum of its parts
- Ecological – human beings are part of wider ecological systems.

According to Burnham,² psychotherapeutic models comprise the three elements of 'approach, method and technique'. We decided to utilise this framework to knit together our version of the compatible aspects of the three main schools of therapy, as it

helps map out the relationship between theory, the counselling process and the actual tools and techniques used.

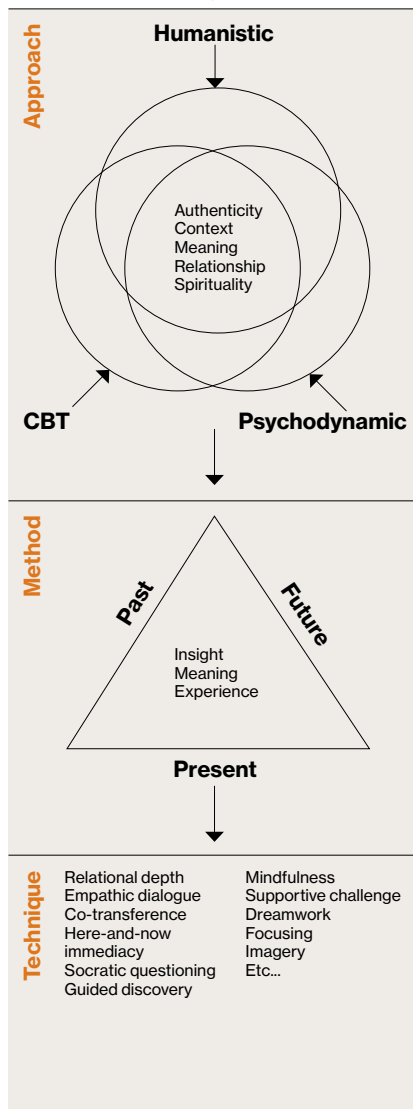
Approach

The top box of the diagram (right) shows that there is much overlap between the three approaches, with part of each approach lying outside the common area. The overlap includes the humanistic belief in the absolute equality of all human beings³ and the relational psychodynamic approach, which is based on the theories of object relations and attachment.⁴ Regarding CBT, we are particularly influenced by mindfulness, which appears compatible with the psychodynamic aim of promoting insight and the humanistic aim of being authentic, in helping us gain a handle on ourselves, and to live our life rather than let it live us.⁵

Individual practitioners may vary regarding what they integrate; indeed one's integration may change over time. Perhaps we become more entrenched in one area, or expand the common area in all directions as we realise that each approach has something important to offer. The three approaches are combined into a holistic framework to provide flexibility in meeting the diversity of client needs. Our 'flower of integration' may even vary from client to client, or may shift over time with the same client. This possibility of movement in the model indicates that it is live, as a flower is live.

In the same way that no two flowers are exactly the same in every detail, so each counsellor's personal version of the

The Relational Integrative Model



model may be subtly different too. Similarly, just as a flower may look different depending on the angle from which we view it, the same goes for our flower of integration – how we see and use it depends on where we or the client are coming from. We see the model as very flexible and applicable to brief, focussed work as well as longer-term therapy, as demonstrated in the examples below.

The core concepts of the model – authenticity, context, meaning, relationship and spirituality – are shown in the common area and refer to the client as well as the counsellor. They are transtheoretical concepts,^{6,7} which are interrelated and interdependent; they form a system, which means that change in one of the concepts is assumed to affect all the others. By being authentic ourselves, we aim to help the client to become more authentic, both intra and interpersonally.

Context is important, both that in which we see the client and that of the client's life. The relationship between the client and the practitioner is crucial, as without a good relationship it is unlikely that the therapy will be effective.¹ So the counsellor is not 'neutral' or a 'blank screen', but a real person who aims to work with clients in a collaborative way. We see spirituality as concerned with ultimate meaning, making sense of our lives, looking beyond the material and living ethically. Thus the spiritual aspect of the approach is inclusive and not affiliated to any particular movement or religion.

Method

We believe that meaning making is a central component of the therapeutic process (see second box of diagram, previous page). There is a reciprocal relationship between experience and the interpretation of the experience, ie the meaning attributed to it and the behaviours that emerge from the resulting beliefs, attitudes and values. A focus on meaning also implies a focus on language as the vehicle for meaning making.⁸ It follows that therapy or counselling can be said to provide a forum for the reinterpretation of meaning and can help us (the client and counsellor) to explore experience from many differing perspectives, taking into consideration the context and relational field in which behaviour is situated. This exploration involves a conversation that explores the territories of the past, present and potential futures. This model provides a structure and method that maps approach and interventions onto a temporal design giving a conceptual framework to guide an integrated way of working and the intentional use of therapeutic interventions.

The way we communicate with our clients is central to the therapeutic process. We are joining with the client and bring all our and their social identities⁹ into the encounter. The co-constructing of alternative meanings can influence the experience and action of the client.¹⁰ Exploring the context from which meaning is derived may open up a multitude of new possible explanations.

Present

Here and now, current beliefs, unconscious and conscious processes, patterns of relating
The therapeutic encounter itself is a new experience and can act as a trigger for insight as well as a laboratory for experimentation in the here and now. It is a relational domain, rich with potential to generate new choices, understandings, and transferable experience.

Past

Narratives, patterns of relating, meaning making
Uncovering the story of our lives, bringing forth new meanings, contextualised understanding and insight into patterns of relating. It can enable the development of a coherent narrative via a co-construction of meaning and the emergence of insight.

Future

Possibilities, choices, vision
Working with this orientation and exploring hypothetical futures facilitates the discovery of the client's own resources, solutions and goals, thus expanding the choices and options available to the client and linking insights with the possibility of change.

Technique

Below are two examples of the practical application of the Relational Integrative Model, which illustrate our model's applicability to longer-term work and brief therapy.

Longer-term counselling

Mervyn, a professional man in his mid 50s, told me that since his divorce two years ago he had been unable to sustain a relationship (*context/relationship*) and felt lonely and depressed (*meaning*). He said: 'Sometimes I feel like chucking in the towel' (*spirituality*).

Mervyn had gone to boarding school from the age of nine, as his parents lived abroad (*past/relationship/attachment issues*). He'd thought his marriage was OK and was shocked when his wife wanted a divorce (*relationship/meaning*). An offer of early retirement was the last straw. 'I'm on the scrapheap,' he said, 'no-one wants me' (*context/meaning*). Mervyn came to realise how his boarding school had made him distant and critical in relationships (*past/experience/insight*).

I helped Mervyn see that this strategy had helped him survive his school days, but how it was now no longer helpful (*insight*). Through the practice of mindfulness, Mervyn became more compassionate towards himself and others, which helped reduce his negative thinking. In the three years that we worked together I helped Mervyn to relate authentically, both in therapy and socially, and relationships with his two sons improved. He rediscovered his love of sculpture and became involved in setting up an artists' studio, where he met Julie, a widow with grown up children.

Brief counselling

Carla, a 21 year-old woman studying at college, worried constantly that she had nothing of interest to say to her fellow

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students and she checked and analysed her every word following any social encounter (*present relating*). She had had a panic attack before she was expected to give a small presentation in class. When we discussed her worries about her ability to communicate and their origins, I discovered that Carla had been bullied at school and her coping mechanism for survival was to immerse herself in her academic work (*past/experience*).

Carla’s mother had suffered from depression for many years following a series of miscarriages after Carla was born. Her father worked all hours and had seemed to her largely absent during her childhood. She had never discussed the bullying with her parents for fear of worrying them. In the room with me she was initially guarded. As we discussed her childhood experience more, she became tearful and revealed that she felt guilty and responsible for her mother’s depression and for making her mother happy (*attachment/meaning making*). Her response was to always be quiet and good at home.

We explored the possibilities of alternative explanations and she began to entertain the idea that she was not guilty (*alternative meanings/constructions*). We debated how important it might be for her to continue to protect herself in the ways that she had when she was at school, by avoiding people and keeping her head down. She accepted the reframe of her current and previous behaviour as coping strategies that she could choose to change given that the context had now changed (*context/meaning/narrative*). She began to experiment outside of the

therapy room by initiating conversations with fellow students. Her success in doing this began to bring about a growth in confidence and the anxiety and panic attacks reduced.

Conclusion

The two examples illustrate how the model is applicable both to brief, focussed counselling as well as to more open ended, longer-term work. How the model is used and where the emphasis lies will vary both between individual counsellors and from client to client. In other words, the emphasis in focus shifts depending on client needs as well as the counselling setting and context. Ultimately we believe that it is the relationship between client and counsellor that will determine the effectiveness of the therapy. The feedback we have received so far suggests that it is the model’s flexibility and adaptability to the needs of the client that helps counsellors to foster sound therapeutic relationships with their clients.

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