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**Eclectic**  
and  
**Integrative Approaches**  
in  
**Psychotherapy**

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**July 2005**

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## **Declaration**

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## **Abstract**

This thesis addresses the issue of eclectic and integrative approaches in counselling psychology, their meaning and theoretical and practical significance amongst a group of practising psychologists.

Part one is a piece of qualitative research using the grounded theory method. It investigates eclectic and integrative approaches in the practice of therapists who were interviewed using a semi-structured format. Research themes included therapists' views on eclectic and integrated practice, what therapy was chosen at which time and common factors in these choices. The interviews were recorded and transcribed. Emergent themes were analysed into superordinate categories: the nature of the therapy, the nature of the therapist and common factors in decision making. The eclectic integrated therapy investigated is viewed within a pluralist constructivist paradigm in which the process of integration occurs within each individual therapeutic alliance. The implications for integrative practice are discussed and areas for further research are indicated.

The literature review in Chapter 2 considers the topic in the context of the understanding and treatment of Borderline Personality Disorder. The subject was reviewed with reference to ideas concerning the nature of the condition, its aetiology and treatment. Reservations were noted concerning the concept of personality disorder within the ethos of counselling psychology. The review suggests that no one therapeutic approach is able to provide a comprehensive understanding or adequate guidelines for treatment. The need for an eclectic approach is suggested.

Integrated eclectic practice is demonstrated in the Case Study in Chapter 3. A therapeutic intervention is described which illustrates the use of the writer's Integrated Eclectic model. It describes how the therapy passed through a number of stages according to client need and in reference to the model used. It details the benefits and difficulties of the approach as well as demonstrating how the latter were resolved. The need for a further refinement of the model is discussed.

# Chapter 1

The discipline of psychotherapy has seen a gradual evolution since its inception in the early days of psychoanalytic theory (Freud, 1910). Gradually, therapeutic approaches have begun to access different routes, such as behaviour and cognition, to effect change (Freedheim 1992, Beck, 1976, 1991). With this came different theories concerning the aetiology of problems and their treatment strategies. (Bennun and Schindler 1988, Boscolo et al 1987, Friedling et al 1984). However, the demands of both service delivery and multifarious client needs have resulted in a move away from pure school theories. Increasingly, therapists are drawing on a number of approaches in their work with clients (Prochaska & Norcross (1994).

Inevitably, this raises a number of issues for therapists wishing to work in such an eclectic way. First, although some integrated theories, such as Cognitive Analytic Therapy (Ryle, 1978), have been articulated, there exists no fully articulated model which provides a definitive guide to practice for therapists who use a variety of other approaches in their work. Further, it is evident, as witnessed in counselling psychology training that many therapists are working in this way. It appeared from my experience as a trainer in eclectic practice and as a practising integrated/eclectic psychologist that some therapists were using a number of approaches, which they appeared to be applying without reference to a discrete theoretical framework. I wished to investigate whether this was in fact the case. Without such a specific theoretical base, therapists run the risk of being criticised for work that is ad hoc. They also lack the grounding provided by firm theory (Garfield, 1995). These are problems with which I have been faced, both in my own work and as a trainer in an eclectic approach. There existed no rationale with which I could explain why I was using a particular approach with a given client at a certain point in the



therapeutic process, or to provide me with a coherent system for the aetiology of problem causation.

My own struggle to demonstrate the coherence in my work, so much of which appeared to be processed at an 'intuitive' level, was mirrored in the gradual development of my students as they trained in eclectic therapy. It was evident that guidelines for eclectic practice were needed for the trainee therapist, many of whom were confused by the possibilities offered by the approach. My own personal journey took me to the basis of my own philosophy and beliefs concerning my therapeutic approach, and encouraged me to identify the theoretical approaches that had influenced me in my development as an eclectic practitioner. This led me to articulate my findings in a model of integrated eclecticism (Austen, 1998). Drawing on the work of Holmes, (1985), Stiles, (1990) and Pinsoff, (1994), this provides both a theoretical base for practice as well as guidelines for choice of approach. It also suggests an over arching meta-theory in which a number of descriptions of the aetiology of problem causation might be accommodated. Further, this research made me curious about how other eclectic practitioners resolved these difficulties. These questions provided the momentum for this thesis.

Chapter 2 describes an investigation into the approach and practice of five such therapists. It seeks to uncover the thinking behind their practice. It also identifies common factors in both their philosophy and their decision making in the therapeutic process.

The literature review in Chapter 3 traces the development of theory and practice in the treatment of Borderline Personality Disorder. This topic was chosen since the condition is one of the most difficult any therapist is likely to encounter. As such, it presents a challenge to the theoretical concepts of all therapeutic approaches, none of which are able to present a comprehensive rationale for the aetiology and treatment of the condition. It thus presents an opportunity to consider the contribution of a number of approaches, their limitations and benefits. It concludes by recognizing that BPD requires an eclectic approach in its understanding and treatment.

Finally, Chapter 4 is a Case Study, describing the author's integrated eclectic model. It explains the theoretical base of the approach, together with the guidelines for practice. The case study demonstrates the therapeutic process, together with therapeutic decision making, along with the difficulties that were encountered and how these were resolved. It suggests principles for a general application of the model together with suggestions for modifications of the approach.

This thesis, therefore, investigates an eclectic and integrated approach in a variety of areas: in the practice of individual therapists, its use in response to an extreme psychological condition and in the author's integrated eclectic model. My research has helped to clarify and develop my own thinking and practice and as such seeks to clarify both theory and its application in this emerging field. As an organic process, psychotherapy is of necessity changing, both in response to the exigencies of external demands and within the interactive feedback loop between theory and practice. As a profession, it is important that our practice, whilst flexible and evolving is still grounded in theory, with a sound rationale for practice. These investigations illustrate the difficulties and the benefits of eclectic and integrative approaches and aim to deepen understanding of the topic.

## **Chapter 2**

# **An investigation into eclectic and integrative approaches in psychotherapy**

## Introduction

Until recently, counselling psychology practice and training were based on an approach which both acknowledges and requires practitioners to be proficient in the use of more than one therapeutic approach. Although this is no longer a requirement, many psychologists have been trained, and now practice, in this way. However, little has been written about how these different approaches are applied in practice by practitioners, both in terms of their interactions with clients and their own conceptualizations of this theoretical eclecticism. The two terms are often used interchangeably in literature on the subject. For instance, Patterson (1980, p571) considers that 'Eclecticism is.....or should be a systematic, integrative theoretical position...attempting to integrate or synthesize the valid or demonstrated elements of .....narrower or more restricted theories'. Hollanders (2000, p32) draws a distinction between the two. He describes eclecticism as being 'primarily technical, using and applying the parts that already exist, basically in the same form, atheoretical but empirical, and realistic'. Integrationism is described as 'primarily theoretical in its development, the creation of something new by blending elements together into a unified whole, more theoretical than empirical and idealistic'. There is an implication that eclecticism is a strategic response in the face to face work with clients, whilst integrationism is a theoretical explanation of the position.

The approach of the profession to these questions is self evidently continually evolving. Whilst the labels eclectic and integrative have both been applied to this approach, the end result of each was similar. Both are based on the assumptions that no one approach is sufficient for all therapeutic situations and that there is much to be gained by learning from other ways of approaching the psychotherapeutic encounter. This realization began to find a voice in the 1960's, when Frank (1961) introduced the idea of a common factors approach to therapy. He identified common processes in all approaches to psychological healing, such as emotional

arousal and an increase in self-esteem. He thus suggested that these factors can be identified in all forms of psychotherapy. Again, the emphasis is less on theory and more on effective treatment by use of what is demonstrated to be the universals in terms of therapeutic intervention, as also illustrated in the work of Goldfried (1991). The focus is on the clinical change process, rather than on theory or technique, and this, as Norcross (1992) suggests, may be the curative factors involved in any therapeutic encounter, which transcends the theoretical orientation of the therapist.

Later, Lazarus (1967) developed the concept of technical eclecticism. Technical eclecticism draws on all available therapy to suit the person and presenting problem. This judgement is based on previous experience and research and the emphasis is placed on what works, rather than why a therapy is effective. This approach is based on a comprehensive assessment of the client's experience, which addresses each of these aspects, by use of an appropriate therapeutic technique, drawn from behavioural, cognitive and humanistic therapies. He thus sought to expand the behavioural basis of his usual approach by including techniques which normally fell outside of this approach. This gradually evolved into his model of Multimodal Behaviour therapy (1973) and then finally into Multimodal Therapy (1981) which he describes as 'a multimodal assessment that evaluates a client's behaviours, affective reactions, sensations, images, cognitions, interpersonal relationships and biological processes, typically reveals a matrix of discrete and interrelated problems - both interpersonal and contextual - that facilitates clinical attention to a wide array of salient issues' (p35). This was an eclectic approach based on a comprehensive assessment of the client's experience, which addressed each of these aspects by use of an appropriate therapeutic technique, drawn from behavioural, cognitive and humanistic therapies. Lazarus poses the question 'What treatment, by whom, is most effective for this individual with those specific problems, and under which set of circumstances? It is impossible to embrace this dictum and yet remain within the boundaries of any delimited school of thought' (p38). As Norcross (1992) suggests, technical eclecticism is 'relatively atheoretical, pragmatic and empirical' (p5)

Other early references to eclecticism include Dimond et al (1978), who describe a prescriptive eclecticism. This was based on a broad framework, which permitted patient-specific treatments. This provided an operational framework of personality functioning which included concepts and theories from biophysical, intrapsychic, phenomenological and behavioural models of functioning. Therapeutic practice, including theory, assessment, goal setting, intervention and evaluation thus took place within these paradigms. However, this eclectic approach did not suggest a rationale by which a decision about which approach might be used with which clients could be made. Nor was there an attempt to construct a transtheoretical rationale.

An alternative approach to the subject was developed in the idea of theoretical integration. In this, an attempt is made to integrate two or more therapies on both a theoretical and practical level. Techniques for each approach would be called upon as thought appropriate. For instance, Wachtel (1970) sought to integrate psychoanalytic and behaviour therapies. The aim is to blend two or more approaches to become a new approach and allow for integrated practice. Similarly, Ryle (1978) in seeking to integrate cognitive and analytic therapies suggested that a common language for psychotherapy would inform the various approaches and allow for eclectic practice. By conceptualizing therapeutic theory and practice in terms of the cognitive processes involved, Ryle argued it was possible to describe the widely different therapies of psychoanalysis and behaviourism in common terms. This conceptualization, whilst usefully providing a common language in cognitive terms, begged the question of how therapists from the different orientations might resolve any perceived conflicts in the approaches.

The literature therefore suggests that eclecticism may be defined as drawing from many sources, to apply relevant therapeutic techniques to the benefit of the individual client. Integration is variously described in terms of the amalgamation of psychotherapeutic theory, common factors in the change process and the absorption of theory and research from other relevant disciplines.

Crucially, the difference appears to lie in the integrationist's attempts to draw together the various therapeutic ideas, techniques and approaches, whereas the eclectic is content to work pragmatically, drawing on what is required without this attempt to unify.

The Counselling Psychologist training syllabus used to require counselling psychologists to be proficient in more than one therapeutic approach, and in doing so, the profession has recognized the basic assumption that no one therapy fits all. There is also an acknowledgement that as the outcome literature suggests, psychotherapy is effective, but that no one therapy is consistently more effective than others (Lambert, Shapiro, & Bergin, 1986, Stiles, Shapiro & Elliot, 1986, Luborsky et al 2002, Wampold et al 1997). As the pressure to see increasing numbers within the statutory services increases, there has been a need to find effective, briefer term therapeutic approaches that are targeted at the specific client.

As the Delphi poll (Norcross, Alford, & De Michel, 1992) found, theoretical integration and technical eclecticism were two approaches deemed most likely to be used increasingly in the 21st century. As Norcross (1992) states ' In terms of interventions and modalities, the consensus is that psychotherapy will become more directive, psychoeducational, present-centred, problem focused, and briefer in the next decade' (p486). There is thus a movement from the position of evaluating a therapy's effectiveness, to assessing its efficacy with a given client. Further, even 'pure form' therapists are now acknowledging the influence of different approaches in what they actually do in face to face contact with clients, as opposed to their theoretical explanation of it. It seems likely that few, if any, clinicians practise a pure form of therapy and contemporary practice is an amalgam to a much greater extent than is acknowledged in theoretical writing (Kerr et al 1992).

On a personal level, as both a therapist and former teacher of eclectic practice, I have been greatly exercised in attempts to articulate the basis of my own practice, both to improve my own work and to present students with a comprehensive and applicable model of eclectic practice

(Austen, 1998). This present research seeks to extend the basis of knowledge in the subject by investigating how other eclectic/integrative practitioners are applying the model in their work.

As the literature shows, there are various definitions of the terms 'eclectic' and 'integrative' and this research first seeks to clarify how these terms are understood and used by practitioners. Whilst the terms are being used with increasing frequency, there is no evidence to demonstrate that there is any common understanding or agreement about their precise meaning. In order to engage in constructive and intelligent debate on the subject, it is crucial for the profession to ensure that there is a commonality of language and meaning in the subject. Also, I wished to investigate the factors on which practitioners make a decision as to which approach to use with a particular client.

Further, as it appears that a large number of therapists consider themselves to be eclectic/integrative (Glass et al 1993, Jensen et al 1990) it is also important that as a profession, we are able to give a coherent and understandable rationale for our practice, both within and without the profession (Norcross et al 1992, Garfield 1995).

Psychology research has traditionally been based in quantitative approaches, but over recent years counselling psychologists in particular have recognized the value of qualitative research in their work (Marks and Yardley, 2004). Given the widely differing philosophy of science between quantitative and qualitative approaches, Ponterotto (2005) has suggested, that it is important for qualitative researchers to understand the philosophy of science underpinning their work. I will therefore explain the basis and method for my grounded theory approach carried out within a constructivist paradigm, against this background.



## **Philosophical Considerations**

Pontoretto (2005) explains that the philosophy of science perspective deals with the conceptual roots which guide the pursuit of knowledge within a given field. This philosophy is contained within a number of areas, ontology (the nature of reality), epistemology (the study of knowledge and the relationship between researcher and participant) axiology (the influence of values within the research process) rhetorical structure (the language and presentation of the research) and methodology (the process and procedures of the research). It is therefore necessary to consider all of these aspects in any research project.

The philosophy of science is expressed within a research paradigm, which until recently in psychology was based within a positivist tradition. This tradition sees the world as objectively knowable, measurable and explainable. There was an attempt to emulate 'hard' science by nomothetic approaches seeking to produce generalizable conclusions free of researcher bias. Thus, phenomena were observed and described within a model or theory and hypothesis was developed followed by a tightly controlled experimental study. Results were analyzed using statistical methods in relation to the original hypothesis (Hood & Johnson 1997, Cacioppo et al, 2004).

In contrast, qualitative approaches are idiographic, concentrating on one or few individuals and find categories of meaning from the participants' studies, as opposed to aiming for generalizable findings (Camic et al 2003, Denzin & Lincoln, 2000, McLeod, 2001).

Qualitative approaches have found expression in a number of research paradigms. Post positivism, which uses similar research methods, also accepts an objective reality. It differs from positivism in that it maintains that reality is only partly apprehensible: the 'truth' is therefore never fully known but findings may become more veridical with the pursuit of knowledge (Lincoln & Guba 2000).

Similarly a qualitative approach may also be located within a constructivist paradigm. This approach differs radically from former approaches in that it advocates a transactional subjective stance in which meanings are socially constructed (Hansen 2004). The ontology accepts that there are multiple 'realities' and no objective 'truth'. The epistemology posits that researcher neutrality is therefore neither possible nor desirable since the dynamic interaction between researcher and subject is vital in describing the participant's experience. It is through this interaction that deeper meanings are uncovered (Schwandt 2000, Sciarra 1999). Qualitative methods are therefore designed to describe and interpret participants' experience in a context specific setting.

The axiology of constructivist theory maintains that the researcher's own values and experience cannot be divorced from the research process (Pontoretto, 2005). The researcher must therefore be aware of the impact of his or her values on the research process, but not eliminate them. As such, the rhetorical structure of qualitative research will differ from that employed in quantitative methods since the researcher's own experiences and expectations are comprehensively detailed, along with any impact upon the researcher.

This subject has been extensively debated within the field of grounded theory research. As Chamberlain, Camic & Yardley (2004) point out, it may prove difficult, if not impossible, for the researcher to set aside their own thinking when the research data is being examined. As such, meanings generated become the product of the interview encounter and are a result of the perspectives of both researcher and interviewer. Indeed, Charmaz (2000) argued for Constructivist Grounded Theory, considering that all material generated in an interview situation was a product of the interaction. Thus, meaning is constructed as part of the interview process itself and it is not possible to objectify the subject under research. Criticising the position espoused by the founders of the method, Glaser and Strauss, she stated: 'Glaser & Strauss (1967) imply that reality is independent of the observer and the methods used to produce it. Because

(they)...follow the canons of objective reportage both...write about their data as distanced experts....thereby contributing to an objective stance' (Charmaz, 2000 p513). She argued that 'data are narrative constructions... They are reconstructions of experience...at best we can recall and narrate, data remain reconstructions' (ibid p514) Thus she posits that '... a constructivist approach recognizes that the categories, concepts and theoretical level of an analysis emerge from the researcher's interactions within the field and questions about the data'. However, Glaser (2002) forcefully refuted this position. He argued that human biasing is minimized in the careful administration of grounded theory procedures of constant comparative method and theoretical sampling, which makes the generated theory an objective finding. The generated categories are thus rendered abstract of researcher interpretations. Any researcher bias is dealt with in the same way as any other and is an important variable to weave into the constant comparative analysis. Bryant (2003) maintains that such a positivist position is no longer tenable. He argues that it is not possible for researchers to 'un-know' previously acquired knowledge and that this will necessarily be brought to bear in the analysis of the data, despite researcher's efforts to be 'objective'. As he points out, Glaser fails to address this point and he suggests that guarantees of neutrality can only be given once objectivist grounded theory methodology can be seen to have engaged with the constructivist arguments. It is therefore necessary for the researcher to reflect on this process and to acknowledge their part in the research interaction. Against this background, this present research may be seen as a part of the continuing discourse on eclectic and integrated practice, being both influenced by and influencing it.

Qualitative research necessarily brings with it a different approach to the quantitative concepts of validity and reliability. Particularly, the constructivist approach, which recognizes multiple realities, has had to develop different strategies in its research methodology. Morrow (2005) suggested the concept of 'trustworthiness' in such research. This includes the concepts of 'authenticity criteria' which include fairness, in the sense that different constructions are elicited and respected, ontological authenticity, in which individual's constructions are improved and developed, educative authenticity, which enhances participants' understanding of other's

constructions and catalytic authenticity which is the extent to which action is stimulated. She further stressed the importance of the construction of meaning within the context of context, culture and rapport. Thus, findings must be viewed within the context from which they developed, within the culture of the participants. Also researchers must aim for excellent rapport to elicit the best material from their participants.

Further, Patton (2002) identified two processes as important components of quality in qualitative research. These were dependability, 'a systematic process systematically followed' (p546) and triangulation, 'capturing and respecting multiple perspectives' (p546). Since grounded theory recognizes that the nature of the data gathered and the analytic processes engaged are grounded in subjectivity, a number of measures have been suggested to manage this subjectivity. Patton stressed the importance of researcher reflexivity in the process of understanding and developing the research. Researcher reflexivity aims at 'self awareness and agency within that self-awareness' (Rennie, 2004 p183). Also, subjectivity is managed by making overt implicit assumptions and biases by 'bracketing off' or 'monitoring of self' (Peshkin, 1988, p20) or being 'rigorously subjective' (Jackson, 2004 p154). Finally, to address the question of whose perceptions are really being described in the findings, described as a 'crisis of representation' (Denzin & Lincoln, 2000), researchers must strive to fairly represent participants' realities by seeking clarification, searching for meaning and taking the stance of 'naïve inquirer' (Morrow 2005).

### **Why Grounded Theory?**

The research question, which seeks to uncover the individual thoughts and meanings of a number of therapists, would I felt, be best addressed by qualitative methods. I was seeking to uncover and describe a phenomenon, not to prove a previously generated theory. I wished to 'understand the meaning of experience, actions and events as these are understood through the eyes of particular participants' (Henwood 1996 p 27). Rather than a generalized causal analysis, I was aiming for a 'thick description' (Geertz, 1979) of the phenomenon under investigation. The

research thus aimed to deepen and enlarge the understanding and to provide a 'deeper' picture of therapists' experience of their practice (Silverman 1997). Grounded theory thus 'goes beyond description of superficial explanation to build a coherent and potentially generalisable theory' (Chamberlain, Camic and Yardley, 2004). Also, as Clarkson (2000) has suggested research should be congruent with its subject matter and the qualitative approach reflects the practice of eclectic/integrative practitioners in that rather than seeking to fit therapist responses into any given hypothesis or theory, the approach relies on inductive methods.

Particularly, grounded theory was chosen because it allowed for the generation of a theory that was grounded in an iterative process with the participants, rather than imposed by an hypothesis. As Glaser and Strauss (1967) suggested, grounded theory aims to 'close the embarrassing gap between theory and empirical research' (p vii). The research has not attempted to define a 'correct' definition of the terms under investigation and to assess the practice associated with them. These issues would be better addressed by a quantitative method which would have had the advantage of accessing a larger sample and given breadth, but not depth of meaning. It would therefore not have achieved the in-depth discovery of therapists' experience which was the object of the research.

Grounded theory also provides a systematic method for its application (Yardley 2004). The grounded theory method has advantages in that its techniques are now well documented and provide a guide for the researcher. It offers a systematic method for the collection, organization and analysis of data from the empirical world and is well suited to an empirically based discipline such as counselling psychology. Grounded theory therefore offered the most appropriate approach for accessing the phenomenon of therapists' conceptions of their practice. Certainly, the results obtained were unlikely to have been delivered by a broader based quantitative approach. On the other hand, grounded theory's strengths were also its weaknesses in that the phenomenon described is inevitably to be viewed in context specific and pluralist

terms (Silverman 1993). It is also an extremely time consuming and painstaking enterprise from the transcribing of individual interviews to immersion in the data and gradual extraction of themes. Without an initial hypothesis, it can be difficult to maintain clarity in the direction of the research. An overwhelming amount of data is generated, requiring much persistence as one becomes 'immersed' in the material, before finally 'emerging' with the relevant categories. Further, it can be difficult to 'bracket off' of one's own values and prejudices since a perspective on the research is required in order to see relevance and connections in the data, whilst holding all potentially relevant facts and theories in the background for some period of time.

This method was chosen rather than, for example, discourse analysis since this method focuses on 'texts in their own right' (Gill 1996, p 141), rather than seeing them as a means of accessing the individual meaning behind the discourse. As Potter (2004) states 'Discourse analysis has an analytic commitment to studying discourse as texts and talk in social practices.' Further, as Silverman (1993) stated, discourse analysis is often related to 'more conventional social science concerns... such as gender relation and social control' (p121). Grounded theory thus enabled the research to focus on the hermeneutics of the interaction, looking at therapists' experience of working in a chosen way, rather than to view therapy as a social action accomplished through talk or to address the social context and function of therapy and how talk structures the experience.

### **The Interview Process**

Interviews may also be viewed as a social process of creating meaning, serving a social function. As Billig (1987) pointed out, there can be an inter-personal motive to be consistent, to avoid contradicting oneself in other's judgement. He contends that thinking is not consistent and that dichotomous and contradictory ideas may co-exist and should be accepted as such. The semi-structured interview is likely to uncover such discrepancies since 'attitudes are not neat bundles of responses...but represent unfinished business in the continual controversies of social life'

(Billig 1987 p225). In addition, the interviewer must also be aware that the wish of interviewees to present themselves in a positive light may skew responses. It is thus necessary to be receptive to nuances of detail within the interview transcripts.

The importance of contextual information (Waitzkin 1990) in understanding the results is also recognized, and participants were asked to describe the orientation of their training and length of time practising before the interview began. Similarly, viewing the interview as a social interaction, it was necessary to consider the respective roles of the participants, their respective positions and the context in which the interviews took place. Participants should therefore be chosen from therapists with whom the researcher was not linked by any supervisory or management relationship to ensure there was no contamination of results. Also, the concept of 'indefinite reflexivity' (MacIntyre 1984) in which each participant is continually monitoring received feedback to modify their responses is highly relevant. For instance, it was important to ensure that my responses did not draw the participants along a particular line of thinking and participants were encouraged to develop their own ideas within the interview conversation. This was facilitated by taking an interview stance of dispassionate involvement. Where 'the interviewer is explicitly active in the interview without compromising the meanings and structures of what the participant is saying. The nature of this involvement is at the active non verbal level '... it is not engagement... which sacrifices the focus on themes emerging from the participant alone' (Hale & Moss 1999). However, the constructivist position (Charmaz 2000), which argues that data are a product of the interaction between both interviewer and interviewee, would question whether the themes emerge 'from the participant alone'. Certainly, the research questions in the interview format are researcher generated and as such respondent's responses are couched in these terms. However, it is fair to say that the approach of dispassionate involvement or 'taking the stance of naïve inquirer' (Morrow 2005), by seeking clarification and delving into meanings does encourage participants to express their responses freely, without undue pressure or bias from the researcher. As Morrow pointed out, this is particularly important when the researcher is an 'insider' with respect to the subject being investigated, which did obviously

obtain in my research.

Such research necessarily draws on the interviewer's empathic understanding of the participant's experience. This is grounded in the personal experience of the interviewer (Atwood & Stolorow, 1984) as well as on the participant's speech and behaviour. It was therefore necessary to be aware of my own personal bias, such as a personal view and previously executed research on eclectic and integrated practice. It was also necessary to be aware of the shared intersubjective meanings between interviewer and interviewee (Taylor, 1979). As therapists working within a milieu where eclectic and integrative practice is acknowledged and encouraged, there is the common assumption that it is both necessary and desirable, which might not be shared by 'pure school' therapists.

## **Method**

The research was conducted using semi-structured interviews, which were taped, transcribed and recursively analysed. This qualitative method was chosen to provide a 'deeper' (Silverman 1997, p15) picture of therapists' experience of their practice. Thus, the research was 'discovery orientated' (Elliott, 1984, Glaser and Strauss 1967, Moon et al 1990), in that no theory or hypothesis was stated in advance. Rather, the research sought to generate meaning in the context of therapists' approach to their work. Analysis and theory thus developed over the course of the research. Data collection and analysis and theory were necessarily concurrent, 'data collection, analysis and theory should stand in reciprocal relationship with each other. One does not begin with a theory then prove it. Rather, one begins with an area of study and what is relevant to that area is allowed to emerge' (Strauss & Corbin, 1990, p23). Whilst a formal questionnaire would have structured the information into the direction pre-determined by the interviewer, this



research sought to uncover therapists' conceptualizations on their practice. The research aimed to deepen and enlarge understanding of the topic rather than to predict or prescribe. Also, as Clarkson (2000) has suggested, research should be congruent with its subject matter and the approach chosen reflects the practice of eclectic/integrative practitioners in that rather than seeking to fit therapists responses into any given hypothesis or theory, the research relies on inductive methods.

The interviewees in the sample were three chartered counselling psychologists, one clinical psychologist and one psychotherapist working within health service trusts psychology department. Two worked in primary care, with one of them working also in learning disabilities. The remainder worked in mental health, either within a psychology department or a community mental health team. There was thus a wide level of experience. This avoided the possibility of a convergence of views based on the experience of a common working environment.

### **Relationship between interviewer and therapists**

As Silverman (1997, p204) has pointed out, the interview is 'essentially socially organized character of discovery,' and is the process through which the relations between elements are articulated. It is therefore important to be aware of any distortions which might occur in the interviews owing to such factors as the different interactional roles. In this case, the interviewees were known to me personally, through professional contact, and there was no dual relationship, such as a difference in management role or supervisory status. We were meeting on an equal professional footing. However, having written published work on eclectic and integrated practice, I was aware that this could be a confounding factor in my relationship with the interviewees, if they were aware of my views on the subject. In fact, only one participant (Therapist 3) was aware that I had written on the subject and had read my article. This did not appear to make any difference to her responses, since hers matched with those of the other participants and none were actually repeating my views.

In order to build rapport, and to encourage the interviewees to feel free to express their views, the interviews were conducted in a supportive and open manner. Once an answer to a question was completed, I gave a positive response, such as '*right*', '*good*', but was careful not to give this response before the interviewee had dealt with the subject matter of the question. In this way, interviewees were encouraged to give their views fully and freely. By interpreting, verifying and clarifying answers during the interviews I was able to elicit spontaneous, rich material.

### **Recruitment**

Participants were recruited through word of mouth. I requested participation from several practitioners known to me to be working in an integrated/eclectic way and from them was recommended to other therapists known to them also working in this way. Initially, I began with therapists who had received an eclectic training and also worked in this way. Later, using relational sampling, I chose therapists who had received a specific training (psychodynamic) who now worked eclectically.

### **Participants**

<b>Therapist</b>	<b>Training</b>	<b>Academic level</b>	<b>Years in Practice</b>	<b>Profession</b>
1	Eclectic	MSc	5	Counselling Psych.
2	Humanistic/Eclectic	PhD	14	Counselling Psych.
3	CBT, CAT/Eclectic	MSc	5	Counselling Psych.
4	Psychodynamic	MSc	13	Psychotherapist.
5	Psychodynamic/ CBT	D.Clin.Psych	5	Clinical Psych.

### **Participant Involvement**

Following transcription of the interviews, a written summary was given to the participants, asking for comments and corrections (Reason & Rowan, 1981) to provide a further perspective.

Further, as Rosenwald (1985) and Sullivan (1984) have suggested, empowerment or enhancement of participants is a legitimate purpose of research. In this context, as Stiles (1993 p11) contends, 'imposition of an interpretation on participants' experience can be seen as a political as well as a scientific act'. From this perspective, all research is political and ethical issues permeate scientific research. It is therefore appropriate to involve participants in the construction of interpretations. These responses formed part of the triangulation of results (see below). Since the grounded theory approach allows for multiple realities, as Sparkes (1998) suggested, this participant checking did not serve the function of validation or verification but served as an elaboration on the findings, providing additional data. Also, as Morrow (2005) suggests, 'the researcher has the responsibility to learn from the interviewee how well the researcher's interpretations reflect the interviewee's meanings' (p254).

### **Triangulation**

Triangulation was employed as part of the process and as a source of additional information. As Yardley and Marks (2004) point out this is a useful method in qualitative research as it allows the researcher to approach the topic from different perspectives. It is thus possible to identify convergence or disparity in the data. As well as feedback from participants, the third part of the triangulation process was the production of peer review document (Rating Document - see Appendix 4) which along with the interview transcripts, was examined by two independent psychology graduates (occupational and counselling - see Appendix 5). I employed this research tool as saturation had been reached within a comparatively small sample and I therefore wished to gain a wider perspective on the data.

### **Coding and Saturation**

Coding 'represents the operations by which data are broken down, conceptualized and put back together in new ways. It is the 'central process by which theories are built from the data' (Strauss and Corbin, 1990, p 57). The tape-recorded interviews were transcribed and common themes

extracted. This was a recursive process, which involved memo writing (Appendix 1) and returning to the transcripts as themes emerged. First, data were collected and analysed using open coding to open up understanding. Open coding refers to the labelling and categorizing of the phenomena as indicated by the data. This produces concepts on which the grounded theory is built. This involved going through the interview transcripts systematically and assigning categories to sections of the text using the cut and paste method. Usually, this involved 'in vivo' codes, quoting the words used by the interviewee. As more material was collected a more extensive list of codes was developed, using a constant comparative method by returning to earlier transcripts to determine whether new codes were supported in the texts. Theoretical sampling was employed to test differences and emergent theories. For instance, one theme common to all subjects was a reluctance to use a psychodynamic approach. I was therefore interested to discover how a psychodynamically trained eclectic/integrative therapist would view this question. I therefore carried out a fourth interview with a therapist who had been trained psychodynamically before undertaking integrative training. The method of constant comparison allowed me to develop the ideas further and to thus further refine my theory. At this stage, no new categories were emerging, although a therapist with a different training had been included in the sample. More elaborate codes, or categories were then generated and the data analysed to a more abstract level of understanding in axial coding. During axial coding, I considered the properties of the categories and the relationships between them, continuing to use the methods of questioning and constant comparison. Three main categories were identified. To further test and refine the theory, using discriminant sampling I interviewed a psychodynamic/cognitively trained therapist. I was interested to see if any difference appeared in a therapist who had been trained in both these therapies. The results provided further support for the categories thus generated, but no new information was generated and saturation was reached. Saturation as described by Glaser and Strauss (1967, p65) occurs when 'no additional data are being found whereby (the researcher) can develop properties of the category. As he sees similar instances over and over again, the researcher becomes empirically confident that a category is saturated...' I therefore suspected saturation had been reached when I had found that my first four interviews contained

closely matching data in all categories. I then further tested this by selecting another candidate to confirm saturation and to elaborate the codings. This fifth interview confirmed that saturation had been reached. It also substantiated the initial findings and helped to further elaborate the theory. A peer review document was also produced as part of the triangulation process.

Once these codes were saturated and no more new information was being generated, it was possible to pass to the final phase of generating and verifying an integrated theory. By the integration of the previously generated categories, selective coding established the over-arching category that encapsulated the generated theory

The data were then reviewed with reference to the relevant literature to allow the generation of wider theoretical constructs (Pidgeon & Henwood, 1996).

## **The Interview**

The interview format contained a few open ended questions. As Morrow (2005) pointed out 'the fewer questions one asks the more one is likely to elicit stories and deeper meanings from participants' (p255). This allowed for depth and richness in the data by eliciting long detailed answers.

## ***Protocol***

The introductory statement to each participant was standardized to avoid any bias or undue influence on the participants. Participants were told that the interviews were being conducted with therapists who used more than one approach in their work. The terms eclectic and integrative were avoided at this stage as part of the research involved investigating practitioners' understanding of these terms. It was explained that the aim of the interview was to gain an insight and understanding of their experience of working in this way as follows:

*I am researching therapists' experience of their practice, specifically therapists who use more than one approach in their work. The interview will be exploratory. I hope to gain an understanding of your experience and thinking on the topic.*

### ***Interview format***

*What do you understand by the term eclectic therapy/counselling and what do you understand by the term integrative therapy/counselling?*

These questions were aimed not only to investigate how these terms were construed, but also to define the terms used by the particular therapist during the interview. Thus the interview would be investigating what the particular therapist understood by the topic under discussion, rather than by any arbitrary or objective definition of the terms under review. It is evident by asking these questions I was in fact inferring that there is a difference between the terms, when in fact some respondents may not have known or felt that there was such a distinction. Some respondents did in fact appear to conflate the two terms and this became apparent as the interview progressed.

*Would you please describe your usual approach to therapy?*

This was to gain an understanding of how the therapist worked in practice and how this related to their ideas on eclectic/integrative practice. It would also elicit information on the approaches the therapist used and how they related to each other.

*Are there any approaches you would not use?*

I was interested to know what approaches would not be used and why, since this might give some indication of the processes behind the integrative or eclectic use of particular therapies. It might also provide information on the philosophical underpinnings of the process.

*Would you use different approaches with the same client?*

This was to explore whether the therapist was using different approaches in a sequential or simultaneous way.

*What do you feel are the advantages/disadvantages of eclectic/integrative therapy?*

These open-ended questions helped to explore therapists' views on the topic in any of the areas of theory or practice that they considered relevant. It was important to phrase the question in this way rather than in a more specifically targeted fashion to avoid imposing my own constructions on the participants.

*Is there anything further you would like to add?*

Where necessary, a supplementary question took the form of

*'Could you tell me a little more about that?'*

### **Researcher Reflexivity**

Whilst carrying out the pilot interviews for this research, I became aware of how much my responses to interviewees were being affected by my own previous thinking and research in to the topic of eclectic and integrated practice (Austen, 1998, 2000). Working as an eclectic practitioner, I had spent some time thinking about my practice and was aware that I was working in an 'intuitive' way, without articulating the basis for my therapeutic decisions. This provided an impetus to find a way to articulate the basis of my practice. I did this by working from practice to theory, tracing the links in my thinking around given therapeutic decisions. As a result, I was able to identify the influence of Stiles' Assimilation model (1990) which describes the development of individual's problems in terms of schema theory. Therapists are able to identify the stage of problem resolution and in consequence, to adopt the most appropriate strategy. Cognitive behavioural therapies are appropriate for clearly articulated problems, whilst the psychodynamic, explorative, expressive therapies are used when difficulties are less clearly defined. I had further developed this thinking, incorporating ideas from Pinsoff (1994) and

Holmes (1995), which drew on systemic and psychodynamic therapies respectively. My ideas about my own practice were therefore comparatively fully defined and the pilot interviews gave me the chance to become aware of this and to develop the skill of 'bracketing off' my own ideas in order to immerse myself in the participant's meanings. I was thus able to reflect on this process during both data collection and analysis. It was in some ways, a parallel process with the experience of eclectic and integrative therapists who, whilst still having a knowledge base in a number of therapies, seek to fit therapy to the client rather than imposing a particular therapeutic stance upon a client's experience.

The research also helped to clarify my ideas on the philosophy of science of the various research methods. My own position tends towards post positivism/constructivism, and I became aware of the need to reflect more deeply and absorb the ideas inherent in the constructivist approach and to implement them in the research process. As a result of this process, I became more inclined to position myself within the constructivist paradigm as I became increasingly aware of the way meanings were generated and constructions of reality changed within the research process.

## **Results**

### **Open Coding**

By transcribing the data in the interviews and immersion in the text, themes gradually 'emerged'. I also consulted the feedback forms which had been given to all participants. By using the cut and paste method, I then produced an initial document (see Appendix 4) which consisted of quotes from each manuscript to support the themes I had identified as follows:

- Change in thinking about eclectic and integrated practice
- Pejorative views on eclectic practice
- Integrative practice has a theoretical base
- Process within therapy
- Integrative practice is an in session process
- Process within which client makes sense of the therapy
- Wholeness of integrated practice



Need for grounding in a theoretical base  
Importance of supervision and training  
No one therapy fits all  
Adaptability in assessment  
Adaptability in therapy  
Factors influencing choice of approach  
    Interpersonal/intrapersonal  
    Depth  
    Issues  
    Client history  
    Personal bias and choice  
Collaboration  
Empowerment  
Psychodynamic approach seen as disempowering  
Accessible therapy - open & understandable  
Fits aims of client  
Importance of therapeutic relationship  
No objective 'truth'  
Multi-factor causality

In order to gain more than one perspective on the research, I then passed the interview transcripts to two postgraduate psychology students who were asked to first read through the interview transcripts and to make notes on the themes that emerged for them. They were asked to then read through my document and to give their thoughts on this, noting areas of agreement or disagreement (see Appendix 5). This allowed for triangulation of the data. Rater responses supported the categories identified. Categories of particular note to the raters were:

1. Therapist confusion
2. Therapists validating their approach in terms of acceptable current discourse.
3. Influence of therapist personal factors on their choice of approach.

### **Axial Coding**

Further analysis in axial coding of the data indicated that both of these observations could be supported. There was evidence of both confusion and conflation of the terms 'integrated' and 'eclectic'. There was also awareness that there was a discourse about how the terms should be described. Therapists then sought to describe their practice in terms of the favoured definition.

Axial coding yielded three overarching categories:

## **1. The nature of the therapy**

Eclectic –pejorative definition

Integration in therapy -

Theoretical base (but no evidence in practice)

In session process- in session change of approach

Change in approach over time

Using different techniques

Integration in client

Importance of therapeutic relationship -

Open & understandable

Collaborative

Non expert position

Aspects of psychodynamic approach not 'transferable' (see memo)

Difficulties & avoiding them

Integrated or eclectic?

## **2. The nature of the therapist**

Confusion over terms

Defensiveness

Legitimizing practice in current discourse

Perception of self-differences

Common Factors -

Need to feel congruent

Scepticism - no ultimate 'truth' - post positivist/constructivist position

Desire to work outside parameters of single approach

Flexibility - adapt therapy to client

## **3. Universal factors in decision making.**

Causality Multifactorial

Assessment: Client -

Emotional state & needs

Goals

History

Problem Factors –

Inter v intra personal

Depth

Issues

## **The nature of the Therapy**

### **Definitions of integrative practice**

#### ***Theoretical base***

Therapists 1, 3, 4 and 5 related this to integrative practice having a theoretical base

.... (integrative) seems to be more acceptable because people are sort of working towards model joining together because of CAT and various models joining together because of analytic ideas coming into cognitive therapy (5, p i, 27-29)

.... Anthony Ryle's Cognitive Analytic Therapy which I'm beginning to think is a very, very effective therapy indeed. And it is quite, as far as I understand it, structured. And it stops you falling into this void. (4, p ix, 19-21)

....as opposed to an integrative model which has a base...you know, a theoretical base (3, p i, 15-16)

....the integrative model is one which, I would say, has its very firm roots in research ... erm... or maybe not so firm, maybe shaky roots in research (laughter) but some sorts of roots in research, that's been tried and tested, (3, p i, 22-24)

.... (CBT) it helps people, there's a lot of research evidence that it helps people then you should use it because you're a psychologist, you know, not a person who's doing their own thing. (5, p iv, 34-6)

.... I think there needs to be a kind of structure and I suppose that's where I would see, you know that when we talk about the discipline of psychology, the discipline of something else, that it is a discipline, it's within that framework and that's where I would see my work is rooted, back to these things, (1, p viii, 46-9)

Despite this acknowledgement of the need for a theoretical base, none of these therapists was able to offer such a base for their work as 'integrated' therapists. Their decisions as to which approach to use were based on other less explicit factors, as detailed below.

Only therapist 2, a self proclaimed 'intuitive therapist' acknowledged this

.... I'd be hard pushed to say, and I don't see it's any value in trying to say, but I would be hard pushed to say, I am using XYZ at this moment, because I'd be, dunno .....even between different things...or some TA, yeh. (2, p i, 53-5)

### *Integration as a process*

Therapists' description of their idea of integration was markedly different from the manner in which they described what they actually did in practice. A number of factors were identified as being common to the integrated therapy they were practising.

#### *In session process*

Integration was also viewed as a way of working within a session, in that the therapist works by moving between approaches as necessary.

*.... Integrative I felt, was more seamless and that perhaps a therapist may be working with a client and within a session may move from one form of working to another. (4, p i, 52-4)*

He illustrated this as follows

*.... Work with her has been quite psychodynamic, I've brought my feelings and how I have felt that she is in the session, her embarrassment and all the rest of it and we have worked on the here and now between us, her diffidence and her treating me like an authority figure, which is how she treated her father. We have done quite a lot of work on that. That I suppose is an integrative approach because you can then look at certain ways that she can then be thinking in certain sessions. (4, p vi, 38-43)*

Therapist 5 described how she moved between psychodynamic and CBT approaches in working with survivors of sexual abuse displaying OCD symptoms

*....psychodynamic stuff does work. But if somebody's OCD was precipitated by sexual abuse then I would do it in parallel. .... Now other people would just do behavioural stuff with them and tackle each different thing. I don't tend to do that. I tend to think of it as the whole thing is functional you know, what's the underlying stuff, can you access it. (5, p ix, 42-50)*

Whilst Therapist 3 incorporated different approaches within a cognitive approach

*.... I might use CAT, I don't use the full CAT, but I use the concepts and I'm working from that model, the reciprocal model, it's in my head while I'm working... ..but the...I would work then with psychodynamic...well, yes...psycho...what else can you call it...psychodynamic...with a*

*client. But it would always be the main orientation, even if I'm switching in a session, would still be cognitive, (3, p iii, 33 -39)*

Therapist 1 drew on different approaches as she felt necessary within the session

*.... I draw on Gestalt techniques... erm... obviously some cognitive behavioural work or some rational emotive therapy but again using those in connection with Gestalt techniques, you know, whether it might be drawing or again constructs of construct theory... trying to draw scripts for people so it might be trying to find a creative way of actually presenting those things.*

*(1, p ii, 29-32)*

She then elaborated how these different approaches would be integrated within the session

*.... but in using different models or using an eclectic approach you're then integrating those pieces of knowledge, insight or awareness or whatever, so that would be how I see an integrative approach (1, p i,39-41)*

She explained how she understood this in terms of a process within the session

*.... I would see integrative as very process oriented as well and.....I don't know if I'm explaining this very well....(laughter) but how it sort of rounds off something rather than it's just a continual line that it's there's a meatiness to it (1, p iv, 26-8)*

*.... Jung axioms of experience, each time it's a different axiom, you know that's how I would see things, so again part of my role is encouraging the client to see that some of these things will come back, they don't disappear but that their level of experience will be different. (1 p iv, 36-9)*

*.... It's not linear; it's more kind of circular... (1, p iv, 34)*

Therapist 2 demonstrated a similarly eclectic approach

*.....so whatever comes my way I will use Rogerian, CBT, Gestalt, whatever. (2, p i, 48)*

and describes integration similarly as the moment by moment process of the therapeutic encounter

*.... whereas integrative is more about going with the flow of what's happening with this person, in this moment in this room in this dynamic with me , and what's going on with me sometimes*

*(2, p i, 32-34)*

*You know I'll just kind of ebb and flow between them so the whole thing becomes of a piece (2, p i, 49)*

*.... integrative just means that the whole thing is more exactly as it says in the way we would understand it in ordinary speech just integrated- the whole thing is more of a piece.*

*(2, p i, 28-30)*

*.... just trying to take the whole view, really, it's...almost, a bit...you know... the whole is greater than the sum of its parts (2, p ii, 14-15)*

### ***Changes in approach over the course of therapy***

As well as integrating different approaches in a session, therapists may change approaches with a client as therapy progresses.

*....so, if somebody came and if they were very depressed then I might do some CBT work with them about that to lift that a bit, but if underlying the depression was abuse or bereavement or whatever, then I would do some work with them about that later on in the therapy, (5, p v, 36-8)*

*....so we made some drawings of this script and put in what people would say and then we actually worked on how you would change that. It's drawing on Gestalt but also constructivist theory and so this is how she saw herself. So if her grandmother was saying...you know... you're a dirty little whatever...this was what she'd taken in and believed. And then we looked at cognitive behavioural work, (1, p iii, 16-20)*

*.... a classic one would be with alcohol, patients where you say 'Right, you've got to do something, so you go to a specialist service and get some help, or you go to alcoholics anonymous and you listen to what other people say and we'll deal with your underlying depression, or the loss of your wife later on. Let's stop you drinking first. Let's start with the behaviour' (3, p ii, 11-15)*

*.... I vary according to the client...that's really the overall....criteria. I vary according to the client...at that moment in time. So I might use one thing with somebody one time but something else in a few minutes time, or something else next week (2, p i, 17-19)*

*.... And they were seeing their difficulties very much as a couple. And there was an implication that the first thing we must do really is to sort this part...I think there were longer-term issues which we needed to... perhaps that may be a possibility later. But getting him actually to look at what he was doing, there and then perhaps may have a greater and more immediate benefit than looking initially at the long term past where the patterns were laid.(4, p iv, 19-27)*

(Describing how he would work cognitively with a client before moving on to work on a deeper, longer standing issue which he was viewing in psychodynamic terms)

On the face of it, these descriptions appear to be of an eclectic approach, as different models are used at different points in the therapy, without the benefit of an articulated theoretical base. However, given their statements on 'wholeness' in therapy, it appears that their conceptions of the therapy are in terms of a whole process, and that they see each of these individual approaches as part of this.

### ***Integration of techniques***

Further, their approach also differs from, for instance, Lazarus' technical eclecticism in that whilst working from one main orientation this may be adapted according to the needs of the client, by incorporating techniques and/or concepts from other approaches. How many different techniques are used appears to depend upon the repertoire of the particular therapist. As follows:

*.... so we made some drawings of this script and put in what people would say and then we actually worked on how you would change that. It's drawing on Gestalt but also constructivist theory and so this is how she saw herself (1, p iii, 16-18)*

*.....rather than trying to find out what their underlying negative thoughts are and challenge them, or... I might look at ways of helping them...making suggestions, suggestions what they might do, that might make them feel better. So we might look at what the client's interested in, so this client's not interested in anything right now because he's too depressed so we might look at ways of getting involved in doing something, like reading about depression on the internet*

(3, p i, 54 ,- p ii, 4)

.... So while I'm using what might have come originally, let's say, from CBT, I don't know about the origins quite honestly, but if I'm thinking sort of slightly CBT mode, I'm also bringing in some Rogerian stuff, I'm also, if it's appropriate, bringing in Gestalt stuff (2, p i , 50-3).

..... I have done writing in sessions with people before now but I tend to do less of that now than I used to. But I don't know whether that's laziness. Or whether that's just naturally, you know, that's not helpful to people. But I have in the past done things with people in the session in terms of writing and then actually tried that and given them, which psychodynamic people never do.

(5, p ix, 14- 18)

Integration therefore works on two levels. First, the therapeutic approach may change as the therapy progresses and different aspects of the client's difficulties are addressed. Second, as the therapist uses one main therapeutic orientation within each individual session, s/he may also incorporate different concepts, such as transference, or techniques, such as empty chair work, within that approach, if this will help the therapeutic process, or make it more understandable to the client.

### ***Process within the client***

Integration was seen as a process also in which the client made sense of therapy. This was described as the client's being aware that they are going through a process of therapy and that their experience of it will change over time

*The client then sees that this is a process towards something that it's not going to stay like that for ever, more that they understand the mechanics of why they have to go through this stage, or maybe how long it's going to last, or why it's happening,*

In this process they will understand that the therapy has various themes related to their past experiences and that these ideas are integrated by the client in the therapeutic process.



*or what theme does it relate to. So I would see the integration as taking all those strands and trying to put them together (1, p ii, 6-9)*

*....(the client) integrates things, it's integrating all those experiences, (1, p i, 54)*

Similarly Therapist 5 describes how she helps clients to see the links between their various experiences and their problems...

*. I will try and get people to think about the links and work on what happened in the abuse to actually precipitate that and what was the first time that they washed themselves and try and work backwards. From the OCD. But I would also try and get them to reduce it down which is more of a behavioural in parallel and I might decide with them which was first, which to do first but certainly the formulation would make the links. (5, p x, 4-8)*

Therapist 3 also describes how she encourages the client to look at the links to past experience

*.... but that may not be the whole story, it might be quite a number of things that have gone on from birth to the person sitting there now, topped by a sudden suicide in the family that's brought about this. And so we can look at that, rather than saying cause and effect*

*(3, p vi, 10-13)*

### ***Importance of the therapeutic relationship***

All the therapists interviewed stressed the importance of the therapeutic relationship

*.... I don't think that one model allows for all those things really, within a session or the relationship that develops. I don't see that I relate to this person in CBT, but you know, I relate to this person (1, p ix, 21-2)*

*.... about the relationship, and with each new person you meet, wherever you meet them, and I don't just mean clients, but each new person you meet, surely you sort of...they draw out from you slightly different things (2, p vi, 34-7)*

*.... it's very much about the patient....the patient's being and the way that that interacts with how I am (3, p iv, 20)*

*....I want to keep an eye on the therapeutic relationship within the session....how a patient might respond to me and vice versa and the counter-transference. Because it seems to me that that is still to me the critical part of the therapy. That certainly to me is the psychodynamic part that I certainly would not feel could be underrated or displaced. (4, p iii, 7-11)*

*.... the basic things are about being able to form a relationship with somebody .And then being able to work within that relationship enough to get them on board to do something useful (5, p iv, 50-52)*

Therapist 4, initially psychodynamically trained, based his work on the concept of a therapeutic alliance contained within this approach.

*... a containing and building relationship. My experience says that...I wouldn't put it quite as bluntly as this, but sometimes it doesn't always matter what you say in these circumstances, but as long as you're there (laughter) and they experience, they experience some sort of containing, right? .... which is very psychodynamic. And in a way you're starting to re-enact some sort of parental support (4, p iv, 44-8)*

Therapists 1, 2 and 3 however based their therapeutic relationships upon Rogers' (1951) core conditions

*.... I use core conditions, sort of Rogers, which I do in my work anyway.....positive regard, non-judgemental, empathy, (3, p ii, 27-8)*

*.... I think one of the things when I started practising, you know even within training what really stuck with me was congruence - how am I congruent to sort of who I am and, if a client's to meet me in the supermarket by accident that I'm the same person I am as when I'm in the session (1, p v, 45-7)*

*..... that Rogerian stuff about the relationship comes back to me. I don't think I've said that specifically (2, p vi, 34-5)*

### ***Collaboration in the therapeutic relationship***

Therapists were united in emphasising the need for a collaborative therapeutic approach

.... they... are looking to me to be the expert that does something to them , in which case, you know, I'd be needing to disabuse them of that idea and try and put across the idea of collaborative work to them, so that it becomes more a joint thing..(2, p ii, 20-23)

....I'm not seen as an expert. It doesn't ...erm... it doesn't become a kind of hierarchy of I know better and I'm presenting this and you should understand that, but that it gives enough openness and ... erm... choice, that the client also makes up their own mind how they understand it.

(1, p viii, 33-6)

.... you draw the diagram with the patient and you talk about the reciprocal roles and it's all there, it's all up front, everybody's seeing what is done. (3, p ii, 36-7)

....so on they seemed to require a more active and.....what's the word I'm looking for... collaborative approach. (4, p i, 33-4)

....I do think of it as very much a collaboration. (5, p ii, 55 - p iii, 1)

### **Openness**

Allied to this, was the idea that therapy should be open and understandable to the client. Therapists described how they aim for the client's understanding of the therapeutic process

.... I'm more comfortable with aspects of each of the approaches that are more accessible or easily available not only to me but also to the client and transparent enough that they can see how it works (1, p v, 26-8)

.... In terms of integrative work I see that it's getting her to understand what each of those methods kind of brings, (1, p iii, 32-3)

....suppose my feeling is that therapy works best if a person understands why they're doing what they're doing, and its roots, because I think that prepares them to be able to address the issues (4, p iii, 28-30)

.... I spend a lot of time at the beginning speaking about, you know, what I make of it, what they make of it, and what we're going to do. And then the doing takes less time in a way, because once people are on board, then that's it, they kind of do it themselves. (5, p iii, 1-3)

Therapist 3 described how she discussed her ideas openly with the client, enabling him/her to disagree

*...that's very invigorating, so you rub it out of the diagram and you go 'Where's the bit that's gone wrong?' And it also helps them when they see it down on paper...it...it gives them a great deal of insight. And they take it away, so that's empowering and they can rip it up and say 'What a load of old rubbish, this is how it is' and make their own (3, p v, 50-54)*

Therapist 2 described her initial discussions with the client in which she ensured clarity and openness within the therapy

*... we come to some kind of agreement at the end of that session, (A) whether it seems appropriate that we should be working together and stuff but (B) over the sorts of areas that at this moment they're thinking they want to work on. (2, p iii, 48-50)*

### **Client led?**

A number of the participants (1, 2, 3 and 5) espoused a humanistic approach, yet their transcripts point to some contradictions in practice:

*... I suppose I would be more comfortable with constructivist theory, sort of person centred approach (1, p v, 34-5)*

Whereas earlier she says

*... Hang on, I need to teach this person (1, p v, 32)*

Therapist 2 states

*... They're the touchstones, really, that I let the client lead, (2, p v, 1-2)*

but later adds a qualification of this statement

*... (I) try to sort of bring things back, so that there's some sense of closure (2, p v 15)*

Therapist 5 claims to be humanistic

*... I suppose you could say I'm humanistic in that I tailor it to what they bring (5, p i, 43)*

yet later states

*... so I would spend a lot of time talking about my formulation. (5, p ii, 41-2)*

Therapist 3 recognizes that she uses person centred core conditions, but states that she would not use the model

*... I use core conditions, sort of Rogers, which I do in my work anyway.....positive regard, non judgemental, empathy, but what I wouldn't use is the model. (3, p ii, 27-9)*

It is important to distinguish between the therapist's use of the terms 'client led ' and 'person centred' and 'humanistic' and the strict definition of the terms. There is a tension in the texts between the therapists' espousal of these positions and their description of their practice. For instance, therapist 2 describes '*let (ting) the client lead*', which itself contains an assumption that the therapist is handing over part of her power to the client. This of course implies that the power initially resides with the therapist. Similarly, therapist 5, whilst referring to herself at one stage as '*person centred*', also talks in terms of '*formulation*'. Therapist 1, talks of '*teaching*' a client. Even the term 'empowerment' acknowledges the client's lack of, and need for, power. There is an implicit assumption that the therapist has a definitive knowledge base from which they are working.

All were prepared to use techniques to help their clients achieve their stated goals, which implied a therapeutic strategy planned by the therapist. Therapists were thus tacitly acknowledging the value of their own therapeutic expertise, experience and personal biases, which they brought to each client. Their definition of 'person centred' appears to be linked to their willingness to tailor their therapeutic approach to each client. They are thus listening to what the client wants and then making a professional judgement on what is the most effective therapeutic approach to bring this about. They then feel free to draw upon any approach within their repertoire, whether this involves a teaching role, creative techniques or using psychodynamic concepts to guide their interactions with clients.

Merry (1990) drew attention to the growing trend away from the use of the person centred model as a discrete way of working. Increasingly, the 'person centred' approach is being used as a way

of creating a climate in which to work using techniques from other approaches. He argues that it is impossible to combine this approach with others without destroying the basic precepts of the 'person centred' way of working. In contrast, Wilkins (1993) distinguished between 'person centred' therapy, which he described as the self contained therapeutic model, and the 'person centred' approach, in which the therapist maintains the values inherent in the approach, such as congruence and does not impose his/her own frame of reference on the client. It is arguable whether it could be said that these therapists are imposing their own frame of reference on the client. In that they are construing their clients' difficulties in terms of a chosen therapeutic orientation, this may be happening. However, their eclectic approach means that they are prepared to listen to the client's description of the problem and then adapt their therapeutic approach as necessary from within their repertoire. In this, they are co-constructing the client's difficulty in the terms, which will be most easily acceptable and understandable to the client. This allows for the use of other techniques and ideas so long as they do not militate against the core values of the approach. The therapists interviewed appeared to be using the terms as expressed by Wilkins, rather than the purist definition of the term. Perhaps the term 'client responsive' is a less confusing and more accurate description of the therapeutic approach in evidence in these interviews.

This issue highlights the difficulty that eclectic and integrative therapists face in resolving the conflict between an approach which accepts all explanations as equal (constructivism) and a positivist 'expert' position which acknowledges the therapist's professional knowledge which was also eschewed by the participants. (See below)

### ***Non- expert position***

None of the Therapists took an 'expert' position in their work. They did not work from a position of making a firm diagnosis, with prescriptive treatment strategies. Rather, the therapeutic relationship was characterized by the therapists' willingness to revise their formulations in the light of the client's response

.... then giving them the opportunity to say 'No, it isn't like that'. So, OK, that's the bit that's very invigorating, so you rub it out of the diagram...and you go 'Where's the bit that's gone wrong?' And it also helps them when they see it down on paper...it....it gives them a great deal of insight. And they take it away, so that's empowering and they can rip it up and say 'What a load of old rubbish, this is how it is' and make their own. So from that point of view, I think integrative models are empowering (3, p v, 49-54)

.... I'm not seen as an expert. It doesn't... erm... it doesn't become a kind of hierarchy of I know better and I'm presenting this and you should understand that, but that it gives enough openness and... erm.... choice, that the client also makes up their own mind how they understand it. (1, p viii, 33-36)

This was also implicit in therapist 2 and 5's approach

.... That's the touchstone, well they're the touchstones, really, that I let the client lead, in the sense that...I'll come back and qualify that in a minute...but I let the client lead and I adapt what I'm offering, or what I'm expecting they might do with a feeling... er ... and I either, as I say, I either adapt my expectation, or I might bring in some other thing...(2, p v, 1-4)

.... if people are saying that they don't want to touch certain areas or whatever, and you are hammering on about that for ten sessions, you are just wasting your time because they are not taking it in and they are not doing anything, so you might just as well decide that you are not going to do that and just do the other bit. And I think that's ok. Personally I think that's ok because it's their life. (5, p vi, 29-33)

Therapist 4, psychodynamically trained, also acknowledge the need for a more engaged relationship

.... they seemed to require a more active and....what's the word I'm looking for... collaborative approach (4, p i, 33-4)

### **Psychodynamic aspects not congruent with integrated approach**

All therapists expressed unease at using certain aspects of a psychodynamic approach:

*.... neither do I like that sort of blank slate, you know, 'I shall sit here for, you know, three weeks before I ever offer you an intervention' It just drives me up the wall (laughter). So I don't want that kind of distanced ...impersonal....er you know, 'I shall be this kind of screen for you'. I can't imagine working in that kind of way. (2, p ii, 54- p iii, 3)*

*....come in and sit down and wouldn't say words for an hour and wouldn't really help people understand the process of what was happening (1, p iii, 54-5)*

*.... I find some of those interpretations highly suspect when I've come across them anyway, which is why I didn't go on and do the advanced CAT course, because it became more psychodynamic and less cognitive, and I found some of that could be quite abusive (3, p ii, 39-42)*

Interestingly, therapist 5, psychodynamically trained, who used this approach in her work, was also critical of some aspects of the use of interpretation:

*.... I mean, I do make interpretations, but, I mean, they are fairly obvious. They are not whacky things that are just in their subconscious or whatever. Because not very many people take very kindly to them but maybe it's the way that I do them I don't know. But I don't really believe that, you know, I think that if you are up front with people and you get them on board (5, p x, 36-40)*

Similarly, Therapist 4, also psychodynamically trained, recognized that the nature of the psychodynamic therapeutic stance was not helpful to some clients

*.... the therapist's more, slightly more considered approach, perhaps more silent approach, didn't seem to help when you were working with people who might have personality difficulties and so on they seemed to require a more active and....what's the word I'm looking for... collaborative approach (4, p i, 31-4)*

These therapists were therefore critical of two aspects of the psychodynamic approach, the perceived emotional distance of the therapist and the practice of interpreting clients' material.

These two aspects are at variance with the therapist values of collaboration and openness expressed earlier, and demonstrates validity in the views expressed.



Although therapists 1 and 3 were all critical of some of the aspects of a psychodynamic approach, they were still prepared to use some of the approach in their work

*.... working with a client who'd been sexually abused and how her transference at one point towards me, her projection was very much seeing me as the silent mother, you know, who kind of colluded with this abuse and actually working psychodynamically was very powerful (1, p vi, 44-47)*

*.... I would work then with psychodynamic ....well, yes...psycho...what else can you call it... psychodynamic...with a client. (3, p iii, 37-8)*

It thus appears that whilst all of the therapists did not feel comfortable with the perceived therapeutic stance of a psychodynamic approach, they acknowledged the value of some psychodynamic concepts in their work. The main difficulties of the psychodynamic approach are those aspects that are not congruent with the kind of therapeutic alliance that has been demonstrated as necessary for therapists working in an integrated way. This relationship must be understandable and open to the client as well as undertaken in a collaborative way. This is inimical to the 'blank screen' and uninvolved 'expert' therapeutic approach required in the classic psychodynamic approach.

### **Difficulties of their integrated approach**

Therapists recognized the dangers inherent in their integrated approach in terms of incoherence and lack of professionalism. Only Therapist 4 admitted to experiencing these difficulties personally, although avoiding the use of the personal pronoun, and thus distancing himself from his comments

*.... you risk the thing becoming a complete mish mash...it's like a porridge in which everything is a bit woozy...this business of what you're thinking and what you're feeling at any particular time...that's difficult, and it... you can sometimes feel that you're beginning to be a bit...rootless, or unbalanced (4, p ix, 4-7)*

Whilst the others acknowledged the existence of such problems

*.... it's a bit importing techniques from different areas and not really knowing much about anything (5, p i, 12-13)*

*.... if they would consider my way of working is somehow inferior, because you've got breadth and not depth... .. (2, p vi, 10)... .. (they) would feel it's not quite so good to...dabble (2, p vi 22)*

*.... it becomes a mish-mash and becomes...I'm not saying not professional but more a lay person chat rather than therapy. You know, let's draw on this and let's draw on that, (1, p viii, 44-6)*

It is interesting to note that the difficulties they describe are in fact, the difficulties of what would usually be described as an eclectic approach, since this is not rooted in a model. This confirms the earlier hypothesis that the integration described by therapists differs from that described in the literature.

### ***Avoiding pitfalls***

The influence of the interview situation must obviously be taken into account in that it would be difficult for these therapists to admit to a lack of theoretical coherence in their own work. They all however acknowledged the difficulties and cited their use of supervision and training as a way of avoiding these pitfalls

*....I certainly would think about skilling myself up in areas that I don't feel I know so much about if I thought that would be helpful to people. (5, p iv, 49-50)*

*But I've always felt I needed the training, in-depth training (3, p iii, 1)*

*.... more formal training and supervision (4, p ix, 16)*

*.... if it isn't sort of...depending on sort of training and experience and supervision (1, p viii 43)*

Therapist 2 whilst not referring directly to this, made mention of her use of these during the course of the interview

*I was at the BAC conference.... (2, p v, 38)*

*.... trying to read between the lines in the literature (about eclecticism) (2, p vi, 18)*

## **Integrative or eclectic?**

In describing their own practice as integrative, the participants were defining integration in terms which differ from the idea of theoretical integration as expressed in the literature. None was able to articulate a theoretical base for their work, which may account for in their noted defensiveness. The therapists' definition of integration acknowledged the need to base their practice in theory and research, but none were, in fact practising from any particular integrative model. Their descriptions of what they actually do seems to point towards technical eclecticism, in that they are working pragmatically, combining and adapting their approach as required, without a clearly articulated model for their practice.

This raises the question of whether the participants are, in fact integrative as they claim, or are in fact, working eclectically, but prefer to use the term 'integrative' as the term eclectic seems to have fallen into disrepute. By terming themselves integrative, as opposed to eclectic, they are seeking to create a respectable professional identity. The references to the need to ground their practice in theory show an awareness of possible criticism on this point, yet there is no clear evidence of such grounding. Whilst they all use approaches which have a theoretical base, such as CBT, none demonstrate a theoretical base for their actual practice, such as is articulated in CAT.

Rather, they are basing their claims to be integrative on other factors. First, integration is described as a way of viewing the therapeutic process in wholistic terms, so that, for instance, a therapist may work in different ways with a client, but will do this within the sense of the whole therapeutic process. Second, it is a way of working within a session in which the therapist moves between approaches. Third, that this movement between approaches should be seamless, in a way that is congruent with the therapeutic process so that the client is able to integrate the experience. Fourth, participants also recognized the need for training and supervision to avoid a lack of discipline, which they felt, might be a danger in an integrative approach. However, the main thrust for their claim to be integrative is in the importance they attach to the idea of

'wholeness', that is, that in using different approaches within a session, the therapist ensures that these are bound together in a cohesive way within the process of therapy. Without a theoretical base as expressed in recognized integrative models, such as CAT it is indeed difficult for these therapists to demonstrate a theoretical base for their work. The decision about which approach to use is made in a moment by moment process within the therapeutic encounter. As such, the integration that takes place is individual to each therapeutic encounter and is thus not explicable in any given theory. It appears that a new 'integrated' therapy is developed within each therapeutic session. In practice, their approach seems to bear more resemblance an eclectic model, which offers no theoretical rationale to link the different approaches used.

## **The nature of the Therapist**

All of the therapists displayed confusion and lack of certainty over their terms 'integrated' and 'eclectic' and as a result, then sought to legitimize their own practice in terms of current discourse.

### ***Therapist confusion***

All of the therapists interviewed showed some confusion in their definition of the terms eclectic and integrative. Therapists 1 and 2 began by describing eclectic practice as drawing from a number of approaches as is appropriate for client need

*....trying to apply lots of types of approaches, erm, and then within practice trying to draw on what's appropriate to work with their clients. . (1, p i, 16-18)*

*...for me it means that you use more than one approach. You can kind of call on them...sort of at will really. I reckon I've got a kit bag and with one person the spanner's going to be the thing that I need, with another person I might need a hammer, with somebody else I might need both and that's alright, but if somebody needs a spanner, then to try to sort them with a hammer isn't going to be alright. (2, p i, 9-13)*

However, when asked to describe 'integrative' practice, their definition of this was in terms of a contrast to eclectic practice. At this point they began to cast 'eclectic' in negative terms:

*... a mish mash of approaches where people don't understand the same end goal or the same end result (1 p i 38-39)*

*.... eclectic is just bringing things out of the air without having any opinion as to why (2, p i, 26-7)*

Similarly, Therapist 4 showed some confusion over terms, when after giving a description of eclectic practice as

*Different systems or different therapeutic approaches, which are brought together (4, p i, 14)*

When asked to describe integrative practice he replied

*Eclectic....well I'm not quite sure really, I've been fonder of the word integrative (4, p i, 49-50)*

Therapists 3 and 5 both distinguished between the two terms when initially describing eclectic practice which they too cast in negative terms in comparison to integrative practice

*...a mixture...of different...erm...models, different orientations , that's not theoretically...that has no theoretical base, a little bit of one, a little bit of another, mixed in, (3, p i, 13-15)*

*...a bit kind of it neither here nor there because it's a bit of importing techniques from different areas and not really knowing much about anything. (5, p i, 11-13)*

However, they too showed some confusion over terms

*.... first of all I said eclecticism is bad...but sometimes at the same time it can be good too ..I suppose it's the degree of eclecticism, really...I'm not sure.' (3, p vii, 38-9)*

*.... so I don't tend to use that word, I tend to use more 'integrative' rather than 'eclectic' (5 p i, 13-14)*

Therapist defensiveness was apparent when seeking to explain their practice in terms of the current discourse about eclectic and integrated approaches.

### ***Therapist defensiveness***

It is interesting to note that the general tenor of the interviews was the same for all therapists, in that they all initially appeared rather nervous and ill at ease with the interview subject matter.

This was reflected in some of the comments made by the interviewees;

.... *Am I saying enough about focusing on the question?* (5, p v, 6)

And in describing how she works

.... *Does that sound feasible? I kind of do it like that.* (5, p x, 22-23)

.... *I'm getting the feeling that, because you've asked me now, two or even three times, that you obviously would do it differently, I don't know if I'm allowed to do this, but I'm thinking well, what would you be taking into account then, that's different from that?* (2, p ii, 32-35)

(Stated after she had been asked one question and one subsidiary)

.... *Well, goodness (laughter)...this is a bit of a swine, this one. Eclectic...well I'm not quite sure really,* (4, p i, 49-50)

.... *I suppose I've got that entirely wrong* (4, p i, 54) (In describing integrative therapy)

.... *Is that what you wanted...I'm not sure I'm answering the question?* (3, p ii, 18)

....*one of the things...talking about the integrative work and again, my understanding may be different from other people's* (1, p iii, 48-9)

....*I suppose when I say I'm integrative, ..erm ....again as I say I suppose there's even a confusion for me well... ..and don't know if I'm explaining this very well....(laughter)*(1, p iv, 23-27)

### ***Legitimizing practice in current discourse***

All of the therapists preferred to describe their work as integrative. They were either critical themselves of an eclectic approach, or else aware that this approach might be open to criticism from other therapists. There is therefore a distinction between how therapists are describing their idea of integrated practice and how they describe what they actually do.

Describing her thinking on eclectic practice, Therapist 2 states

*I suppose I have seen the two terms as interchangeable (2, p i, 27-28)*

However, aware of the criticism of eclectic practice, which might be thought of as

*Bringing things out of the air without having any opinion as to why (2, p i, 27)*

She states that

*.... I suppose eclectic becomes almost a pejorative term (2, p i, 30-31)*

*.... I'm not sure where people who have very much one hat to wear, I'm not sure where they would put me, as it were, I'm not sure if they would automatically consider my way of working is somehow inferior, because you've got breadth and not perhaps the depth (2, p vi, 8-10)*

Therapist 5 as well as casting eclecticism in negative terms (see above) also recognized the criticisms of eclecticism in the zeitgeist of the times

*(Eclecticism) It was seen as a kind of dirty word in a way so I don't tend to use that word, (5, p i, 13)*

*'Eclectic' to me sounds like somebody who doesn't know much about it, but knows a few things about lots of different models, (5, p i, 14 -15)*

And recognized that understanding of terminology might change

*.... This was a few years ago when people weren't very keen on eclectic (5, p i, 16)*

This therapist is very aware of the changes in attitude over time

*.... It's whatever's in vogue (5, p i, 23)*

*.... I don't know what it's like these days (5, p i 15-16)*

and thus preferred to use the term integrative

*.... I tend to use more 'integrative' rather than 'eclectic' (5, p i, 13-14)*

Again, this therapist's description of her work is clearly eclectic

*....the assessment.... is more atheoretical ... then I would think about what model would actually help that person (5, p i, 42-3)*

When asked about an integrated approach, Therapist 1 developed her theme by describing integration as a further stage from eclecticism, which was then talked of negatively (see above)

*.... but in using different models or using an eclectic approach you're then integrating those pieces of knowledge, insight or awareness or whatever, so that would be how I see an integrative approach (1, p i,39-41)*

Therapist 3 stressed the need for an underlying model as opposed to an eclectic approach which she had previously criticised

*....one does need to have knowledge of a model rooted in research and I think that heaping on a bit of this and that isn't rooted anywhere and isn't good practice(3, p vii, 1-3)*

However, in describing how she actually works the therapist is clearly working eclectically

*....the degree of how cognitive or how behavioural or how...I hate to use the word psychodynamic, but perhaps developmental I would be..... (3, p i, 43-45)*

She also later conflates the two terms

*So I think the benefit of eclecticism or integrative model is that it's giving....that dimension to it, (3, p v, 15)*

She also later acknowledges that terminology may be used to legitimize practice

*.... if you call it integrative it's giving you permission to use it... (3, p v, 16)*

Therapist 4 was aware of the criticism of an eclectic approach from 'pure school' therapies

*you can see the conflicts, because last year I supervised a master's student from B... who was on a psychodynamic course and she was in real trouble, I think, this young woman, the course wanted her to work in a classically psychodynamic way, and my end, I didn't have a real issue about how she worked, as long as she worked effectively, (4, p ix, 24-7)*

He also preferred to term his work integrative

*....I've been fonder of the word integrative (4, p i, 50)*

This tendency of therapists to reframe therapy into the current discourse was summed up by

Therapist 5 with some accuracy

*These days people do see themselves as more integrative I think which to my mind is what people were already but they are just saying it now (5, p i, 29-30)*



Crucially, these therapists are equating eclectic work with a lack of planning by the therapist and it is to distance themselves from this that they describe themselves as 'integrative.'

It is interesting to note that all of the therapists preferred to describe themselves as 'integrative' although all of them appear to be working eclectically in terms of current definitions. The interviews show an awareness of the possibility of criticism of the eclectic approach and tend to describe their work in terms of the latter because this seems more professionally acceptable.

A distinction was drawn between integrative and eclectic practice in that integrative practice was described as an approach which had coherence, based on a number of different ideas. The main message of the text was that integrative practice had some kind of base, rationale or grounding such that practitioners are able to justify, at least to themselves, that their therapeutic practice at some level 'makes sense'. This was further exemplified in the assertion that integrated therapy should have a 'theoretical base'

### ***Perception of Self as Therapist***

In the same way that therapeutic integration was individual to each encounter, it is evident that each therapeutic approach expressed the personal values and personality traits of each therapist.

Therapist 1 stressed the importance of clarity

*I can feel my hands tied today actually, 'cause I want to sort of draw it and write it to make it clear. I suppose clarity is something that's very important to me (1, p ix, 14-15)*

She also sought to make therapy accessible

*I feel quite strongly that looking at an approach that makes therapy accessible (1, p vi, 14-15)*

*One of the things I believe is that the client should have...it should be accessible (1, p iii, 49-50)*

*I'm more comfortable with aspects of each of the approaches that are more accessible or more easily available (1, p v, 26-27)*

She used creative methods that helped her to make the process of therapy clear and understandable to her clients. Often this would include drawings and other written work

*...sometimes it's having it visually rather than just having it spoken ... it's using creative techniques....drawing,... maybe Gestalt....sort of empty chair (1, p v, 18-22)*

Therapist 2 preferred to work 'intuitively', responding to what the client brought to the session  
*...so again the joining, the collaboration, the gut to gut. It's that meeting with another human being...that's the sort of joining, the beauty of it, the inspiration (2, p iii, 26-28)*

When asked to describe her work, it was evident that she was making judgements which she found difficult, or was resistant to articulate, as she preferred to present herself as an intuitive therapist

*I vary according to the client that's really the overall criteria at that moment in time. So I might use one thing with somebody one time but something else in a few minutes time, or something else next week (2, p i, 17-19)*

*I can flow between the different things. I see it as much more fruitful than saying 'I am a anything...Rogarian, Gestalt CBBT, anything else person' so whatever comes my way I will use....I'll just kind of ebb and flow between them (2, p i, 47-49)*

She is unwilling to analyse in a cognitive way what is actually happening

*I might be hard pushed to say I am using XYZ (approach) at this moment because I'd be...dunno...even between different things...or some TA, yeh (2, p i 53-55)*

This reluctance may be attributable to a defensiveness borne of a perceived criticism of her person centred approach

*...if ...clinical psychologists doing just cognitive work it might feel a bit...as it is there are enough different approaches (2, p vi, 23-24)*

Rather than an inability to identify the models she was using as evidenced in her description of client work .....

*With that lady we started out with the cognitive stuff at the beginning of the session...But that wasn't where she was going at all, she went down into this other stuff...Then we came back full circle to the cognitive (2, p v, 24-29)*

..... in which she identifies the transition from a cognitive approach to an experiential intervention which accessed deeper issues.

Both Therapists 1 and 2 were eclectically trained and it was therefore possible that their views might be coloured by a lack of in depth knowledge of one therapeutic model. Theoretical sampling yielded three more therapists with different training backgrounds. Therapist 3 had trained in an integrative model (CAT), Therapist 4 had been psychodynamically trained and Therapist 5 had been trained in psychodynamic and CBT approaches as part of her clinical training. These therapists did indeed tend to rely more heavily on their background training, but still included other approaches in their work.

In contrast to Therapists 1 and 2, Therapist 3 described her work as firmly rooted in theoretical model

*Just thought I'd add that I believe that we should always attempt to stay within the parameter of all talking therapies built on the interrelated pillars of theory, practice and research. The distance between them may vary and at times one may predominate but if we ignore them then we step out from science to the creative arts - dangerous for therapists and clients (Note on feedback form)*

*As long as there is a core framework on which to work....now this might be saying something about me, I must have my boundaries right but I feel safer myself as a practitioner if I know what I'm working from, which is my core model (3, p v, 7-10)*

*My usual approach I would say is cognitive...I would use a cognitive approach, wherever I was, with anybody (3, p i, 42-43)*

She goes on to contradict this

*The degree of how cognitive or how behavioural or how...developmental... I would be (3 p i, 43-44)*

She also talks of .....

*The ability to switch models when I need to (3, p iv, 21)*

.....And that

*There's a lot more going on than me sitting in front of a patient using various models (3, p iv, 48)*

This is acceptable to her so long as she can justify this in relation to the work

*When I shift I'm aware of what I'm doing to some degree, so that when I'm shifting into developmental I know what I'm doing, when I'm going more behavioural it's because I've made the decision that the person has difficulty working cognitively..(3, p v, 10 -12)*

However, she also admits that in reality the therapeutic process can be so rapid she may not be able to do this 'in the moment' .....

*(it would be) interesting (to see) what exactly is going on, because there's a lot more going on than I think (3, p iv, 46-47)*

.....and the fact that she is

*I'm revising changing and adapting, so much goes on in the process, it's so fast that you're not even aware of it (3, p iv, 40-41)*

It is evident that whilst it was very important personally for this therapist to present herself as working from a distinct model, in practice she was mixing models in response to the exigencies of her work, in a similar manner to therapists 1 and 2. With a predisposition to work cognitively, she needed to be able to articulate her therapeutic bases, even though as she admits herself, this may be post hoc.

*I do try to keep very much to a model, without trying to move into something else...unless there are times...and when I do move, I'm very aware of what I'm doing, if not at the time, later on when I'm writing the case notes (3, p viii, 7-10)*

She also acknowledges

*Even though we'd like to think that we're rooted and grounded in science as psychologists, there is an element of eclecticism, I think, with all practice. (3, p vii, 32-34)*

Therapist 4 expressed his views through the prism of his initial psychodynamic training

*I want to keep an eye on the therapeutic relationship within the session....and the counter-transference (4, p iii, 7-8)*

*What this young woman needs to do is to have the experience of a containing and building relationship... which is very psychodynamic (4, p iv, 44-46)*

He described how his transition to an eclectic approach developed from the demands of an increasingly therapeutically demanding case load

*We came under increasing pressure...to find a quicker way of seeing clients.....a lot of the patients that we were getting were beginning to change, ceasing to suffer from short term neurosis....and we were seeing people that had very long term traumatic life histories... (4, p i, 21-26)*

He found his way of working subject to criticism within this setting

*The whole business of working psychodynamically...a classical taught way, but one psychiatrist said to me a rather precious way (laughter) (4, p i, 38-40)*

As such he described how he recognized underlying longer term issues with a client but acknowledged that what was needed was shorter term cognitive work to deal with the presenting problem

*One would need to spend a lot of time working on this man's childhood.....but the client wants to understand 'why the anger?' And I think that is more readily accessible in a quicker way from a directly cognitive approach (4, p iv, 2-8)*

He was thus prepared to include CBT within his repertoire, as well as an existentialist approach

*There have been occasions when working with very erudite and well educated people.... when I've found myself working in what was an existentialist way, about the construction of meaning (4, p viii, 16-20)*

However he expressed a disinclination to use a Gestalt approach, which he felt, put patients under undue emotional pressure

*Gestalt... I wouldn't feel comfortable (4, p vii, 13)*

*Gestalt and some aspects of drama therapy which suggests that it's all very well you can almost badger a patient and put them through the mill (4, p vii, 40-42)*

These approaches would seem to be at odds with the more gentle 'nurturing' approach he had earlier expressed.

Therapist 5 had similar disinclination to use therapies outside of the mainstream

*I don't like new fangled therapies...and I don't really know what they are (5, p iii, 42-45)*

*I don't think they are needed. I think we've got enough therapies already (5, p iv, 14)*

She described her approach as 60% psychodynamic, 40% cognitive

*My manager was trying to describe what I did to somebody else, and he said I was 60/40 psychodynamic/CBT (5, p vii, 30-31)*

*I guess the 60/40 is probably right (5, p viii, 53)*

However, she expressed irritation with various aspects of both of these approaches

*I choose less CBT because it gets on my nerves (5, p iv, 33)*

*(CBT) the things they said which get on my nerves (5, p xi, 5- 6)*

With CBT she felt that there was inadequate recognition of the origins and causes of patient's difficulties

*It gets on my nerves is the early experience kind of box. The little box at the beginning in their model and there's nothing more said about that really. And that gets on my nerves (5, p vi, 10-11)*

Her reservations about the psychodynamic approach included her experience that patients failed to make the links to gain insight, although this was theoretically indicated in the psychodynamic approach by the use of interpretations

*....when I did my psychodynamic placement, it (the client making links) didn't happen (5, p x, 33)*

She had also experienced the ineffectiveness of some interpretations

*And make interpretations back and peoples would look at me blankly saying what's all that about? I mean, I do make interpretations but I mean they are fairly obvious. (5, p x, 36-37)*

She considered that some of the interpretations made in this approach were too obscure and unrelated to the client's experience

*.... wacky things that are just in their subconscious or whatever (5, p x, 37-38)*

It is interesting to note that although all of these therapists described themselves as integrative, each of their approaches was very different. Therapists 1 and 2 were drawn to the experiential and expressive therapies, whilst Therapists 3, 4 and 5 tended to use largely cognitive and psychodynamic approaches. The personality of each therapist is mirrored in their predilections.

For instance, 1 and 2 both stressed the need for individual creative working which they felt was expressed in Gestalt, whilst 4 proved very suspicious of this method and 5 dismissed it as 'new fangled'. All were disinclined to use approaches which were not congruent with their ideas of themselves as therapists.

## **Common therapist factors**

### ***The need to feel congruent***

Therapists also acknowledged that the need to feel at ease and congruent with their chosen approach were factors in their decision about which therapeutic approach to use

*I don't believe in it, is basically why I wouldn't use it, that sort of non-directive. I mean it could go somewhere if you were prepared to sit in a chair for twenty sessions, maybe it will and maybe it won't. I'm sort of more directive in my approach (3, p ii, 29-31)*

*.... as long as there is a core framework from which to work....now this might be saying something about me, I must have my boundaries right...but I feel safer myself as a practitioner if I know what I'm working from, which is my core model (3, p v, 7-10)*

*I suppose the relaxation techniques can feel a bit like me doing something to somebody...so again the joining, the collaboration, the gut to gut. It's that meeting with another human being, whoever they are, whatever their issues are, whatever their needs are and that's...that's the sort of joining, the beauty of it, the inspiration, that I don't know how I'm going to be working with them (2, p iii, 25-9)*

*I don't like the new fangled therapies, just because I don't feel very familiar with them (5, p iii, 42-7)*

*.... I have this thing about...Gestalt and some aspects of drama therapy which suggests that it's all very well you can almost badger a patient and put them through the mill, but what happens when they walk out the door, where then? So that could be part prejudice on my part, (4, p vii, 40-43)*

.... *I suppose I feel quite strongly that looking at an approach that makes therapy accessible but also that allows me to be congruent, (1, p vi, 14-15)*

### **Scepticism**

Despite these differences in approach, certain themes were common to all participants. All expressed a degree of scepticism that any one approach contained the 'truth'. All voiced the opinion that no therapy contained the total 'truth' and that a number of approaches were needed to fully explain human experience, indicating post positivist/constructivist ontology.

*I suppose it's having an appreciation that these are only models, they're only approaches, they're not the be all and end all, they're not the magic cure (1, p vi, 49-50)*

....*because I've not yet come across in my life one therapeutic model that encompasses everything (3, p v, 16-17)*

*I don't think any therapy contains all the truth; it only contains a partial view (4, p viii, 41-42)*

*I don't fit in. That's why I'm integrative. I can't cope with these sort of extreme ideas as I see them. They just sort of see them as kind of being the truth I guess (5, p xi, 17-19)*

This idea was implicit in Therapist 2's assertion

*If all we've got is one thing...you know it doesn't really matter what it is, the idea that it's going to be perfect for every person that walks through the door strikes me as peculiar really (2, p v, 36-38)*

The second common factor was a questioning approach to all therapeutic models and the desire for a freedom to work outside of the parameters prescribed within one sole model

....*the other thing was to say I don't know. So for me that was the most empowering thing I learned from training. And I hope I'm aware, or take challenges (1, p vi, 31-32)*

....*that's the joining, the beauty of it, the inspiration that I don't know how I'm going to be working with them. You know you said to me what's your usual approach...I don't know... that's the delight that's the brilliant bit (2, p iii, 28-30)*



*.... and giving them the opportunity to say 'No, it's not like that'. So OK, that's the bit that's very invigorating (3, p v, 49-50)*

*.... the reformulation had to fit in to that model, the reciprocal roles. Now some of it did, but what about the bit that didn't, and that was the bit that interested me (3, p v, 31-33)*

*It's (integrative working) also more interesting....more not inspiring exactly but it certainly keeps you on your toes (4, p viii, 41-31)*

Therapist 5 expressed irritation at the limitations of both CBT and psychodynamic approaches and tended to take an overview of both models, seeing their similarities and complementarities

*And that (CBT) gets on my nerves, but the schema focus stuff is getting closer to.... I mean they talk about they have invented the wheel but a lot of it is just psychodynamic ideas that people were talking about a long time ago. So I suspect it will come round together eventually (5, p vi, 11-14)*

### ***Flexibility***

All recognized the need for flexibility in their approach to each client, and expressed the need to draw on a number of different approaches according to client need.

### ***Adapting to the client***

A theme common to all participants was the need to adapt the therapy to the client.

*I reckon I've got a kit bag and with one person the spanner's going to be the thing that I need with another person I might need a hammer, with somebody else I might need both and that's alright, but if somebody needs a spanner, then to try to sort them with a hammer isn't going to be alright. (2, p i, 10-13)*

*I vary according to the client....that's really the overall....criteria. I vary according to the client at that moment in time. So I might use one thing with somebody one time but something else in a few minutes time, or something else next week (2, p i, 17-19)*

*....there are lots of people with lots of different skills and personalities and maybe one approach isn't always appropriate for them so it's trying to draw on what's going to be most understandable and most beneficial to them. (1, p i, 20-2)*

*.... the therapeutic style psychodynamically, although very valuable and the insights which were extremely valuable in terms of object relations, seemed to be inadequate (for these particular clients) (4, p i, 28-30)*

*....the therapist's more, slightly more considered approach, perhaps more silent approach, didn't seem to help when you were working with people who might have personality difficulties and so on they seemed to require a more active and....what's the word I'm looking for.... collaborative approach (4, p i, 31-34)*

*Well, the whole area now is patient centred, isn't it? It's like you can have any car as long as it, any colour as long as it's black...(laughter) You can't quite do that to the same extent now, not quite (4, p ix, 45-7)*

*....you could say I'm humanistic in that I tailor it to what they bring in a way (5, p i, 43)*

*.... the main thing for me is about tailoring it to them, than about them tailoring themselves to me. That's the main benefit I think. And that actually helps people I think (5, p vi, 45-6)*

*.... it's flexibility, it's the ability to adapt to the person you have in front of you and you are treating that person...you're not going to be sort of so fixed, sort of 'Here I am with my training and my model and I will ...stick rigidly to this come rain or shine' (3, p v, 1-3)*

## **Universal Factors in Decision Making**

### **Causality**

#### ***Multi-factor causality***

Therapist 3, 4 and 5 worked from a basis of multi-factor causality in assessing client's difficulties

*.... Because people have got multiple difficulties at multiple levels, (5, p ii, 6)*

Whilst therapist 3 acknowledged this belief as a basis for her assessment as to the origins of client's difficulties

*....I would see it as multi-faceted, and we're not sure whether there might be more links to the childhood abuse than to the relationship with the partner, but we don't really know that...they are links, but that's all they are... (3, p vi, 19-21)*

This was also apparent in Therapist 4's description of his assessment of one of his clients, which included a psychodynamic formulation along with the recognition that current relationship problems were another factor in the client's presenting problem.

*....there seems to have been a very strong maternal influence rather all encompassing from which he has never really divorced himself, and the death of this particular woman. There was an absent father, not an unkind man but very strict, rather distant, competition with other siblings, ok...and we feel there may well be a strong connection with that sort of structure, if you like and the depression which appeared to start when his first child was born. (4, p iii, 20-25)*

This demonstrates a psychodynamic formulation. He then continues

*So we work on that from an understanding and then perhaps in the sessions, whoever would be working, whatever was happening there and then between him and his partner because that's what was causing him the immediate distress and his wife of course, the immediate distress. Perhaps that would be best looked at by quite a cognitive approach (4, p iii, 25-28)*

He then acknowledges that there are problems in his relationship in the present which can be viewed through a cognitive approach

Therapist 2 shows that she is also considering a number of factors in her client's presenting problem, all of which have the potential to be addressed in the session, including the client's relationship with various family members.

*....I've seen a lady who came with a GP letter, where the presenting problem was abuse by father....So we've been looking at it from various directions and she's now considering whether to talk to her sister and her mother (2, p iv, 17-34)*

This was also implicit in Therapist 1's constructivist approach and her perception of different explanations and approaches in the origin of client's difficulties

*....that this is a path and it's constantly changing and it's constantly developing you'll need different things at different times (1, p iv, 2-3)*

## Assessment

A number of factors were considered by therapists in their assessment of each client in terms of deciding which therapeutic approach was appropriate:

### *Client Factors*

#### *Emotional state and presenting emotional needs*

The client's perceived emotional state was also a factor couched in terms of each therapist's therapeutic background and training as well as the client's present situation.

Therapist 4 described a client in terms of his psychodynamic understanding of her need for containment

*...they experience some sort of containing... which is very psychodynamic (4, p iv, 46-7)*

Therapist 3 described how some clients may need to work in a more exploratory way to look at the origins of their difficulties

*.... sometimes clients find...the can't...that cognitive work isn't giving them what they want, there's something missing...and you....and that's usually the client that has a ...great deal of awareness and might have come round the therapy track before they've come to you, or they may not, it may be that that's where that person is, part of the way that person is, and part of that moment in time when they need to talk about it. (3, p iii, 51-5)*

Therapist 1 talked about a client's immediate need to emotionally contain a difficult situation

*Now there were lots of things that actually were quite pertinent at the time and needed to be challenged but actually the priority for that client was to get through the court case and they needed to wait. (1, p viii, 2-4)*

Therapist 2 described responsiveness to the client's emotional state in terms of her therapeutic decisions

*.... The person is...what...how they are presenting, what they are needing and what they are presenting in terms of the material and content but also presenting in terms of just themselves. ....I think I'd be.....just trying to take the whole view, really, it's almost a bit...you know, the*

*whole is greater than the sum of its parts, I can't really pull out what the things are but if they're sitting there in, you know, floods of tears, then to say 'OK, what you need is a behavioural programme, let's work out a hierarchy of...(indistinct) and decide which one'...that doesn't sound to me like the best thing that person needs at that moment... so, I'd be looking at that sort of thing, their emotionality at this moment, (2 p ii, 7-18)*

*.... (the) issue isn't the first criteria, the first criteria is what does this person seem to need (2, p i, 20-21)*

Therapist 5 was aware of the client's emotional state in terms of risk factors

*.... so if someone was really vulnerable, and this has happened, where somebody has got a long history of self-harming, they have got a history of sexual abuse that is pretty severe and they are coming in and they are very depressed and they say they want to tackle the sexual abuse then I would say to them look, I would be a bit worried about you doing that now, let's do some management of this first, you know, and I would explain why (5, p iii, 22-6)*

*....what they want, what they have had before, their history of risk, what they might make use of.....so it's more to do with their own needs (5, p v, 16-20)*

*Like some people come in and say I'm going to beat up the person next week, you know, so you have to think about that straight away. Although my tendency would be to shelve that 'til later. And that's what I'd say to them. Whereas other people just kind of weep the whole time and there's no sense of being able to talk about the abuse at all (5, p ix, 28-31)*

Therapist 3 assessed the client's emotional state in choosing the most appropriate approach

*.... What can we do to make you feel better, to get you out of the house right now, to help you feel better. If you feel better, you feel less depressed, basically is what we're going to do. And so what we're going to do is action first, rather than changing thoughts leading to action, we'll do the action, leading to changing thoughts. (3, p ii, 8-11)*

## **Goals**

It should also begin with the stated aims of the client

*.... we come to some kind of agreement at the end of that session, (A) whether it seems appropriate that we should be working together and stuff but, (B) over the sorts of areas that at this moment they're thinking they want to work on. (2, p iii, 48-50)*

*But the client himself wants to understand, as he said yesterday, why the anger? (4, p iv, 6-7)*

*....I think it also depends of the goals of the client. You know if the client wants to access feelings, or they want to explore something very deeply, well then it's sort of trying to facilitate that, but there may be a client who actually doesn't want to touch any thing and it's how to maybe say look at, you know, so it may be an issue about decision making, so it's how you actually look at how you can empower them to maybe make decisions more positively, but actually they don't want to explore it any further than that ( 1, p vii, 28-33)*

*.... I suppose the other thing is what they want as well and whether that is feasible (5, p ii, 25-6)*

## **History**

Therapists 2, 3, 4 and 5 took account of client's histories as part of their decision as to the approach they might use

*....if I had a particular patient, who was quite... the sort of person which we do get from time to time..., who had a great deal of psychological insight and awareness, and might even have been in therapy before and worked on developmental issues, then in that case I might use CAT. (3, p iii, 30-33)*

*.... from my view and when you look at clients and their histories, the way that they react, then perhaps you can make a judgement as to where that is. So yes, the assessment and the history is quite important (4, p v, 17-18)*

*.... what help they have had before, how successful that has been. So if they have had a lot of help I would think very carefully about what we are actually kind of embarking upon (5, p ii, 18-19)*

*....what they'd told me about their history. (2, p ii, 19)*

## ***Problem factors***

### ***Interpersonal v intrapersonal***

In investigating how therapists came to a decision as to which approach to use with a particular client, a number of different problem factors appeared to come into play. All therapists drew distinctions between work which was intrapersonal and that with an interpersonal focus

*....you are looking at early childhood experiences and you're looking at some of the interpersonal ...relations between people, so you're looking at other...relationships with other, which originally was not within the remit of CBT, it was very sort of individually focused. It was all about the individual, whereas schema focused does look at relationships with other people (3, p i, 31-5)*

*....people are not islands and a lot of what goes on with the patient isn't just relative to the client, it's all to do with how they manage their interpersonal world. The world is interpersonal, there's partners, there's children, there's mothers, there's fathers, there's relationships, (3, p iii, 6-8)*

Therapist 2 describes how she expected to be focusing on interpersonal issues, but her client led sessions dealt with intrapersonal issues

*....pragmatic stuff that I was sort of expecting us to do you know 'why was Auntie Ollie....to be considered', we never came back to that, we stayed with the 'what kind of person am I? (2, p iv, 41-3)*

Therapist 1 talked about intrapersonal work with a much damaged client....

*.... it was emotional abuse but it was also sexual abuse and quite repeated and quite vicious. Erm... so some of the work we were undertaking was to clarify who was responsible...erm..., who was to blame... erm..., looking at her feelings of self loathing, guilt... (1, p iii, 2-4)*

... ..and later focused on interpersonal issues

*.... One of the really big changes, you know, when we did her script of what used to happen with her step grandmother who again was very beastly towards her and she was quite scared of women....so there was a sense of fear when she started seeing me. So she was very unsure about*

*writing but was very happy drawing, so we made some drawings of this script and put in what people would say then we actually worked on how you would change that. (1, p iii, 13-17)*

Therapist 4 recognizes there are intrapersonal difficulties with his client but realizes that need to focus on interpersonal issues

*...And they were seeing their difficulties very much as a couple. And there was an implication that the first thing we must do really is to sort this part (laughter) right? That meant, I suppose looking very closely at this particular issue. That, I think would lend it to a cognitive approach. ....But getting him actually to look at what he was doing, there and then perhaps may have a greater and more immediate benefit than looking initially at the long term past where the patterns were laid (4, p iv, 19-27)*

Therapist 5 talks of interpersonal work during therapy for survivors of abuse

*Thinking about relationships with partners and children and mothers. Thinking about the relationship with the abuser. All these things somewhere, have to come in the therapy. Whether they come first or last depend on the person I think. (5, p ix, 25-28)*

### ***Depth of processing***

Allied to this, was the idea of the depth of working with clients and the recognition that some approaches are more appropriate for this

*... seeing that some approaches access feelings a lot more quickly than others and some are more painful to work through for the client (1, p vii, 10-11)*

*You know if the client wants to access feelings, or they want to explore something very deeply, well then it's sort of trying to facilitate that, but there may be a client who actually doesn't want to touch anything and it's how to maybe say look at, you know, so it may be an issue about decision making, so it's how you actually look at how you can empower them to maybe make decisions more positively, but actually they don't want to explore it any further than that (1, p vii, 28-33)*



....So we kind of carried on going down, you know, we'd gone down in the sense of her breathing and speech rate, pitch, everything that went with it, we kind of went down further as she made the connections. (2, p iv, 39-41)

.... I feel that might be appropriate because of the way the client has opened up in therapy and is at a stage where we don't want to say 'Well, yes, let's just look at your negative automatic thoughts'. We need to look at the underlying schema, if we're using schema focused, or looking at the reciprocal roles in CAT, so we're unpacking all of this stuff at a certain level, a psychological level, in more depth, perhaps, than we would in a cognitive therapy (3, p iv, 8-13)

.... she feels rejected and abandoned every time this happens. She's showing signs of increasingly using suicidal feelings every time there's a presumed rejection some of this looks rather worrying from the point of view of a future history. To me, that would steer you away...a little away from a cognitive approach because it seems that what this young woman needs to do is to have the experience of a containing and building relationship (4, p iv, 40-44)

.... you need to tackle something underlying, or it just moves to another... Now other people would just do behavioural stuff with them and tackle each different thing. I don't tend to do that. I tend to think of it as the whole thing is functional you know, what's the underlying stuff, can you access it? (5, p ix, 47-50)

### *Issues*

As well as taking into account the focus and depth of therapy, all therapists recognized the issues that needed to be addressed as a factor in their decision making process

... I take into account what the issue is, (2, p ii, 28)

.... we also have to be congruent in terms of the theory or the way you're working, so I would see the way I use models as a way of living or a way of striving towards particular things ...empowerment or choice , you know I'd use different models (1, p ii, 13-15)

The degree of how cognitive or how behavioural or how... I hate to use the word psychodynamic, but perhaps developmental, I would be would very much depend on the type of problem the client was bringing (3, p i, 43-5)

*And there was ...an implication that the first thing we must do really is to sort this part...that meant looking closely at this particular issue. (4, p iv, 19-21)*

*....I wouldn't work in a behaviourist or cognitive behaviourist way with a particular person, a woman who has sexual difficulties. I think that comes better from women therapists. (4, p viii, 22-24)*

*.... the issue of blame is I think quite an important one in the beginning. The issue of trust (5, p ix, 24-5)*

## **Discussion**

### **The nature of the therapy**

#### **Eclectic v Integrative Practice**

It is interesting to note that all of the therapists interviewed drew a distinction between eclectic and integrative practice and each preferred to describe their own work as integrative, although their definition differs from that described in the literature.

All therapists are describing the term 'integrated' in relation to work with clients, rather than in terms of a theoretical base, contrary to the descriptions in the literature. Their description of 'eclectic' shows awareness of a pejorative connotation for the term. There appears to be no supporting empirical evidence for the questionable view of eclecticism, although this view is shared by Clarkson (2000), perhaps expressing a zeitgeist when she writes 'Various forms of so-called eclecticism have emerged, ranging from well considered and arguably justified approaches such as that of Lazarus (1981) to the slipshod variety which characterizes the intellectually lazy magpie kind that takes indiscriminately and without rigour or discipline from whatever comes to hand' (p306). It seems that this idea has permeated thinking in eclectic/integrative therapists. The most obvious explanation for this offered by the texts is the perceived criticism by pure form theorists, who are believed to consider such therapy as inferior.

The problem that seems to exercise the therapists interviewed is to how to provide professional credibility for their work in the face of this perceived criticism. This is also borne out by the general tenor of the interviews, in that these very experienced therapists were none the less quite diffident in talking about their practice and appeared to anticipate criticism, in terms of their responses. As all of the therapists interviewed were experienced NHS practitioners, it seems likely that the description of themselves as 'integrated' rather than 'eclectic' is an attempt to describe themselves as having a coherent basis for their work by contrast with a system which they construe as being criticised as being atheoretical and ad hoc. The development of the concept of integrated practice may, it seems, have received impetus from the need to justify a multi-dimensional approach in the face of perceived criticism by pure form practitioners. Thus, although these therapists were now describing themselves as 'integrative' rather than 'eclectic' the evidence seems to suggest that any change is more in terms of their ever-evolving conception of their practice rather than a change in their practice per se.

None actually offer a theoretical rationale for their work and the integrative practice they describe derives from other factors which are explored below. Crucially, the main difference between definitions of integrative approaches in the literature and those expressed by the therapists was the idea that integrative therapy entails moving between approaches within a single session and in integrating this process. Their definition is not in terms of theory, but in terms of the therapeutic process. What is of great interest is the fact that the factors identified in this research are common to all the participants. All of the participants were viewing integration in the same way: each shared common values in their approach to their therapeutic work and each worked from common factors in deciding which therapeutic approach was appropriate. A distinction was drawn between integrative and eclectic practice in that integrative practice was described as an approach which had coherence, based on a number of different ideas. The main message of the text was that integrative practice had some kind of base, rationale or grounding such that practitioners are able to justify, at least to themselves, that their therapeutic practice at some level 'makes sense'. This was based on a number of factors: first, the idea of wholeness,

expressed in terms of circularity, or of binding the therapy together, described in terms of the therapeutic process. Therapists draw on different approaches, which are then woven into the fabric of therapy to make what was often described as a seamless whole. Although described in different terms according to the therapist's main therapeutic orientation, all shared a collaborative approach to their work with clients and put great emphasis on the therapeutic relationship. This is supported by the research into the common factors approach, which found that one of the most effective ingredients in therapy are the shared factors embodied in the therapeutic relationship (Murphy, Cramer and Lillie 1984). Their findings suggested that 'advice' and 'talking to someone who understands' were curative factors. Similarly, Bennun and Schindler (1988) concluded that 'Researchers and clinicians should not be too occupied with technique, favourable interpersonal conditions are also essential for therapeutic change' (p151).

The research has indicated that the participants' way of working bears some resemblance to technical eclecticism. Any therapist congruent available theory is drawn upon to suit the person and the problem, without reference to any wider all encompassing theory. Technical eclecticism has however been criticised because its approach appears to assume that a therapeutic technique can be readily transported from one context to another (Lazarus & Messer, 1991). For instance, would a Gestalt 'empty chair' technique have the same effect if used by a cognitive therapist? However, there are also fundamental differences from technical eclecticism in the way that these practitioners conceptualize and describe their practice. Chiefly, technical eclecticism provides no acknowledgement of the sense of wholeness in therapy, which is fundamental to the participants' view as their work as integrated. This sense of wholeness incorporates the movement between approaches within a session and the sense of both client and therapist understanding the therapeutic process as a movement to a stated goal. The research has shown evidence of a personal therapeutic integration particular to each therapist, as each chose the approaches with which they felt congruent and which fitted with their own value systems. Further, emphasis on the therapeutic relationship is a major factor in their description of their work as integrated. The notion of integration as a process occurring in therapy and within the client reflects the realities

of the therapeutic encounter and describes practitioners' pragmatic use of the different therapeutic approaches. Within this context, the importing of techniques from different approaches appears to take place within a client responsive therapeutic alliance which avoids conflicting messages.

There is also evidence of a second type of technical eclecticism described as prescriptive matching (Beutler and Clarkin, 1990), differential therapeutics (Francis, Clarkin and Perry, 1984) or selective eclecticism (Messer, 1992). As the name suggests, the therapeutic approach is chosen on the basis of the presenting problem. The research showed that the client's type of problem was taken into account by the respondents. This approach has been criticised since it fails to take into account differences in client's personal characteristics (Collins & Messer, 1991). Also clients change both within one session and over the course of therapy (Safran, Greenberg and Rice, 1992). It was evident from the research, however, both that client factors were taken into account and that therapists demonstrated a responsiveness to change their approach over the course of therapy in accordance with client need and progress.

The position taken by the interviewees finds some resonance in the work of Garfield (1995) who recognizes the difficulties presented by eclectic practice. His common factors approach suggests that eclecticism may become unplanned, ad hoc and atheoretical and calls for an integrated eclecticism. The approach integrates ideas common to the major therapeutic approaches and incorporates the methods that have been shown to be effective in working with specific disorders. He identifies the common therapeutic variables of the therapeutic relationship, insight and understanding, cognitive modifications, catharsis and emotional expression, together with the therapeutic techniques of relaxation, desensitization, information and reassurance. The therapist is able to call upon any therapeutic orientation in working with of these factors, so long as the therapy is following an identifiable therapeutic process that is understandable to therapist and client. Similarly, the understanding by the client of the therapeutic process was a factor identified by participants in their understanding of the term 'integration'. Whilst he does not

articulate a wider theoretical base for his model, Garfield does present a coherent and pragmatic approach to integrated eclectic practice. This 'common factors' approach has however been criticised as an insufficient model of therapeutic change (Ogles, Anderson and Lunnen 1999). Common factors are thought to be obscurely defined, over generalized, insensitive to client, therapist and problem differences and the commonalities identified have been thought not to be as similar as they appear. For instance, the therapeutic alliance in psychodynamic therapy will be of an entirely different nature from that encountered in humanistic therapy. Further, common factors may be erroneously described as sufficient change agents when research has revealed several additional explanations for outcome equivalence (Luborsky et al, 1995).

It seems evident that the common factors approach must be viewed contextually, within the setting of each therapist's approach. For instance, a therapist working within a psychodynamic meta-theory might have a different understanding of the term 'support' than a therapist working within a cognitive-behavioural theoretical framework. What appears to be important, however, is the consistency in approach of the therapist, in other words, the sense of wholeness and completeness within the therapy itself as identified by the participants. Also, the therapists interviewed did not rely entirely on a common factors approach. The research has shown that they also took into account client factors, including presenting emotional state and needs, history, goals and issues, so were in fact demonstrating sensitivity to client factors.

In that the interviewees did not espouse a single view on the aetiology of problem causation, they considered this to be multifactorial. Similarly, the idea of multifactorial models in therapeutic work was developed in Gausson's (1999) model of Dynamic Systems Theory as an approach to therapeutic work. This theory rejects reductionist, single cause theories and seeks to understand causation in terms of a process of complex interrelated and mutually influencing transactions. This marks a shift from the ideas of linear, single factor causality, to the concept of circular, multifactorial causation in which outcome is determined through transactions within the system. In this, it shares some aspects of General Systems Theory (Bertalanffy, 1968) but it also provides

a model to accommodate an interactive view of the individual's development and problem aetiology. As Gaussen states, 'The crucial factor in the application of DST models to clinical intervention is that they are based on the potentiality for change in the individual self as an 'emergent process' which is the product of past and current transactions at every level from the physiological to social and human interactions' (p28). He maintains that to fully understand clients' difficulties, therapists must take into account the preceding complex developmental pathways and multiple influences, which have brought them about. The individual is regarded as a dynamic system, with therapeutic intervention at the level required according to the client's demonstrated therapeutic needs and the model used. It follows that as Stern (1995) stated, the clinician can use several 'ports of entry' into the system, and each may be effective in bringing about change, so long as the therapist is aware of the other existing levels. This approach finds a resonance with the work of the therapists interviewed, who were all aware of the wider aspects of client's difficulties and tailored their 'port of entry' according to individual circumstance.

Such integration, rather than being viewed as the theoretical fusion of two discrete models to form a new form of therapy, was viewed in terms of the process occurring during the therapeutic encounter, taking place both within the client and within the therapy. It is interesting to note that more recent publications are now also expressing, albeit implicitly, this view of integration (Owen 2001), rather than the view described thus far in the literature. It is arguable that the definitions expressed by these participants are widely held, and the profession's use of the term is evolving on the interface between theory and practice. If indeed the profession is moving towards this view of 'integration in practice' as opposed to 'integration in theory' this needs to be clearly articulated. It is arguable that the difficulties expressed in terms of professional identity experienced by the interviewees are in part attributable to this rather fluid definition of terms.

It is therefore likely, in an ever-evolving field such as integrated and eclectic practice, that practitioners may well not be able to articulate their practice in terms of a clearly understood model. The models of therapy identified are expressed more in terms of therapist values, clients'

therapeutic needs and therapist responsiveness to them. What is remarkable is that despite any clearly defined model, all of the therapists interviewed showed convergence in these factors.

To avoid confusion, I shall refer in what follows to the therapy described by the participants as an eclectic-integrated model. I have chosen this term as participants describe an eclectic approach to assessment and treatment choice, and refer to integration as the process occurring within the therapy.

## **Nature of Therapist**

### **Common values**

Horton (2000) has described a model of the philosophical underpinnings in any therapeutic approach. It is possible to identify, in terms of Horton's classification, common philosophical underpinnings for the approach of these integrative practitioners. In terms of their views of the therapeutic process, all acknowledged that there is no one therapy that has the whole 'truth', and none is able to fully explain human experience. All were prepared to accept a definition of multi-factor causality in terms of the origins of client difficulties. All felt the need for their therapeutic approach to be personally congruent for them and felt that no one approach could allow for this with sufficient latitude. They shared a common view of the therapeutic relationship in that it should be collaborative and sensitive to client goals. All recognized the unique nature of each client and considered that the therapy should be tailored to suit the client rather than the client having to fit in to the therapy. In consequence they were prepared to draw on any therapeutic approach within their repertoire according to their view of client need as articulated in terms of their training and experience. In terms of formal theory of the origins of client difficulties and client development, therapists were prepared to acknowledge multi-factor causality, whilst each holding a particular personal view on the more general origins of disorder and the development of pathology. This varied according to individual experience and training, with different theories and approaches being used according to the focus of the therapy. Perhaps



a useful analogy is the concept of therapeutic binoculars, which may be focused on close up or wide range views of client's difficulties, the wide angle lens viewing partners and wider systems, whilst close ups reveal intrapersonal issues. Each of these views has a theoretical formulation through which the therapist makes sense of client experience. Each co-exists and each is thought equally valid.

Clinical practice is driven by the view constructed by both client and therapist jointly. From this agreement of the change required, the therapist draws on the theories which she considers helpful and relevant in the understanding of the problem, and in the promotion of change. From this understanding, she may then draw on any number of techniques, drawn from a number of approaches to facilitate client progress. These processes are all eclectic in that they are drawn from many sources, and integrated in that they are presented in such a way as to make meaningful links for both client and therapist.

Stated explicitly by some and implicit to others, was the idea that there is no therapy having an objective 'truth', so that any number of therapies may offer something of value. These therapists were therefore moving away from the concepts of scientific positivism, which posits that an objective truth exists and can be understood through the use of reason. They saw each therapy as having a partial 'truth'. This pluralistic view would necessarily be in conflict with any model that required strict adherence, even a theoretically based integrative model such as CAT. This pluralistic vision necessarily encounters the problems of relativism, which may engender lack of intellectual rigour along with an 'anything goes' attitude. Safran and Messer (2005) have suggested that in answer to this, a new understanding of the nature of science is emerging. They highlight the importance of dialogue as a way of moving beyond our preconceptions and moving towards an improved understanding of other's ideas. They suggest that true dialogue involves an active engagement in the process of seeking to uncover the truth. This suggests an open minded approach to all therapeutic ideas which values all, with the aim of deepening our understanding of both our own and others' positions.

## **Professional identity**

It is apparent from the rather diffident tenor of the interviews that the integrative position does raise difficulties of professional identity for practitioners. As Hollanders (2000) suggests, adherence to a particular school of therapy endows a therapeutic identity, which an eclectic or integrative position does not. It also, one suspects, risks a kind of exposure for the therapist who has no specific well tried theory on which to hang his or her practice, when faced with a request to explain their work. This also may explain the participant's contention that their practice was based on theory, although there was no evidence of this in the transcripts. It may also explain their explanation of the term eclectic in critical terms, throwing into relief their own practice, which they describe as 'integrative'.

All therapists shared the basic belief that no one approach fits all, and that the therapist's role is to adapt therapy to suit the client. This basic belief meant that these therapists largely eschew the position of expert in the collaborative process of therapy. This recognition that they do not hold the ultimate 'truth' may account for the diffidence of the therapists interviewed. The acknowledgement that their therapeutic approach is tailored on a case by case basis meant that they were, perhaps, aware of the lack of firm theoretical paradigms in which to locate their practice. This would also account for the sensitivity to perceived criticism of their approach, and their description of their practice as 'integrative' rather than eclectic to counter such criticism. This problem was addressed by Szasz (1974), writing from a position as a pure school practitioner, suggested that the eclectic practitioner may suffer from a crisis of professional identity, that s/he is a 'role player', ill at ease with all therapeutic approaches because s/he is at one with none. He adds the caveat that ' the therapist who tries to be all things to all people may be nothing to himself'. (p41). However, the research contradicts this view of these practitioners, whose professed need to feel congruent with the approaches they are using belie any idea of 'role playing'.

Further, the emphasis on the therapeutic relationship, which demonstrates recognition of the need to engage fully with their clients, also points to these practitioners feeling secure in their own personal therapeutic role. Also, rather than being 'all things to all people', these practitioners were drawing on approaches with which they felt personally at ease. They did not use any approach with which they felt uncomfortable. So although they were adapting their approaches to suit each client, this was only within the parameters of the approaches with which they felt personally congruent.

It is also interesting to note that as Kerr et al (1992), Friedling et al (1984), Sloane et al (1975) point out, even in pure school practitioners, 'discrepancies (exist) between what therapies prescribe at a theoretical level and how therapists actually behave in practice' (p 274). Kerr's paper identified the fact that intrapersonal therapists were in practice making almost equivalent interpersonal links in therapy as were their interpersonal colleagues and that 'prescriptive therapy was closer to exploratory therapy than one would expect from theory' (p 274). Kerr also suggests that interpersonal and intrapersonal approaches may work synergistically to the mutual benefit of both. The benefits of the intrapersonal approach of CBT have already been recognized in Ryle's CAT in which it is combined with an analytic interpersonal approach. This suggests a movement towards a merging of therapies, even amongst practitioners who espouse a pure school position and that eclecticism is rather more widespread than is openly acknowledged.

Perhaps, as Prochaska (1984) suggested any lack of therapeutic integrity shown by eclectic or integrative practitioners may be a difficulty, not of eclectic/integrative practice, but of the stage of professional development of the practitioner. He argued that therapists pass through several stages in their development as eclectic practitioners who strive for a transtheoretical rationale, culminating in the 'committed' position. The practitioner then accepts the value of a variety of therapeutic systems, with a commitment to the whole project of therapy. S/he is concerned with the central question of 'what is the best way to be in therapy, what is the most valuable model we

can provide for our clients to enable them to have a better life?' (p367). As all of the therapists interviewed were well experienced, they appear to have reached this committed position.

This issue of professional identity was keenly felt by all of those interviewed, both in terms of how they are viewed within the profession and by how the therapy can be presented to referrers in an easily understandable way. Whilst a clearer meta-analysis of the eclectic-integrated approach will make the approach more easily identifiable by practitioners, this would probably be of limited use in presenting the method to referrers from outside of the profession. Perhaps a more pro-active approach by such therapists is required. The diffidence apparent in the interviewees is perhaps part of the difficulty that eclectic/integrated therapists encounter. Possibly a more assertive approach about their therapeutic orientation together with the professional credibility engendered by their work will enhance the perception of their practice both within and without the profession. Further empirical research into eclectic and integrative approaches would also provide a firmer basis for practice. Crucially, also, there needs to be a clear understanding and agreement of the terms 'eclectic' and 'integrated,' so that practitioners can describe their work with accuracy and hold a firm therapeutic stance.

### **Personal therapeutic identity**

Bond (2000) describes this as a process of personal integration. The practitioner develops a way of practising which draws upon a variety of approaches, with which s/he feels at ease. This is influenced by personal values, beliefs and personality type. This process of personal integration was described by Bond (1995) in his 'pond' model in the development of personal integrative practice. In this, the therapist's own philosophy, or personal belief system underpins their choice of formal theory, which is translated into clinical theory that in turn underlies their skills and strategies. This congruence between personal belief and practice was, perhaps, one of the more important ways in which these therapists grounded their work. As Skovolt and Ronnestad (1992) suggest, in order to develop fully as a therapist, it is necessary for the practitioner to practice in a way that is consistent with their own personal philosophy.

## **Personal bias**

Therapists also acknowledged that personal bias and choice were factors in their decision as to which therapeutic approach to use. Within their integrative approach, the personality of the therapist permeated how these different approaches were used. For instance, Therapist 3 needed a framework within which to work, whilst Therapist 2 preferred an approach which allowed her freedom to respond on a moment by moment basis within the therapeutic process. Therapist 1 sought clarity by using visual aids within each approach whenever she could, whilst Therapist 5 preferred to use established therapies, principally CBT and psychodynamic. Therapists' sense of their own personal identity thus helped to forge not only their overall 'world view' or meta-theory, but also their professional identity as therapists.

Individual philosophical differences were apparent, related to therapist's experience and training. Therapist 2 based her integrative practice on a constructivist view. Therapist 5 saw the similarities in psychodynamic ideas and schema focused CBT, as did Therapist 3, whilst Therapist 1, initially humanistically trained, was guided by client led principles to utilize anything within her therapeutic range which helped the client. This difference in background and personal preference necessarily impacts on the nature of the therapeutic alliance engendered by each individual therapist. It seems that the general tenor of each therapist's approach may be traced back to the original metatheory of their therapeutic world view. As Safran and Messer (2005) point out, the higher level constructs of an approach should not be ignored, since these theories have a 'trickle down' (p 6) effect on clinical practice. What draws therapists to a particular 'world view' is open to speculation and is a topic worthy of further research.

Messer and Winokur (1984) have illustrated the difficulties of integration of such 'world views' at a meta-theoretical level. For instance, psychoanalytic therapy is based upon a tragic view of reality in which people are subject to unconscious forces and which can be only partially ameliorated. Humanistic therapies in contrast, are characterised by a romantic vision which values individuality, spontaneity and possibilities for development of the individual. Each

therapist's 'world view' will necessarily affect their choice of therapy. These individual predilections were apparent within the research. As Safran and Messer (2005) suggest, these differences in world view whilst incompatible in terms of integration conceptualize a dialectic which can take into account the paradoxes and contradictions within client's lives. As such, the respondents showed a willingness to utilize ideas or techniques which they found helpful to clients from approaches with which they did not feel at ease. For instance, the concept of transference was found useful although many therapists were not at ease with the 'world view' of the psychodynamic approach.

This pluralist vision also allowed therapists to create dialogue with clients holding a different world view from their own and to utilise compatible approaches. For instance, the psychodynamically trained therapist, whilst on the one hand viewing the origin of a client's difficulties as based in his childhood experience, recognised that the client needed a speedy resolution to the relationship problem displayed and therefore chose to work in a cognitive way.

That these differences exist amongst therapists is not surprising. What was identified by all therapists as important was the idea of congruence. This appears to be a necessary factor in integrated eclectic therapy, since when techniques or ideas are 'imported' from other approaches, this must be effected in a way that is congruent with the overall therapeutic approach and supported by the therapeutic alliance.

None of the participants articulated any unease at switching between approaches as necessary, in terms of either theoretical constructs or the ideas articulated in the different approaches. Each however, did express a disinclination to use a certain therapy. The reasons given for this were always couched in terms of a personal uneasiness with the approach, rather than a criticism of its theoretical base. For instance, the counselling psychologists interviewed were highly sceptical of the psychodynamic approach. The psychodynamically trained therapist, in contrast, felt that what he perceived as the emotionally pressurized Gestalt approach was too intrusive for clients. This

was defined in opposition to his own approach, which emphasised the importance of a nurturing therapeutic relationship that provided for emotional growth at the client's pace. Therapists are thus defining their sense of therapeutic identity by defining their approach as different from others, which they construe in negative terms. This process, one suspects, may be present in all practitioners, and may partially account for the criticism of integrative practice by pure school practitioners, who are similarly defining their professional identity. Safran and Messer (2005) suggest that this tendency to identify ourselves in contrast to 'the other' deprives 'others' of genuine standing. This definition of our reality has the effect of marginalizing those whose views are divergent from our own and this cuts us off from the opportunity to learn and grow. They suggest an open attitude of 'surprise and eagerness to learn' (p 3) which will allow for better communication in the search for deeper meaning within the eclectic/integrative debate.

The fact that all of the therapists interviewed were practising eclectic therapy which they were integrating in their own idiosyncratic way raises a number of issues and questions for practitioners working and training in this orientation. All of those interviewed were experienced therapists, whose integrative practice had grown out of their years of training and experience. As such, each had worked out a philosophy of their practice by which they could define which approach was personally congruent for them. This does present difficulties for both trainers and trainees who wish to work in an eclectic-integrated way, in that there is no clear definition in terms of what makes an eclectic-integrative therapist. The only common factor is one couched in negative, rather than positive terms: that no one therapy holds the whole 'truth' or the answer to every client's needs. However, the common values identified amongst the therapists interviewed provide a basis for an integrated approach, chiefly a collaborative, non-expert open approach, a belief in multifactorial causality and an acceptance of the need to use more than one therapeutic approach. This research has also indicated the necessary nature of a therapeutic alliance based on a consistent meta-theory, or 'world view'. Within this framework, therapists are able to draw on any available theory, so long as the therapeutic process is understandable to both therapist and client. Perhaps therefore, the crucial factor is not how such an explanation of the process is

couched, but that there is one. As Stiles et al (1986) point out; there is no evidence to support the superiority of any one explanatory model.

As it is evident that personal bias and choice are important factors in the use of eclectic therapy, it is perhaps important to recognize this more fully in training. Trainees need a tolerance of uncertainty, and a willingness to understand their own therapeutic prejudices and preferences. This philosophical development is a crucial part of the development of the eclectic integrated practitioner, which is required to a much lesser extent by practitioners working in a more formulaic way who are able to define themselves by adherence to a particular therapeutic school of thought. The early identification of a trainee's 'world view' would thus appear to be a vital part of any eclectic/integrated training in order to maintain a consistency in therapeutic approach.

### **Theoretical base**

It is possible that these practitioners could be criticised for working in a way that has no base in theory. However, it is clear that their approach has developed both through their own beliefs, training and experience and in response to the exigencies of dealing with a wide variety of client populations. There is a pragmatic response to a situation in which they find the limitations of a pure school theory. As such this is a developing field which as yet has not been articulated into theory. Arguably, this is the way that psychotherapeutic theory grows and changes: it is an organic rather than a prescriptive concept. What gives their practice its validity is that all are working to common factors and that these factors can be identified from the literature and are not peculiar to the therapists interviewed.

As has been shown by this research, the eclectic-integrated approach demonstrated begins with a global assessment of the client, taking into account multifactorial problem causation as well as individual client and problem factors. An appropriate therapeutic approach is then chosen from the therapist's own personal repertoire, which is influenced by personal bias and individual training. All of the therapists interviewed were experienced practitioners yet they were unable to



articulate a theoretical base for their eclectic approach. This raises issues for the training and practice of eclectic/integrative practitioners, since such a wide ranging model is not only difficult to articulate but also to grasp for inexperienced trainees. Given the difficulties of training in the method identified, perhaps, as Safran and Messer (2005) suggest, in order to incorporate ideas from different therapies, one must be 'knowledgeable about and firmly rooted in one tradition and know where one stands' (p 9). This would indicate a basic training in one particular approach, before attempting to integrate different ideas and techniques from other approaches. Alternatively, it could be argued that initial elementary training in the three major schools might then be followed by more intensive study of the school of thought which reflected their particular 'world view' might prove more beneficial. Further research in this area is indicated.

## **Universal Factors in Decision Making**

### **Which approach?**

#### ***Inter/Intrapersonal***

A number of factors came into play as therapists decided which approach to use with a client. First, along with the client responsive approach, what the client wants from therapy is taken into account, along with the nature of the presenting issue. Second, therapists also take into account whether the therapy has an interpersonal or intrapersonal focus. This distinction was suggested by Kerr et al (1992) in defining the nature of feedback given by therapists to their clients. This was first posited by Prochaska (1979) who noted that the different schools of therapy tend to emphasise one or the other. As Kerr suggests, the therapeutic focus is influenced by the belief about the origins of the client's problem inherent in the approach. Thus, those orientations which see the origins of psychopathology within the individual will focus on intrapersonal factors, whilst those who describe the problem in terms of interactions with others will have an interpersonal focus.

However, the therapists interviewed switched between these approaches. This idea is supported in work by Stiles et al (1990), who developed an assimilation model to describe the process of client change. The process of change is thought to be similar in all psychological therapies. Based on the work of Piaget (1958) the theory proposes that the individual develops mental schemata in the adaptation of problematic experiences. These schemata involve the conceptual reorganization through which the individual gives meaning to the environment. Experiences are viewed in the individual's frame of reference, which is constructed of a series of associations. These series of associations are formed in two processes, assimilation and accommodation. Accommodation refers to the modification of each schema that occurs as assimilation takes place. These processes are concurrent, complementary and occur at all levels of the processing and understanding of problematic experiences. A problematic experience will be experienced as alien to the idea of the self or self-schema and will therefore be unassimilated. Stiles describe how assimilation occurs through a continuum from warded off, painful feelings, through unwanted thoughts, to vague awareness, to problem statement, to understanding, insight, application, working through, problem solution and mastery. The model acknowledges that clients experience problems in more than one area of their lives and that the resolution of these problems may occur at different rates and at different points on the continuum. Stiles suggests that certain therapies are more appropriate for work at different points on the continuum. For instance, clients experiencing warded off, painful feelings will benefit from psychodynamic and experiential therapies, whereas those with a clearer problem statement will benefit from cognitive behavioural work. This model also allows for the difference in outcome sought in different therapies. Psychodynamic and experiential therapies, working at the early end of the continuum, result in insight or understanding. Those working further along the continuum, such as behavioural therapies, have the aim of behavioural change. This model takes into account some client and problem variables but can also be criticised as insensitive to other personality and problem differences. The therapists interviewed were making a judgement on the basis of the client's presentation which included an assessment of where the problem is focused, either intra

or interpersonally, and tailoring their approach to suit. However, they also took into account the client's presenting emotional state, needs, history and goals.

### *Depth of processing*

There is also a sense of the depth of emotional processing required in the situation, with the realization that some therapies access this more quickly than others. This has previously been posited by Holmes (1985) who suggested that different therapeutic approaches may bring about two different levels of change entailing different levels of processing and awareness. Similarly, Dimond et al (1978) suggested that therapeutic change may take place at the 'environmental' (p 241) or interactional level, which involves wider parts of the system such as partner or family, or at the level of personality change. Pinsof's (1994) Integrative Problem Centred Therapy similarly distinguishes between work that focuses on the individual and that which works with the wider system of partner and family. All therapists were aware of these distinctions and were processing their assessment of their clients in terms of the level of change required. This in turn, influenced their choice of therapeutic approach.

### *Client's presenting emotional state*

Allied to the assessment of the required depth of emotional processing was an assessment of the client's readiness in terms of emotional work. This includes an awareness of events taking place in the client's life which might affect their ability to engage in therapy or to limit their involvement in terms of emotional engagement. Individual factors, such as the client's psychological mindedness and familiarity with the therapeutic process were also taken into account.

### *Assessment*

It is evident that in terms of their assessment process, the participants were drawing on a number of theories and concepts. The assessment process is rarely described in the literature on eclectic

practice, Lazarus (1981) being a notable exception. The process identified by the research differs from the largely behavioural assessment offered by his multimodal therapy in that it provides a more comprehensive framework that allows for a wider access to different approaches. For instance, the identification of the inter v intrapersonal distinction and the recognition that different therapies work at different emotional depth, allows for the use of both behavioural and psychodynamic approaches. Also, client factors such as emotional state as expressed in the therapeutic process and previous history are considered.

### ***Implications for training practice and research***

These therapists are recognizing not only the common needs of their clients, but also the unique nature of their clients in terms of the processes required to reach their therapeutic goals. The problem for these practitioners, in any attempt to explain their work, is that this understanding is not clearly articulated but implied. This presents difficulties for those wishing to train such practitioners or to research their practice. There is however, support in the literature for the concepts evident in their approach. However, it is arguable that psychotherapeutic theory grows out of practice. It is rarely, if ever, imposed from a purely theoretical standpoint which has no basis in experience and remains a product of the interactive feedback loop of theory and practice.

It is arguable that for this approach to develop in a cogent way that will also allow it to be comprehensively researched, it is imperative that a coherent theoretical model on which to base practice is thought through and articulated. This model would necessarily need to be placed within the constructivist paradigm and based on the idea of multifactorial causality. Also, whilst the initial assessment for an experienced eclectic practitioner presents the opportunity to tailor the therapy to the client's therapeutic needs, for the inexperienced practitioner, this process may be beset with pitfalls. In order to assess accurately, an understanding of client factors and issues has to be combined with a sound understanding of a number of therapeutic approaches. This is obviously more difficult than the process required by trainees working from one discrete therapeutic approach. This research has, however, demonstrated common factors involved in

clinical judgement during assessment, which may provide pointers for practice. Further, the identified recognition of the requirement for an adaptable therapeutic approach needs to be tempered by the finding that therapists choose to work only in ways with which they feel personally congruent.

### **Limitations to the study**

The research has not attempted to define a 'correct' definition of the terms under investigation and to assess the practice associated with them. These issues would be better addressed by a quantitative method which would have had the advantage of accessing a larger sample and given breadth, but not depth of meaning. It would therefore not have achieved the in-depth discovery of therapists' experience which was the object of the research.

The grounded theory method chosen has advantages in that its techniques are now well documented and provide a guide for the researcher. It offers a systematic method for the collection, organization and analysis of data from the empirical world and is well suited to an empirically based discipline such as counselling psychology. It is however, an extremely time consuming and painstaking enterprise from the transcribing of individual interviews to immersion in the data and gradual extraction of themes. Since no initial hypothesis is generated, there can sometimes be a lack of clarity in the direction of the research. The amount of data generated can seem overwhelming at times and the process can require much faith and hope in the execution. Further, the 'bracketing off' of one's own values and prejudices is a difficult task, since a perspective on the research is required in order to see relevance in the data and to extract categories. It is difficult to maintain the necessary totally open attitude required as well as to hold all potentially relevant facts and theories in the background for some period of time. This was especially difficult for me since I had already done a fair amount of thinking and research into the topic. Also, the fact that saturation was reached within a comparatively small number of participants meant that I had to ensure that I was not allowing my own views to permeate my

analysis, thus allowing for a comparatively early generation and identification of categories. Further, empathy with the participants requires the researcher to understand the setting for the research, which of course I was able to do. Conversely, as a practising psychologist within the NHS setting, there was a danger of over-involvement on my part and an inability to distance myself from the data. A self-reflective approach and the use of two independent assessors were invaluable as a balancing check on these factors. The independent assessors also provided another perspective on the material, opening up new areas for investigation. Also, an unplanned extended break during the process of the research had the unforeseen benefit of allowing me to return to it with a fresh eye and thus perform the delicate balancing act of holding the relevant material in abeyance before finally extracting categories and subsequent theory generation with greater facility.

As a qualitative study, the research provides an in depth investigation into the subject of choice. The information was given within a particular context in the engagement with me as a fellow professional and would perhaps differ on another occasion, in a different setting and with another researcher. For instance, all participants were NHS employees and views from psychologists in private practice may differ. The research is essentially an 'insider' view of therapists' work: in many ways this helped the research since there were many shared understandings and inter-subjective meanings. On the other hand, this also meant that there were shared assumptions about the 'givens' of working in the NHS, which might have been questioned in an 'outsider' view. Also, the research is a construction of how these therapists describe and think about their practice which may possibly differ from what actually happens in the therapeutic interaction itself. Analysis of video taped sessions would be useful in this context and provide a possibility for further research.

The NHS context of the study raises issues of the culture and ethos within which the participants worked which although recognized in the research was outside its scope and not directly addressed. Inevitably, their practice is affected by the context which provides constant pressure

and constraints of time and resources. These issues may have played a role in the development of eclectic and integrated practice which allows for a wider based approach and is not limited in its application to a discrete client base as are the 'pure school' therapies. These questions concerning the nature of counselling psychology and the nature of therapeutic approaches within a socio-political context were also outside the scope of this research. Similarly, this has been a qualitative analysis of experience, providing a conceptual framework through which to view the subject under investigation rather than an analysis of the discourse itself. I have therefore chosen to look at therapists' experience of working in a chosen way, rather than to view therapy as a social action accomplished through talk or to address the social context and function of therapy and how talk structures the experience.

Further, grounded theory is a process approach rather than a product-oriented approach. As a construction of meaning, the theory produced is ever evolving and therefore not a perfected product since it allows for change over time and allows participants to offer their own perspective on the events under investigation: it is not accessible to measurement. The goal has been to construct a theory to describe the phenomena under investigation and is justified in terms of its explanatory coherence. It may not explain or predict totally or be completely testable, but should have what has been described as 'fit', 'grab' and 'work' (Glaser and Strauss 1967). These terms refer to the theory's applicability to the data, its relevance to the group under study and its ability to predict and describe what is happening (Glaser 1978). This research thus aims to further thinking and practice in integrative and eclectic approaches by providing an alternative conceptual framework within which to consider the subject.

The research is therefore limited by the qualitative method, which gives depth but not breadth and which provides no 'objective', fixed data: the theories generated are recognized to change over time. The issues of therapy as a social action and its socio-political aspects have not been directly addressed. The research is a study of therapists' experience at a given time, within the limits of a specific context, generated in interaction with a specific researcher.

## **Conclusion**

### **The Nature of Eclectic-Integrative Therapy**

This research has identified a number of factors underpinning the eclectic-integrative work of the participants which can be viewed within the constructivist paradigm.

#### ***Constructivist Pluralist view***

The eclectic-integrative therapy identified in the research differs from that described in the literature. It has no articulated theoretical base, but can be described as founded upon a pluralist, constructivist therapeutic vision, which of itself would preclude such a theoretical base. Arguably, once a therapeutic approach becomes codified, it is no longer, in terms of this definition, eclectic-integrative, since other therapeutic possibilities will be excluded. The adaptability inherent in this approach has been recognized as an important aspect of the therapy by all participants. Perhaps this recognition that any prescriptive system runs the risk of becoming ossified, leaving little room for flexibility, prompted Jung's comment 'I am not a Jungian and never could be' (in Progroff, 1953).

#### ***Eclectic Assessment***

This pluralistic vision allowed an eclectic client assessment based on multifactorial causality which took into account individual client differences and history, together with problem factors. As such, the identified approach shared some of the features of technical eclecticism, prescription matching and the common factors approach.

#### ***Integration as a process***

Therapists chose an appropriate therapeutic approach from an eclectic mix of models. These are then described as integrated within the client and within the therapy.

#### ***Contextually based***

Such a wide ranging approach will necessarily need its component parts to be viewed contextually, within the setting of the therapeutic alliance engendered by each particular



therapist. In order to identify this in more detail, further research is indicated perhaps by detailed analysis of therapist/client interactions.

### ***Therapeutic Alliance***

The research has also indicated the importance placed on the therapeutic alliance, which differs in its nature according to the 'world view' or meta-theory of each therapist and maintains therapist congruence. This may have implications for trainers as students on eclectic/integrated courses may be helped by identifying their own philosophical position early on. The alliance provides a context within which different techniques and approaches may be combined to become part of an integrated therapy. Further research is indicated to compare how this process occurs across therapists with different 'world views'.

### **Therapy as Dialogue**

The process of the eclectic-integrative therapy described may be usefully captured within a pluralist vision in the concept of 'therapy as dialogue'. Therapist and client can be seen to engage in a dialogue, out of which grows a deepening understanding of the client's problem and a decision about the most appropriate form of therapy. Meanings, understanding and direction may change over the course of therapy within a client responsive, adaptable therapeutic approach. Eclectically chosen therapeutic approaches are then integrated in the therapeutic process.

### **Summary**

This research has clarified how the terms 'eclectic and 'integrated' are understood and used by practitioners. It has also investigated their methods of choice and ways of practice employed and has given some insight into the thinking underpinning the eclectic-integrative approach. In doing so, it has identified a number of common factors in the approach of the eclectic-integrative therapists interviewed. It has also identified the importance of a therapist congruent therapeutic alliance as the context for an eclectic-integrative therapy. This congruence is founded upon each therapist's particular 'world view' which in turn stems from their own personal experience and predilections. The eclectic-integrative therapy identified can be seen as based within the constructivist paradigm, with a pluralist vision. Within this context, it has been suggested that the

therapy may be usefully viewed as a dialogue, where meaning is co-constructed between therapist and client and where integration occurs within the therapeutic process. This approach presents challenges in terms of both training and research.

### **Final Reflections**

In this research, I hoped to understand how other therapists approached eclectic and integrative therapy, and how they solved the dilemmas such therapy presents. Particularly, I wished to discover how therapeutic choices were made, as well as practitioners' views on the overall approach. The research has answered these questions and allowed close examination of the emergent meanings.

It is evident from this research that eclectic-integrative practitioners value the flexibility afforded by broader based therapies which allows them to work with a wide range of clients. There was though, evidence of defensiveness in the face of perceived criticism from 'pure school' therapists. It is important under these circumstances, not to fall into the trap of taking a justificatory position and forming an integrative/eclectic defensive 'laager'. This research has not been an attempt to justify this approach, or indeed to prove it is 'better' than pure school models. Rather, it has been an attempt to engage in a dialogue with experienced practitioners to deepen my understanding of the topic. It can be seen as part of the necessary continuing dialogue, both within the eclectic/integrative movement and between that movement and pure school theorists, to the mutual benefit of both.

# **Chapter 3**

## *Literature Review*

### **Borderline Personality Disorder - the Emergence of an Eclectic Approach**

## **Introduction**

### **Research rationale**

A narrative method was employed in this review to investigate thinking and research concerning the nature, origins and treatment of borderline personality disorder (BPD) and how these have developed over time. Particularly, the aim was to discover how the condition is classified, as well as the thinking and theories concerning both aetiology and treatment. The method used was a search of a number of data bases: BIDS, Google Scholar and Web of Science. Research was chosen by its relevance to the three subject areas within the topic. This method allowed for a wide 'broad brush' approach to the subject which included early work and thinking, allowing the development of thinking about the topic to be traced. Early psychoanalytic work was thus included, although much of this was not supported by empirical research. My method therefore did not assess the quality or methods of the research included, or compare one piece of research with another in any formal or systematic way, as would have been the case in a formal systematic review.

An alternative method would have been to do a systematic review of the literature. A systematic review is a 'method of locating, appraising and synthesizing evidence' (Petticrew 2001). It aims to answer specific questions, reduce bias in the selection and inclusion of studies, appraise the quality of the selected studies and to summarize them objectively. A protocol specifying areas for investigation is drawn up as well as explicit, pre-specified inclusion and exclusion criteria for determining which research is to be included. Research methodology is assessed by the use of formal scoring rules and considerations of internal and external validity and bias may also be considered. Data are then extracted, compared according to the guidelines of the original protocol and synthesized to provide a conclusion. This method was not used for this review since it was not given as the researcher's brief at the time. Also, it would not have provided the historically based perspective chosen by the researcher.

## **Borderline Personality Disorder**

Borderline personality disorder (BPD) is probably one of the most difficult and challenging conditions a therapist is likely to encounter. This paper traces the development in the understanding of the condition, its possible causes and the treatment approaches that have grown out of this. The paper does not deal with the psychopharmacological approaches to treatment although the importance of these is not underestimated. As Koenigsberg (1997) stated, it is important to avoid an all or nothing tendency to biologize or psychologize the condition.

The paper seeks to draw together the understandings and insights offered by different psychotherapeutic approaches together with the various approaches to treatment. It traces a gradual diffusion of therapeutic thinking and boundaries, which has served to progress the understanding and treatment of the condition and concludes that no therapeutic approach is able to provide an adequate description of its aetiology and treatment. The paper suggests the requirement for further methods of integration in the understanding and treatment of the condition.

## **Diagnosis**

The complex and extremely disturbed behaviour of BPD sufferers has long challenged therapists, who have sought to describe and understand the condition within the parameters of existing psychiatric and psychological theories of mind (Kernberg 1967, Fonagy, 1991, Holmes, 1995). Psychoanalytic theory has been the major contributor in our understanding of this perplexing condition, possibly because BPD is most understandable in the context of a developmental perspective. This provides an interpretation of the sufferer's intense emotional reactions, usually evident in the very young child.

For instance, the first clinical description of BPD was given by Stern (1938) based within the psychoanalytic school, when the condition was defined as an area between psychosis and

neurosis. This view was challenged by the psychoanalyst Kernberg (1967), who postulated that the BPD's have in common a specific, stable form of psychopathological structure, rather than disorders in the area between psychosis and neurosis. BPD thus describes a fixed, highly structured personality organization. He identified four critical features of personality structure; non specific manifestations of ego weakness, such as poor anxiety tolerance and impulse control, a propensity to drift towards irrational, dream like thinking patterns in the context of intact reality testing, a preponderance of less mature psychological defences such as splitting and identity diffusion with internal mental objects of significant others as fragmented and strongly charged as good or bad.

Kernberg thus focused on intra-psychic structural characteristics, formulating a structural diagnosis which described the predominant organization of the sufferer's personality structure. He thus described the frequency of symptoms and an observable abnormal behaviour. Kernberg suggested a genetic predisposition to BPD and described mental structures based on Freudian formulations of id, ego and super-ego and based his diagnosis of BPD on the analysis of both intrapsychic structures and internal conflicts. In viewing BPD as a discrete personality organization, Kernberg drew a clear distinction between BPD and neurosis and psychosis. He postulated that the individual with BPD stabilizes his psychological functioning in terms of this organizational structure, which provides a template for the behavioural symptoms. The personality structure is described in terms of a predominance of defensive psychological mechanisms, such as splitting and identity diffusion. There is also ego weakness in areas such as anxiety tolerance, impulse control and the capacity for sublimation. Lack of super-ego integration results from primitive sadistic and idealized object relations. Unlike psychosis, reality testing remains intact.

Research by Greene (1996) supported Kernberg's notions of a reciprocal relation between splitting mechanisms and problematic object ties in BPD pathology as well as pathological defence mechanisms specific to the condition. Gunderson (1995) identified psychopathology in

five areas of functioning, social adaptation, impulse control, regulation of affect, psychotic symptoms and interpersonal relations. Behaviourally, these difficulties are manifest in repetitive self-destructive behaviours, drug abuse, brief paranoid experiences, severe devaluation or 'manipulation' (p 191) in close relationships and often highly troubled past therapy experiences. Grotstein et al (1987) drew together ideas from biological psychiatry and psychoanalytically informed psychological theory. He described BPD as a disorder of self-regulation, characterized by a primary breakdown in the regulation of the states of self, such as arousal, sleep, wakefulness and self-esteem needs, along with their secondary sequelae. Similarly, Stein (1996) found that BPD is associated with a unique pattern of affect dysregulation. More latterly, Hirschfield (1997) has described BPD as being classified by four groups of symptoms, affective, impulsive, ego-interpersonal and psychotic.

Research by Brodsky et al (1997) has also identified a relationship between dissociative experiences, which may be linked to BPD, and the self-mutilation which is frequently a characteristic of the condition. Clients with BPD who dissociate are therefore more likely to self-mutilate. However, the diffuse nature of the descriptions of BPD has led to criticisms of the concept. It can be argued that the classification of personality disorders is unsatisfactory in that current classifications include diagnostic overlap, have limited evidence of validity and poor empirical support. As Stone (1994) states, BPD can be accompanied by a wide variety of other DSM defined personality disorders and it may further vary in respect of a large array of possible personality traits. Further, clinicians may over-diagnose the disorder, using BPD as the principal diagnosis when two or more personality disorders are present (Herkov & Blashfield 1995). Also, females have been found to be significantly more likely than males as meeting the criteria for BPD (Grilo et al 1996), whilst males are more likely to receive the diagnosis of narcissistic or anti-social personality disorder.

This of course, may tell us more about the social construction of gender behaviour than of personality disorders per se. As Hatzitatos et al (1997) found, men with introverted hostility

tended to be diagnosed as having BPD whilst men showing extroverted hostility received a diagnosis of antisocial personality disorder. Similarly, as Paris (1997) points out, both BPD and antisocial personality disorder have a common base in impulsive personality traits, but the behavioural differences are shaped by gender, thus raising the question as to whether there are indeed two discrete disorders or one disorder manifested in two different ways. Further, social and cultural factors have been shown to be implicated in diagnosis. As Taub (1995) found, BPD was primarily diagnosed in females who were either single or divorced, compared with other personality disorders or affective illness, and was diagnosed less than these disorders in patients from ethnic minorities. Social and cultural constructions of identity may thus affect diagnosis.

Higgitt & Fonaghy's (1992) view is that the concept is an 'heuristic device', to compensate for the lack of a comprehensive psychological model which is likely to be of limited duration. He identifies three major features of BPD. First, a heterogeneity of symptoms and diagnosed mental disorders which co-exist with borderline personality organization, such as affective disorders, schizophrenia (Steinart & Schmidt michael 1995), eating disorders (see also Rosser 1995), substance abuse and temporary psychotic episodes. Second, there is a cyclical pattern of improved behavioural adaptation, followed by disintegration. Finally, impairment in interpersonal relationships leads to a chaotic social world where idealization and submissiveness are followed by denigration and rage. Fonaghy concludes that 'as long as epidemiological psychiatry cannot provide a realistic single description for this group, the term 'borderline' will do' (p 25).

Whereas Kernberg and other authors spoke of a borderline organization or borderline syndrome, in DSM 111R (1987) and DSM 1V (1994) there is registered a borderline personality disorder. The DSM 1V criteria for BPD are given as a pattern of unstable and intense interpersonal relationships, alternating between idealization and devaluation, impulsive, self damaging behaviours, affective instability, inappropriate intense anger or lack of control of same, recurrent suicidal threats, persistent identity disturbance, with uncertainty over two life areas,



such as sexual identity or self image, chronic feelings of emptiness or boredom and frantic efforts to avoid real or imagined abandonment. Using these criteria, a figure of 7.5% prevalence has been given for BPD in the USA. Gunderson et al (1995) found that 14.5 % of patients admitted to psychiatric care fulfilled the criteria. It is interesting to note, however, that further research into the complexities of PTSD has allowed the recognition of an overlap in this condition and Axis II personality disorders, especially BPD (Rosser, 1995) which may in time again alter our conceptions of the condition. It is also important to bear in mind the social, cultural and gender factors operating in the client's life to avoid misdiagnosis.

Also, the notion of a 'diagnosis of disorder' in counselling psychology is also problematic, since the discipline is concerned with people in a developmental and interpersonal context which cannot be reduced to the treatment of 'disorders'. Further, given the gender bias in diagnosis, there is a danger that the diagnosis of BPD may be used in a pejorative sense to describe difficult behaviours which are unacceptable in terms of their emotionality. In the same way that 'hysteria' was a term used to describe unexplained and little understood female responses within a society based upon male power, the term BPD may be in danger of misuse in the same way. Indeed, it is possible to argue that the notion of 'personality disorder' with its pejorative connotations does clients a disservice and should be avoided since the term pathologizes the condition and thus helps us to distance ourselves from the client. As Gallop, Lancee and Garfinkel (1989) demonstrated, health professionals respond in stereotypical, less empathic ways to clients diagnosed with BPD. The emotions aroused by some of the behaviours attached to the condition are uncomfortable for professionals to experience, and there may be a tendency to project these feelings by 'blaming the patient'. A diagnosis of BPD may provide an outlet for this, unless the term is used cautiously, possibly until another more appropriate term has been generated. It is thus acknowledged that the term BPD is an imperfect attempt to describe a perplexing set of behaviours, indicative of extreme forms of emotional distress and conflict.

## **Aetiology**

Early work and understanding of the condition was carried out by psychoanalytic practitioners, basing their theories on the work of Freud (1915) and Klein (1923, 1926). Their formulations were primarily developmental in nature. These explanations were based on the concept of inner psychic conflict, as explained by Kleinian object relations theory and contended that the borderline child's relationship with its mother was based on reward for regression and withdrawal of maternal attention when the child attempted to separate and individuate. This 'push-pull' quality, introjected by the child becomes the basis for BPD. Thus, an attacking introjected maternal part-object that is critical, hostile, withholding and angry, reacts to any assertive behaviour or any attempt to separate. This results in chronic anger, frustration over abandonment and depression. The associated part self-representation is self as ugly, evil and empty. The rewarding libidinal part object is associated with regressive, clinging behaviour, which results in feeling good, gratification and a wish for reunion. The part self-representation is the good, passive, compliant child. Similarly, Kernberg (1968) emphasised the inevitability of psychic conflict in early human development, with its concomitant feelings of anxiety, guilt and shame. Kernberg identified the origin of BPD in the intensity of the child's aggressive and destructive impulses and the relative weakness of the ego structures available to contain them.

Kohut and Wolf (1978) proposed a trauma arrest model in which a traumatic fault in the child's early environment, namely unempathic treatment by caregivers, results in the child's inability to introject a soothing self-object. The child thus lacks any sense of self-cohesion and as an adult may resort to primitive self-object relationships, such as rage or excitement, or sedation through drugs to support self-cohesion and self-esteem.

Fonagy (1991), writing from a Freudian perspective, sought to amalgamate the conflict and deficit models in the development of BPD. He suggested that the root of the child's deficit lay in the child's accurate perception of the caregiver as experiencing destructive and hostile feelings

towards the child. In order to protect himself against the painful awareness of such knowledge, the child inhibits his capacity to think about the mental states of others. There is also an inhibition in the consideration of the child's own mental state. This leaves the individual extremely vulnerable to psychic conflict in that he is unable to conceptualize and thus modulate his own psychological state.

The disorder has also been explained in terms of attachment theory (Winnicott, 1964). Sable (1997) suggests that BPD is characterized by a profound insecure attachment, with extreme vacillations between a desire for proximity and a dread of emotional engagement. These feelings have their origins in early traumatic emotional experiences. Without a secure base providing consistency, affirmation and reliability from which to explore and separate, the child is unable to resolve loss experiences or to modify inner working models of itself or form stable relationships with others. These models, whilst giving us an insight into the emotional experience of sufferers, and providing a valuable developmental perspective, did not identify the degree of emotional neglect or abuse that we now know is usually present in the development of the condition.

More recently, the role of trauma in the development of the condition has been extensively researched. For instance, psychodynamic thinking has included the realities of early trauma in the development of BPD (Masterson 1981). Sachsse (1995) described the effects of early traumata, such as deprivation, loss of a parent, or incest as destroying the individual's ego functioning. Depersonalization is described as a splitting of the physical experience during the abuse, derealization as a relegation of the traumatic experience into the realms of fantasy. Acting out, self-injurious behaviour is seen as a defence against the fearful recollections of the abuse. Research by Stalker (1995) based on attachment theory, found a relationship between BPD and unresolved attachments resulting from childhood sexual abuse. Similarly, research by Fonagy et al (1996) highlighted the link between BPD, and the experience of severe trauma and lack of resolution with respect to it. Patients also experienced unresolved feelings of loss. Brodsky et al (1997) identified a link between childhood abuse and adult impulsivity, which is highly

correlated with suicidal behaviour. Similarly, Vanderkolk (1994) found that profound trauma especially that which occurs early in the life cycle tends to result in a chronic inability to modulate emotions. These result in a range of behaviours, which may be self damaging or disruptive. These are best understood as attempts at self-soothing in an individual whose skills in this are minimal or non-existent.

Brodsky (1997) found that 60% of BPD patients reported a history of childhood physical and/or sexual abuse. Of these, 50% experienced symptoms of dissociation and 52% reported a history of self-mutilation. Dissociation was found to be the strongest predictor of self-injurious behaviour. Childhood sexual abuse has been found to correlate highly with a diagnosis of BPD. Silk et al (1995) found that a history of ongoing sexual abuse experienced in childhood was a strong predictor of BPD. Silk hypothesized that such ongoing abuse created an expectation of the world as an empty, malevolent place resulting in regressive and distancing behaviour.

Unsurprisingly, problematic interpersonal family relationships have also been identified in adult BPD sufferers. Hayashi (1995) found that BPD patients perceived both parents as less caring and more neglecting or hostile than patients without BPD. Similarly, James (1996) found families of BPD adolescents were more angry and irritable and had a higher rate of sibling pathology and abusive behaviours than matched psychiatric controls. Unsurprisingly, relationship difficulties, particularly oscillating attachments, were frequently observed. Allen (1996) observed that family interactions in such patients were often characterized by coexisting extremes of over involvement and under involvement. Negative family reactions to changed behaviour in patients were also likely to undermine progress, and these interpersonal patterns were identified as generating and perpetuating self-destructive behaviour.

Dubo et al (1997), researching the link between childhood experience and the self-destructive behaviour found in BPD, found that both parental sexual abuse and emotional neglect appeared to play a role in the development of this behaviour. He concluded that the aetiology of borderline

symptoms was likely to be multifactorial. Zanarini (1997) suggested a tripartite model of the development of BPD, a vulnerable hyperbolic temperament, a traumatic childhood, and a triggering event. This hypothesis thus assumes mutually influencing interacting causative factors. In practice, it should be borne in mind when attempting to diagnose the condition that as Dulz & Lanzoni (1996) suggest, intensive diagnostic investigation can be experienced on a psychodynamic level as a repetition of previous traumatic abuse.

Similarly, Linehan (1993) proposed a biosocial theory of the development of the disorder. She described BPD as a disorder of the emotion regulation system, resulting from biological irregularities, leading to emotional vulnerability, and a dysfunctional environment. Thus, an invalidating environment in childhood leads to emotional dysregulation, where the child is not taught how to identify or regulate emotional arousal. The child is thus unable to tolerate emotional distress, or to know when to trust its own emotional responses as valid interpretations of events.

Corwin (1996) postulates that BPD is associated with substantial parenting limitations, family discord, and family isolation from social supports, suggesting that the child who is without any support at all to act as a buffer from traumatic experience is likely to suffer from BPD. The disorder may thus be seen as developing in a context where there is a lack of reparative kinship or community relationships. Similarly, Paris (1996) noting that BPD pathology is most prevalent in North America and Europe suggests that social protective factors may suppress the development of BPD traits in developing countries. Miller, (1996) disputes this, suggesting that BPD exists under other names in different cultures. He gives a sense of powerlessness, marginality and a perceived sense of social failure as defining aspects of the condition and suggests that such individuals are to be found in all societies.

Psychoanalytic theory thus sought to explain the behaviours associated with BPD in terms of intrapsychic conflict. However, sufferers' experience has only been more fully understood in the context of an abusive, damaging environment. The research therefore suggests that BPD is likely

to be a result of a vulnerable child within an invalidating, usually abusive environment, where attachment to caregivers is fragmented and insecure and where these effects receive no moderating influence from the wider cultural context.

## **Treatment**

Higgit and Fonaghy (1992) have described how treatment based on psychoanalytic theory developed through Freudian analysis with the incorporation of concepts from object relations theory, chiefly through the ideas of Kernberg. An approach described as expressive, restructuring, and uncovering sought to bring about personality change through the resolution of intra-psychic structural conflicts, undoing deficits and unblocking arrested developmental processes. Other approaches based on models of developmental deficit differ slightly, but as Higgitt & Fonaghy observe, the shared aspects of these approaches are more remarkable than their differences.

Treatment was located in the transference where the oscillating patterns were traced back to their genetic origins and the patient was encouraged to progress to new experiences by developing more adaptive ways of coping with life. The patient was encouraged to take responsibility for his own life and much emphasis was placed on the therapeutic alliance. Any testing by the patient was met with reliability, steadiness and a real interest in and concern to help the patient. There was thus an identified need for the therapist to be fully emotionally present in therapy.

Chiefly, these approaches focus on the transference relationship, particularly its pre-genital aspects. Interpretation of primitive defences, therapist neutrality and limit setting are paramount. Regression within the transference is permitted, but not encouraged, and as Kernberg acknowledged, increased therapist activity is required, since these clients respond poorly to an unstructured therapeutic approach. Transference reactions are found to be volatile and dramatic (Kohut and Wolf, 1978). The effects of such intense transference reactions upon the therapist have been recognized by McHenry (1994). The complex ongoing mutual conscious and

unconscious interactions with such clients result in transference and counter-transference responses to their own and each other's issues. Therapists may struggle with such raw expressions of anger and find difficulty in setting the necessary boundaries (Bot 1997). When these reactions are not understood by the therapist, they cannot be addressed in therapy and will thus impede progress, especially since the client's relationship with the therapist has been shown to be of prime importance in treatment (Chabrol et al 1996). Therapists should thus be mindful of the effects of their absence on vacation (Stein et al 1996) which was shown to bring about an increase in acting out and somatizing behaviour in these clients.

Higgitt and Fonagy emphasise that the therapist must be able to contain and withstand the client's transference rage and hostility. The therapeutic aim is to acknowledge the existence of such feelings within the context of the patient's current life and relationships. It is therefore essential that any interpretations remain firmly rooted in the present, since reference to childhood events as causative factors in present behaviours are thought likely to undermine attempts to focus on existing pathological behaviour. However, the therapist should be aware that as Fonagy et al (1996) found, in the majority of BPD clients, there is a link to severe unresolved trauma accompanied by a lack of awareness of mental states. Thus, as Levine et al (1997) showed, these clients demonstrate significantly lower levels of emotional awareness; have an inhibited capacity to co-ordinate mixed emotion, lower accuracy at recognizing facial expressions of emotion and more intense responses to negative emotion than controls. Such responses may explain the finding that self-criticism is a primary factor in BPD depression and is often underestimated by practitioners (Southwick et al 1995). Such poor affect regulation has been shown (Herpertz et al 1997) to have a strong correlation to impulsive functioning with a marked reactivity to environmental events. There is thus a tendency to acting out and self-harming behaviours. Dulz (1997) drew a distinction between aggressive and self-harming behaviour. He related aggressive behaviour to physical abuse and self-harming behaviour to sexual abuse. Each requires a different therapeutic response; a holding function for self-harm and firm limits setting for aggressive behaviour. The functional place of self-injury in patient's

behaviour should not be overlooked. Kemperman et al (1997) found that self-injurious behaviour serves a mood regulatory function. Patients were found to have significant mood elevation and decreased dissociation following self-injury, with a peak in dissociative symptoms during self-injury.

Opinion differs on whether emphasis should be placed on the content of interpretation or on the therapeutic relationship itself. Classical analysts (Masterson 1981) advocate the interpretation of defensive distortions within the transference and the self-destructiveness inherent in the client's stance. Others from the self-psychology tradition (Adler 1984) emphasize the importance of experiential factors, particularly in the early stages of treatment and the focus is on the holding environment since the client is unlikely to be able to comprehend interpretations until s/he has the intrapsychic structures required available. The therapist must create an emotionally secure holding environment, thus encouraging a sufficient decrease in client anxiety to allow the necessary cognitive work to take place. In concrete terms, the need for a secure holding environment may be met by brief periods of hospitalization (Miller 1995), which provides optimum levels of secure holding to allow clients to express and experience affect in safety.

It is also recognized (Grotstein et al 1987) that constancy and reliability are of paramount importance in work with these clients. Any disappointment or frustration assumes gigantic proportions in the minds of these individuals. He posits that the stability provided by the therapist is often paradoxically, undermined by the client him/herself, by arriving late, failing to attend, self-injurious behaviour, or other similar attempts to test the safety of the therapeutic holding environment. Gunderson (1996) suggested that intolerance of aloneness is a core deficit in the condition, demonstrated by clinging, attention seeking or detached forms of attachment. Therapist awareness, sensitivity and reliable handling of these issues are of prime importance.

Some workers (Miller 1995) recommend a specific contract for therapeutic work, defining the limits as to what may be acceptable and tolerable in terms of client behaviour. The therapist would clearly state the responses to any behaviour threatening the client's life or treatment, from



confrontation or interpretation to terminating treatment. An important part of this approach would be to constantly draw the client's attention to the adverse consequences of self-destructive behaviours.

Viewed within the context of the damaging childhood experiences generating BPD, emotional instability and destructive behaviours can now be seen as a response to highly traumatic life events. The psychoanalytic formulations of the intra-psychic structures present in BPD needed to move beyond the concepts of unconscious conflict and defences: useful ideas were drawn from self psychology and attachment theory, which recognized the symbiotic relationship between infant and caregiver. Increasingly, therapists have acknowledged the need to emphasize the role of trauma and deprivation in the BPD client's life.

Further, few of the psychoanalytic writers have specifically addressed the ongoing problems of managing the acting out and self damaging behaviour usual with these clients. Also, the usual methods of working within the transference, encouraging regression and challenging defences is counterproductive with these clients, whose ego states are not sufficiently intact to cope with these methods and who have been shown to react with worsening levels of antisocial behaviour (Clarkin et al 1992). Further, the need for a structured therapeutic frame, contracted at the beginning of therapy, along with high therapist understanding and involvement were also identified.

Holmes (1995) sought to address these issues in his model of supportive analytic therapy. This acknowledges the psychodynamic aspects of both the development of the condition as well as the dynamic aspects of the therapeutic relationship, such as transference and counter-transference. However, this understanding is expressed in a pragmatic and structured approach to client behaviour and experience, with an emphasis on enabling clients to cope and adapt in their environment.

Holmes acknowledges that inexperienced dynamic therapists may become 'engulfed in a regressive transference' (p824) whilst the more experienced may consider the solution is to see the client five days a week. Supportive psychotherapy steers a course between an over intensive and possibly abusive therapy leading to a regressive overdependent transference relationship, or an approach which focuses only on management of the condition. Holmes recommends comparatively short half-hour sessions, on a monthly basis: this usually avoids the need for holiday breaks which are often experienced as disruptive in the therapy. Clients may be seen more frequently in times of crisis, for a limited period. The therapist needs to manage the spacing of the sessions so that the therapeutic relationship remains alive but does not arouse unmanageable feelings in the client. The therapist must be 'caring, consistent, reliable, professional and positive' (p 825), so that the client feels that the illness is 'held by the therapist in and between sessions'. Unlike classic dynamic therapy, the client's defences are shored up rather than challenged (Bloch 1987). Similarly, the therapist allows a strong positive transference, which will be interspersed with outbursts of rage, both of which should be accepted rather than challenged (Kohut 1971). Research (Najavits & Gunderson 1995, Sabo et al 1995) has demonstrated that such approaches show an improvement in self-damaging behaviour over a three to five year period.

These modifications to the psychodynamic approach, whilst useful, are lengthy and still did not offer therapists a specific method for dealing with the various disruptive and self-damaging behaviours of BPD clients. Ryle (1997) addressed this issue in his Cognitive Analytic Therapy model for BPD. He emphasized the role of trauma and deprivation in the development of BPD rather than emphasizing the classic psychoanalytic focus on issues of unconscious conflict and defence. In this, he replaced the classical psychodynamic model of intra-psychic conflict and emphasised the role of dissociative states, which act as defensive attempts to cope with early childhood trauma. Based on attachment theory and self-psychology, Ryle's theory posits that dissociation accounts for abrupt switching between self states in BPD sufferers which is experienced by others as emotional instability. CAT combines cognitive and analytic therapies to

mobilize the client's capacity for self reflection and control. Client and therapist aim to identify behavioural and phenomenological links to the client's past and current relationships, with the aim of helping the client to learn to self-monitor his/her own behaviour. Importantly, this includes identifying their own self-states and how they affect others around them. The main psychological challenges posed by sufferers of the condition are thought to be; the tendency to destroy what they need most, the use of anger to defend or conceal their vulnerability and the persistence of dissociation. Research into the effectiveness of CAT by Ryle and Golynikina (2000) has shown some encouraging results, although further research is needed owing to the limitations of the study. Further, their outcome data focused only on the behavioural aspects of BPD, not on the associated depression which is experienced by most sufferers and their BDI scores remained elevated throughout the study.

Similarly, the therapeutic advantages of addressing the troubled behaviour rather than the client's intrapsychic conflicts have been addressed by Marsha Linehan (1993) in her Dialectical Behaviour Therapy. Based in the cognitive-behavioural tradition this is a biosocial theory that acknowledges the psychodynamic contributions to the understanding of the condition. BPD is viewed as a dysfunction of the emotional regulation system that is a result of biological irregularities and a dysfunctional environment; that is a vulnerable child within an invalidating environment. This damaging environment results in emotional dysregulation. The child is taught neither how to tolerate emotional distress nor how to trust his /her own emotional responses. As adults, these clients therefore invalidate their own emotional experience and look to others for accurate reflections of external reality. Clients tend also to oversimplify the ease of solving life's problems and thus set unrealistic goals. They are unable to use reward rather than punishment for achieving small steps to their goals and experience profound self hate at their failure to achieve their objectives. This shame reaction is seen as a characteristic response to uncontrollable negative emotions within a social environment that shames expressions of emotional vulnerability.

This is a psychosocial treatment, which aims to reduce self-injurious behaviour as its first goal. The focus then moves to behaviour that interferes with the treatment process, followed by the targeting of behaviour that interferes with the client's quality of life. A dialectical approach underpins the behavioural orientation in that the therapist aims to allow the client to develop a synthesis between their problematic extremes of experience. There is thus dialectic of both acceptance and change in therapy and this is reflected in the client's finding a middle way within their extremes of emotion and behaviour, to counter the rigid thinking characterized by these clients.

DBT includes special techniques of acceptance and validation to counter the self-criticism experienced by BPD sufferers. There is also a programme of problem solving skills to teach more adaptive ways of coping. These focus on mindfulness skills, in which patients are taught to focus on their own experience, interpersonal effectiveness, such as assertiveness, emotional regulation, such as anger management, and distress tolerance. These skills, taught in groups running in parallel to the individual therapy sessions, adopt a cognitive behavioural approach. Much emphasis is placed on the quality of the therapeutic relationship. Linehan stresses the need for genuineness and the requirement for the therapist to 'be herself' (p389). The sensitivity of such clients to therapists' responses in session is described by Linehan as 'like having a supervisor in the room' (p ix). There is thus an acknowledged need for the therapist to demonstrate acceptance and congruence, as well as appropriate self-disclosure, all of which are drawn from the humanistic tradition (Rogers 1951). Within therapy, the core strategies are validation of the client's experience and problem solving. The therapy is behavioural in the sense that an overt connection is made between behaviour and reinforcement, but the client's experience is validated in the understanding that behaviour may not be carried out purely to receive reinforcement. Behavioural analysis is thus used as a method of responding to maladaptive behaviour in a way that shows concern but without reinforcing the behaviour.

Indeed, follow up studies (Linehan et al 1993) have shown that the importance of the dialectical approach is an important contributor to the cognitive behavioural method and social skills training in this treatment. Therapists who maintained a dialectical stance and were seen as both controlling and autonomy fostering were found to correlate with reduced parasuicidal behaviour in their BPD clients. This therapy, whilst showing good results with comparatively short term treatment in the reduction of self injurious behaviour, has not shown such favourable results on non-behavioural symptoms such as depression, feelings of hopelessness and suicidal ideation which may indicate that longer term treatment is required. It is interesting to note that CBT, which has been demonstrated as an effective treatment for depression, seems to be ineffective when used for this purpose with BPD sufferers. This raises a number of questions about the nature and function of the depression involved in BPD, which may be different from that suffered by patients without the disorder. Further research into this topic may help to identify more suitable therapeutic approaches.

The value of integrated approaches in the treatment of BPD has also been demonstrated (Albeniz & Holmes 1996). Both psychodynamic and cognitive conceptions of containment have been shown as relevant in the treatment of BPD. Similarly, Young (1990) argues for a cognitive-behavioural schema based approach, taking account of transference, which acknowledges links to psychoanalysis. Similarities may also be noted between the holding environment advocated by psychodynamic therapists and the containment provided by the therapist's dialectic stance in DBT. Also, as Keonigsberg (1995) recognizes, Zanarini and Frankenberg's (1994) concept of emotional hypochondriasis as a core borderline defence mechanism with a requirement for the therapist to validate the client's pain has much in common with Linehan's therapeutic stance. Conversely, Perris (1994), in advocating a cognitive behavioural approach which focuses on unconscious schemata which act as templates to clients' relationships, approaches a position akin to the psychoanalytic object relations theorists. Similarly, Teasdale (2000) recognizes the need to move beyond a cognitive approach with these clients and suggests that 'mindfulness techniques' such as meditation are also needed to help clients distance themselves from their emotional pain.

The literature suggests that when working with BPD sufferers, the self-injurious behaviour must first be addressed before moving to any work at a deeper level. This behavioural work must include elements not usually identified with behavioural therapy, including a dialectical stance by the therapist. This stance has its roots in the psychoanalytic theories of the need for containment. Such an approach is informed by the thinking of psychoanalytic therapists who have described the inner conflicts and deficits exhibited by BPD sufferers. Rather than focusing on resolving these at the intrapsychic level, current thinking in DBT, psychodynamic therapy and CAT acknowledges the necessity to provide a therapeutic frame of containment. Both acknowledge the need to work within the limits of the client's poor ego functioning to deal with the realities of the self-damaging behaviours and problematic interpersonal relationships and both emphasise the importance of 'mindfulness' or self-reflection in self-regulation. DBT and CAT have provided a structured, prescriptive approach to BPD that demonstrate positive results in reducing behavioural symptoms such as self-harming. However, the research indicates that further progress needs to be made in relieving the non-behavioural aspects of the condition. It is possible that the therapies which have as their aim the gaining of insight and the resolution of intra-psychic conflicts and the experiential therapies may prove productive at this later stage. Thus, once the client's behaviour has stabilized, and ego functioning has improved it may be possible to address the non-behavioural symptoms using a psychodynamic or experiential approach. Further research is indicated in this area.

## **Conclusion**

It is thus possible to note that BPD, which appears to reflect the extremes of the human emotional condition, requires the therapist to draw on a wide repertoire of therapeutic approaches. The condition is challenging to therapists both personally and professionally and no single therapeutic approach contains a full solution. Whilst the psychoanalytic therapists provided a developmental model which allowed some useful insights into the childhood experience and conflicts of sufferers, their theories did not fully explain the development of such

a distressing and disturbing condition. Later research, which indicated the presence of severe early childhood trauma in the lives of individuals who develop BPD has added a dimension to psychoanalytic concepts which provides a fuller understanding of the development of the condition. This does not, however explain why all abused children do not develop BPD and a biological predisposition may also be a relevant factor. This multifactorial description of the aetiology of the condition is of course difficult to prove incontrovertibly, but provides the most useful model to date.

As evidence for the aetiology of the condition draws from many sources, so, it seems does an effective treatment. The deep understanding of childhood experience and calm holding environment offered by the psychoanalytic therapists has not been fully effective in treatment, especially when trying to cope with injurious, self damaging behaviours. The cognitive behavioural approach suggested, for instance in Dialectic Behaviour Therapy has provided an answer to this, but it seems that in order for this to be fully effective, the therapist must have an excellent understanding of the condition, drawn from psychoanalytic insights together with an understanding of the multifactorial nature of causation.. Further, the cognitive behavioural approach, whilst reducing self-harm and acting out behaviour, has not successfully addressed the treatment of depression and hopelessness experienced by sufferers. It appears that therapists may need to draw on experiential or psychodynamic approaches when addressing these existential issues.

This paper has demonstrated the limits of psychological theory in demonstrating a clear aetiology for the development of BPD and has therefore also shown the difficulties of identifying any discrete therapeutic approach that is effective in treatment. The extremes of both intrapsychic and behavioural symptoms apparent in BPD have thus forced therapists to reflect beyond the confines of their discrete approaches to draw on the approaches and insights offered by a variety of therapeutic traditions.

# **Chapter 4**

## ***Case Study***

***The application of an integrated eclectic model***



# Appendix 1

## **Memo 1**

Eclectic practice is seen as ad hoc and inferior. Therapists describe themselves as 'integrative', based on a theoretical base (but no evidence of this), a process within therapy, process within the session and a sense of 'wholeness'. Adaptability is important, to the client, within the session and in the assessment. Approach is changed as necessary. Are these therapists integrative in terms of an 'accepted' definition? It seems that there is an evolving understanding of the term which may change over time.

## **Memo 2**

Rater 1 questions quotes re 'change in thinking', especially

*Is what people were already but they are just saying it now (5 p1 26)*

*It's all about emphasis (3 p1 33)*

She talks of 'ventriloquism' by participants. Does this mean that this should be viewed as part of the presentation by therapists of what they see to be the publicly acceptable face of their practice? Is this to be seen as part of the discourse of legitimizing their practice?

## **Memo 3**

Rater 2 in her feedback gets a sense of confusion about the terms eclectic and integrated. The evidence seems to show that there is no clear cut definition for these therapists. Evidence shows a development of their ideas through the course of the interview.

## **Memo 4**

Rater 1 questioned quotes on 'wholeness'. Texts seem to indicate both idea of 'wholeness' in therapy in that different approaches are linked within session

## **Memo 5**

Therapeutic relationship based on humanistic principles (with caveats re. client 'leading')  
Psychodynamic approach seen as not congruent by therapists. What does this tell us about integrated approach? Some aspects of psychodynamic approach are used, but therapist 'distance' and obscure interpretations are eschewed.

Disempowerment of client when therapist takes the expert position- this is at odds with the post-positivist/constructivist approach that the integrated therapist has to espouse (no one 'truth') These aspects of psychodynamic approach can't be adapted to 'fit' other approaches since the nature of the therapist/client relationship is fundamentally different. Nature of the therapeutic alliance has to be collaborative, based on mutual process of discovery for an integrated/eclectic approach to be viable.

#### **Memo 6**

Relationship between therapist taking non-expert position in terms of listening to the client and adapting their approach and 'knowing more' which is implicit both in their transcripts and within the idea of a profession founded on a knowledge base. Psychology based on scientific positivist principles, therefore how do therapists resolve the conflict between a constructivist 'all explanations are equal' approach with its resultant relativism & their professional approach as scientist within an expert knowledge base?

#### **Memo 7**

There is evidence in the texts that Therapists work on implicit assumption of professional expertise, as psychologists. This base is empirically proven. Many therapeutic approaches are not. Some evidence that empirically chosen symptom based approaches are used appropriately (e.g. for depression). Is lack of empirical research into integrated practice a problem for eclectic therapists?

#### **Memo 8**

All therapists take the position that there is no 'one' explanation in therapeutic terms. This position is incompatible with any therapy which has an articulated theoretical base- therefore training in one 'integrated' model would presumably not change their underlying philosophy and approach. These therapists would remain sceptical and questioning, seeing all models as constructions or alternative explanations and drawing on them at will.