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F. Diane Barth

Integrative Clinical Social Work Practice

A Contemporary Perspective

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To Joel and Simon, with love
and gratitude forever

Preface

In recent years integrative practices have become part of the political and professional landscapes. Not only in medicine and mental health, but also in business, politics, international diplomacy, education, and many other aspects of modern life (e.g., see Fawcett & Hurrell, 2000), the idea of integration, that is, of bringing together parts that may not appear to be connected in order to make a more complete and complex whole, has become part of contemporary thought. In my years as a clinical social worker and psychoanalyst, I have found that many—perhaps most—of my colleagues and students draw from a wide variety of practical and theoretical perspectives in their work. Yet for many clinicians the integrative process is an unformulated and often unacknowledged part of practice. In this book I hope to open up a discussion of this often silent, "unthought known" (Bollas, 1989) component of clinical process. I hope that the book will encourage clinicians to find words for their own unarticulated integrative theory. It has been my experience that there is an important, often unnoticed parallel between clinical work, human development, and clinical theory. Just as contemporary research has shown the importance of talking to another person about what one thinks and feels both as part of development and as a therapeutic tool (e.g., see Fonagy, Gyorgy, Gergely, Jurist, & Target, 2003; Goodman, 2013; Hersoug, Hogland, Monsen, & Havik, 2001; Schore, 2003; Siegel, 1996; Steele, 2008), talking about how, when and, why we bring in different techniques enhances a professional's practice and provides a framework for choosing interventions with each client.

I therefore hope that this book will function as the beginning of a conversation in which readers begin to find words with which to formulate their own thinking about human behavior and what leads to change. Of course, bringing together different ways of thinking also means finding ways of managing conflict. In this book we will look at and attempt to understand conflicting theories, with the understanding that conflicts cannot always be resolved, but that they can sometimes enhance an experience.

Since my own personal and professional values are woven into the fabric of this book, I should probably take a moment to share a little about my own integrative background. Having grown up in a politically active family during a time of great social unrest, I came to social work with strong interests in education and political action. An avid reader, I was fascinated by anything that gave me clues to, as my mother put it, "what made people tick." I chose to become a social worker because the field appeared to honor and weave together these disparate threads. However, my placement in my first year of social work school at the Traveler's Aid Society, an organization that offered financial assistance to travelers stranded in New York City, appeared to address none of the issues that interested me. Neither ATMs nor the Internet existed at the time, and long-distance phone calls were often out of the financial reach of many of the people who presented themselves at the agency's offices. It seemed to me that I would simply be babysitting wanderers stranded until their spouses or parents could wire money to get them on a train or bus back to their homes. Disappointed, I asked my advisor about the possibility of changing placements to somewhere that would be more likely to give me a chance to work psychodynamically with clients. Then as now this was a goal not generally encouraged in social work graduate schools, but my advisor assured me that at the Traveler's Aid Society I would learn more about psychodynamics than I would even at a psychoanalytic institute. Furthermore, she said, I would get a hands-on experience in what Freud called the psychopathology of everyday life.

She was right; the work was fascinating. Clients included paranoid schizophrenics who lived on the streets not because of poverty, but out of fear of being contaminated or damaged. For example, one of those early clients had uncashed checks hidden in her bags but refused to live in an apartment because she believed that people in the building would read her mind and send radio waves to control her thinking. In my dealings with political and war refugees, run-away teens, and a variety of families and individuals from an incredibly broad spectrum of socioeconomic situations, I learned much about the human condition. I also learned that clinical social workers have been bringing together various theories and practices for many years. The idea of an integrative practice, formulated on a theoretical and research base, is more recent. This book offers clinicians, teachers, supervisors, and clients an opportunity to consider the what, when, how, and why of an integrative practice. It is intended to help clinicians think about and evaluate reasons for choosing to utilize specific tools with some clients and not others; and it provides theoretical grounding and evidence for both making and implementing these decisions. Clinical examples throughout illustrate ways that this can be done.

Extremely important to integrative work is the ability to combine flexibility with clear boundaries. One physician I interviewed during the process of collecting material for *Integrative Clinical Social Work Practice* said that underlying any integrative medical practice is a willingness both to recognize when one approach is not working and also to try something else. It is helpful for a clinician to be comfortable with other options in order to respond to what a client needs (Winnicott, 1987) rather than what a specific approach dictates. I believe this is also one of the ideas

behind Kohut's (1971) ideas about offering clients "experience-near" explanations of their difficulties, rather than "experience-distant" interventions.

A note about confidentiality: all clinical material in this book is an amalgam of a number of different client/therapist dyads that were working on the issues being discussed. Identifying material has been disguised so that none of the clients or clinicians can be recognized. As I have noted elsewhere, like other authors (e.g., Spence, 1984; Williams & Schaefer, 2005) I have found this to be the best way of communicating important clinical concepts without breaching confidentiality. At the same time, I have sometimes used first names and others used last names because in our field, depending on agency policy and individual preferences, clinicians and clients may be called by either title. In each instance, I have used the same appellation for both client and clinician. Although I am aware that this is not always the case in actual practice, I have done so in the book because I believe it is an indication of respect and mutuality when a clinician and a client address one another in the same way—and can be experienced as a subtle sign of disrespect and inequality when they do not.

Each chapter in this book offers readers a way of thinking about specific aspects of clinical work while maintaining flexibility, theoretical clarity and clear-cut limits. Chapter 1, Integration or Eclecticism: Rationale for an Integrative Theory, explores some of the basic ideas behind developing an integrative clinical practice—what it means and what it entails. It offers three basic organizing principles that anyone who is drawn to such a practice can begin to apply immediately: (1) a clinician's personal and professional values; (2) a client's direct and indirect communications; (3) ongoing consultation, training, and professional education. Integration as an ongoing and developing *process* is discussed, as is the importance of integrating professional training with personal values. This chapter also presents the idea of an interactive approach to the work, which allows a clinician to make use of a wide range of techniques in a way that is meaningful and individualized for each client.

In Chap. 2: Contemporary Psychodynamic Models, readers are introduced to psychodynamic theory as a tool for understanding and making meaning out of what lies behind a client's behavior and experience. To some extent, such meaning-making is about articulating and mirroring a client's personal story, or narrative. Here too, an integrative perspective provides flexibility of approach to exploring and understanding such meaning. Clarifying that a psychodynamic approach does not necessarily mean offering a client such insight, the chapter focuses on eliciting what lies behind some of the thoughts, feelings, behaviors, and symptoms that may not be immediately clear either to a person experiencing them or to an observer. Understanding unspoken, unarticulated, or unconscious meaning can help a therapist determine a client's capacity for insight and as a result can aid in deciding what will be the best therapeutic approach to take.

Chapter 3: Developmental Models, offers a view of developmental theory as an umbrella for both thinking about a client's dynamics and also for thinking about the stages through which a clinical encounter often goes. Erikson's (1980) life stages are adapted to contemporary thinking and used as a model for one way that developmental thinking can be utilized in an integrative approach. In applying Erikson's

epigenetic unfolding of different abilities and skills, a clinician may draw from developmental theory to understand both historical and current issues for a client. The idea that developmental theory can both expand and also constrict a clinician's ability to listen to a client's specific needs and concerns is also discussed.

In Chap. 4: Cognitive and Behavioral Models, discuss the idea that many clinicians integrate cognitive behavioral techniques, either intentionally or unintentionally, into work that is done from other perspectives, including psychodynamic and psychoanalytic ones. Similarly, many cognitive behavioral practitioners integrate a variety of theories and techniques into their work. In this chapter we also begin to explore the idea that integrative work can be understood not only as a single clinician bringing in a number of different theories and practices in her work with a single client, but also the work of several clinicians with a single client, in an integrative team. Traditionally, it has frequently been frowned upon when clients saw more than one psychotherapist at a time. Today clinicians are not only accepting, but even encouraging clients to work with other professionals who can offer them more tools for managing their symptoms. For example, a growing number of clients work with both a cognitive behavioral therapist and a psychodynamically oriented clinician at the same time.

Chapter 5: The Body–Mind Connection explores the complex interplay between body and mind, and their mutual interactive influence. Psychodynamic theories increasingly take the body into account Freud (Breuer and Freud, 1893–1895) paved the way for this view in his earliest discussions of the psychological and physiological aspects of hysteria. Conversely, many somatic therapies integrate psychodynamic, developmental, and even cognitive formulations into their premises. While recent explorations of body–mind dynamics have focused on trauma and neuropsychology, this chapter suggests that clinicians broaden the discussion to the interactive nature of body and mind in any therapeutic encounter because of the importance of integrating these aspects of any client's self into a more integrated, well-functioning unit.

Chapter 6: Making Assessments and Choosing Interventions looks at the ongoing nature of both assessments and choosing interventions. It begins with a discussion of the Mental Status Exam (MSE), which can be a useful integrative tool that asks for information about a variety of different aspects of a client or potential client's current and past psychological, social, cognitive, and developmental functioning. The importance of ongoing assessment is noted. Continuing to construct a detailed picture of a client's condition, symptoms, and strengths over the course of the work with any client can help a clinician choose interventions that make sense for that specific client at that specific point in time. Drawing from a variety of different perspectives can be particularly important in assessment. In this chapter we look at ways of dealing with some of the confusion that can also result from looking at a client from diverse and sometimes conflicting perspectives.

Chapter 7: An Integrative Approach to Therapeutic Relationships addresses the question of therapeutic relationships from different perspectives. Given the body of research that suggests that a relationship between therapist and client can be a key factor in therapeutic outcome, no matter what type of therapy a clinician is

practicing (e.g., Bacal and Herzog, 2003; Frank, 2004, 2005; Leichsenring, 2005; Parish & Eagle, 2003; Roth & Fonagy, 1996; Schore, 2003; Siegel, 1999; Wallerstein, 2000; Wampold & Brown, 2005), it is clear that clinicians need to pay close attention to the factors involved in such relationships. An integrative approach helps a clinician answer questions such as what sort of relationship leads to change and whether clients with different diagnoses need different kinds of relationships. Further, bringing together developmental and other theories, an integrative approach can help a clinician decide whether to talk about a relationship or allow it to be a background presence, an often important and sticky clinical question.

In Chapter 8: Small Steps and Manageable Goals, we explore the process of goal-setting and evaluation. One key to this process is breaking large, often overwhelming problems and goals into smaller, more manageable components. This activity is presented not only as a tool but as an important part of a therapeutic process and captures an essential aspect of integrative work. Helping clients take small steps toward their goals can address immediate symptoms and engage long-term change, whether using cognitive or behavioral tools, focusing on body–mind dynamics, or working psychodynamically. As part of this process, we clinicians also need to find ways to break our own goals into manageable segments. We want to help our clients feel better immediately even as we help them make changes that will point toward a happier and more productive life in the future. In this chapter we will discuss the way that an integrative position can help us find a place to start that journey.

Chapter 9: Building and Working with an Integrative Team, looks at the idea that teams, whether formally structured or barely linked, can provide support and amplify the effects of any therapeutic experience. Team members can provide different perspectives on dynamics and behaviors, support one another through difficult situations, and provide backup so that a client is never without the support of a known and trusted professional. Research that underscores the importance of such backup, especially with fragile or difficult clients who need extra support or tend to fragment or destabilize when their primary therapist is unavailable, is discussed. Difficulties that can arise as a result of a team approach are also considered. Problems managing conflict are often part of clients' struggles; engaging in and untangling problems that arise in both interpersonal and interdisciplinary aspects of a team can be part of any therapeutic process.

In the final chapter, Working Through and Working On, we take an extended look at two clinical moments to talk about the actual practice of integrative psychotherapy. Recognition of patterns and continuity of experience are discussed. In this chapter, readers have an opportunity to see how the different elements in the preceding chapters can be brought into a practice on a regular and smoothly integrated basis.

Ultimately, of course, the purpose of this book is to engage clinicians in a discussion of how different approaches work, and why they do or do not help clients at any given time. An integrative practice is, almost by definition, a work in process. Hopefully this book will contribute to that work.

New York, NY, USA F. Diane Barth

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myself I did not know, helped me accept qualities I would rather not know about, and have repeatedly shown me the importance and the beautiful complexity of the clinical process.

A note about clinical material: In order to protect confidentiality, all clinical examples in this book are composites of several different people and situations. Following the suggestion of Spence (1984), I have changed names, genders, ages, presenting problems, family makeup, and other identifying information about all clients and clinicians included in these composites. I have similarly disguised settings and professions. Thus, in the telling of the stories, I have distorted and reconfigured facts while keeping dynamics and what Spence calls narrative truth.

Contents

Chapter 1
Integration or Eclecticism: Rationale for an Integrative Theory

Keywords Integrative psychotherapy • Integrative social work • Research • Evidence • Third party requirements • Third party payment • Evidence-based approaches • Personal values • Professional values • Direct communications • Indirect communications • Consultation • Training • Professional education • Therapeutic process • Clients • Clinical social work practice • Psychodynamic • Cognitive • Behavioral • Mindfulness • Body-mind

Once condemned for muddying the waters of clinical theory, integrative thinking is now an important part of the contemporary mental health field. This climate change (Connors, 2011) is partly due to research showing that an integrative approach can be significantly more effective than a single method (e.g. Boulanger, 2011; Busch & Sandberg, 2007; Monti & Beitman, 2009; NIH, 2008; Raja, 2012; Zerbe, 2008). It is also a perfect response to third party requirements and evidence-based approaches. Even more significantly, however, today clients are far better educated about therapy than ever before. Many seek out a clinician who specializes in specific methods, and very few are willing or able to come for multiple sessions a week. Even fewer tolerate a clinician's silence for an extended period of time. Clients quite reasonably want to see results, and to some extent, clinical theory has shifted in order to meet this expectation.

Given these changes as well as the extremely complex world in which clients and clinicians live today, an integrative approach can enhance any clinician's work (e.g. see Fawcett, 1997; Gitterman & Germain, 2008). Perhaps one of the most striking examples in my own experience has been that whereas in the past some psychopharmacologists with whom my clients worked indicated that medication, and not therapy, was the major change factor in psychological issues, today psychiatrists often offer behavioral and body-mind strategies in addition to—and sometimes instead of—medication (see also Fawcett, 1997). Still, with more than 400 different

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psychotherapies in practice today (Roth & Fonagy, 1996), most of which now weave in ideas from a wide range of other fields, including biology, genetics, neuroscience, medicine, law, religion, philosophy and history, clinicians often find it difficult to decide what to integrate, when and how. Demands from insurance companies make the process even more complicated. Yet not only do many clinicians spontaneously assimilate a variety of ideas and techniques into their practice, sometimes without realizing or articulating the integration, but, also, as we will see, growing amounts of evidence suggest that an integrative approach may well be the most beneficial to clients. The time has come for us to find ways to talk openly about the integrative process so that we can make use of the wide range of available interventions in an organized, efficient and meaningful manner.

One lesson that has stayed with me from my days at the Traveler's Aid Society is that concrete services and psychodynamic thinking are not antithetical, but that these two approaches to the human experience are deeply and inextricably linked. They simultaneously inform, enhance and explain one another. In social work agencies, psychiatric hospitals and during psychoanalytic training, and in three decades of teaching and supervising, I have seen many clinicians bring integrative practice into their work on a daily basis, almost unconsciously. Consciously, we imagine the voices of teachers and professional "ancestors" telling us not to mix and match: that to offer a mindfulness practice to a psychoanalysand or to be curious about transference with a client who has come for CBT may interfere with and even damage the work. Yet I would suggest that almost any therapeutic offering, whether a psychoanalytic interpretation, a cognitive behavioral exercise, a mindfulness technique, a self-soothing strategy, a prescription for medication or anything else drawn from the deep basket of contemporary psychotherapeutic possibilities, is in and of itself an integration (see Strohle, 2009). Many times we are influenced by ideas that we do not even think of as aspects of different theories. For example, although mindfulness practice may have originated in Buddhist tradition, it has been integrated into dialectical behavioral, cognitive behavioral, psychodynamic and movement therapies (for other examples see Bromberg, 2001; Ekblad, Chapman, & Lynch, 2011; Epstein, 2004; Frank, 1999; Linehan, 1993; and Segal, Williams, & Teasdale, 2012).

Today, with the emphasis on evidence-based and recovery models of treatment in all mental health fields, both in agencies and from insurance companies, it is more important than ever to be able to think in a clear, theoretically informed way about integration, and to have a framework from within which to practice it. In this book, I offer several possible interventions, along with explanations for their application at specific times and with specific clients. I also provide a framework from which clinicians can formulate a choice of interventions within the context of both a theoretical perspective and their own professional values. As often as possible, I will draw from research showing the efficacy of particular interventions with particular symptoms. However, although research can be useful, I also encourage readers, as I encourage my students and supervisees, to read any scientific study carefully.

Statistics can often lead to more than one conclusion, and it is important to understand how any study and any technique does and does not apply to each specific client (for further discussion, see Fonagy, 2002; Leichsenring, 2005; Stern, 2013; Wachtel, 2010; Wallerstein & Sampson, 1971). Experience has shown me that we must be ready to explore various possibilities with every individual with whom we work. Of course, this does not mean practicing techniques for which we are not trained. To do so is not only a violation of The Clinical Social Work Code of Ethics, but is also ethically and pragmatically wrong. With that in mind, let us now turn our attention to some of the practicalities of developing an integrative practice in clinical social work.

Developing an Integrative Practice

In my own work, I have found it productive to think in terms of two organizing principles: one based on Sullivan's (1953) ideas about "*detailed inquiry*" and the other based on the concept of process. Both of these principles help clients live with confusion and begin to explore their experience from the inside. Let us turn first to the detailed inquiry. This is the phrase Sullivan used to describe his belief that the core of an analysand's psychodynamics can be found in the small details of experience. Kanter (2013) suggests that Sullivan's ideas are closely linked to social work assessment, in which a clinician gathers material about a variety of aspects of a client's life. Hirsch (2002) sees the concept as one of the pivotal ways that contemporary psychoanalysis differs from traditional Freudian analysis. I have borrowed from Sullivan's idea to help clients pay close attention not only to the details of their history and personal circumstances, but also to the minutae of daily life, which most of us tend to ignore or write off as unimportant. Not only does a detailed inquiry help clients begin to formulate unarticulated or previously unrecognized or dissociated material, as described by Bromberg (2001) or what Bollas (1989) calls the "unthought known." It also provides an integrative umbrella for the work itself, bringing together an empathic attitude and a sense of professional curiosity. Clients often feel both secure and comforted by the experience that a therapist is trying to understand them.

Process, of course, is the idea that experience, development and therapy unfold over time. As we will discuss in the following chapters, the idea of both psychotherapy and change as process is often unfamiliar to clients today. Expectations, often underscored by both external demands (such as those from insurance companies) and internal needs are for quick change. An integrative approach helps clients find relief from painful symptoms while also recognizing that longterm solutions to difficulties can take time.

According to Roth and Fonagy (1996) many of the 400 different contemporary psychotherapies share common features and few clinicians practice any in pure

form. Although merging theories and techniques has been criticized for lacking consistency and conceptual clarity (see Boulanger, 2011) an integrative method can actually be a carefully organized, cohesive and thoughtfully applied synthesis of ideas and techniques (Boulanger, 2011; Connors, 2006, 2011; Fawcett, 1997; Frank, 1999; Wachtel, 1997). Developing such a practice can be daunting, particularly early in one's clinical career. However, it is possible to do so even from the beginning. In this book, I will discuss three basic organizing principles that anyone who is drawn to an integrative practice can begin to apply immediately: (1) a clinician's personal and professional values; (2) a client's direct and indirect communications; (3) ongoing consultation, training and professional education. These are, obviously, broad categories, but they are important components of every clinical approach. Each of the theories discussed in this book encompasses specific and distinct aspects of these issues. As we articulate our professional and personal understanding of each client's needs, we are better equipped to hear what clients communicate about these needs and what will be most useful to each individual. We can also use this understanding to delineate treatment plans for third party payers, a crucial skill in today's world.

Personal Values

It may seem surprising to begin a professional discussion by suggesting that one pay close attention to the personal values which made the field interesting in the first place. However, according to a number of authors (e.g. Smith, unpublished; Stern, 2013; Wallerstein, 2000) clinicians base most professional decisions on personal, often implicit or unarticulated, beliefs. One way to begin to integrate the professional with the personal is to start to articulate beliefs and values. Theory, research and experience gradually come together as we identify and think about personal guiding principles in a professional context.

How does one develop a solidly based synthesis in clinical practice? Integration can be the result of a conscious decision to blend specific techniques, an intuitive response to a client's circumstances and needs at a given time, and/or an attempt to manage external requirements such as agency or government guidelines. A combination of a growing population of clients and increasingly limited resources often leaves clinicians little time to consider more than the most pressing needs that can be legitimately met under the umbrella of specific agency policies. The idea of theory building seems a luxury. Yet although they may not have ever put it into words, most clinicians begin their professional lives with an already existing, albeit often unformulated theory about what motivates human behavior and what leads to change. Researchers have found evidence that talking about what one thinks and feels to another person can actually change the brain and alter feelings and behavior (Busch & Sandberg, 2007; Damasio, 1999; Schore, 2003; Siegel, 1999). Similarly, when a clinician at almost any stage of professional development tries to put into words thoughts that went along with any intervention or choice of technique, this is

a step toward clarifying the theory behind that person's practice. In many cases, such choices are based on an unrecognized integrative theory.

Developing one's own integrative theory is a *process* which makes space for both flexibility and firm limits, finding a theoretical grounding (see Bromberg, 2001; Mitchell, 1993; Renik, 2006) while also allowing room to move away from a given platform when necessary or useful. A clinician developing a clinical practice must, therefore, be able to manage contradiction and embrace conflict. I have found over the years that that change occurs best in a climate of understanding, acceptance and curiosity. I have become convinced that no particular approach has a monopoly on these ingredients.

Before describing an example of how this can work, I would like to explain my use of both clinical material in this book. Because confidentiality is paramount when writing and discussing clients, I have chosen to illustrate points by creating examples from components of many different cases described by a wide range of therapists not only during my research for this book, but also throughout my years in practice. Thus no case is based on a single person, family, clinician or agency. All identifying information has been changed to further protect both clients and therapists. Since in our field there are differing practices about the use of first and last names, I have attempted to illustrate this in the examples throughout the book, but because of my own commitment to mutuality and respect, in most instances I have maintained the same format for both client and clinician. That is to say that even though this might not be common practice in some settings, I have usually called all participants (except young children) by either their first name or by their last, rather than the unequal practice of addressing a professional by last name and a client by first.

Let us turn now to an example in which a clinician attempts, with his supervisor, to put his own thoughts and reactions into words in order to help a client begin to think and talk about herself. Like many of the examples in this book, this one does not take place in a psychodynamically-oriented setting, but the process of trying to understand is integrated into and informs the concrete actions taken by the worker. Mr. Andrews was a social worker in a medical facility. When Ms. Robinson, whose seriously ill child was a patient at the hospital, asked for transportation for her own mother and sister to visit her son, he had to make a quick assessment of both the legitimacy of the request and the best response to it. "I could provide the transportation vouchers," he told his supervisor, "but we have had problems with this client from the moment she brought her child into the hospital." Mr. Andrews wondered whether she would even use the vouchers appropriately, but he also thought that there might be a good therapeutic reason to act in good faith to help with her family's transportation, no matter what she actually did with the vouchers. He thought Ms. Robinson might be more cooperative with the treatment team if she felt that she was getting something concrete for herself. Still, Mr. Andrews feared he might be allowing himself to be manipulated into colluding with her acting-out behavior.

When his supervisor asked him to explain his thinking about this situation, he said, "Underneath all that anger and acting out is a frightened, needy woman." He

added that on the one hand he thought the mother and sister might provide emotional support for Ms. Robinson in a difficult time. "Except that when they're here, they actually tend to argue and amp up her stress level," he said. Putting these thoughts together with his supervisor, who reflected them back to him, helped Mr. Andrews not only manage his negative reactions to Ms. Robinson, but also to think about what his reactions were telling him about what might be going on with her. Although this was not a setting for insight-oriented psychotherapy, Mr. Andrews's supervisor helped him mentalize (Fonagy, 2005; Fonagy, Gyorgy, Jurist, & Target, 2003; Bateman & Fonagy, 2004) his own unformulated experience, which then helped him formulate an approach to his client. He helped her begin to examine her own conflicting feelings and engaged her in problem-solving. At their next meeting Mr. Andrews asked Ms. Robinson to talk to him about how she felt about her family's being at the hospital and how she thought it affected her and her child to have them there. The ultimate goal was to help her think out and decide whether or not she wanted to provide her mother and sister with transportation assistance.

Ms. Robinson's first response when Mr. Andrews asked if they could speak about the vouchers was, "Oh here we go again. I work my butt off, but nobody wants to help me out." Mr. Andrews held up a hand and said, "You know, that's your automatic response to almost everything I ask you about. But you also know I've been giving you vouchers when you ask for them. I just want to ask you a question about how it's working for you." She seemed surprised at the question as well as at the fact that Mr. Andrews did not respond angrily to her attack. After a minute's thought, she said, "It's been going fine." Mr. Andrews asked if she felt that her mother and sister gave her the kind of support she had hoped to get from them. Again she hesitated briefly, then said that she thought that sometimes they made things harder for her. "They make me feel bad, like I'm not doing everything I should be doing for my baby," she said, tears welling in her eyes. Mr. Andrews nodded. "I had sort of gotten that feeling," he said. "So they don't really provide you with the support you're hoping they'll give you?" She shook her head. "But they're my family. And they're all I've got."

Mr. Andrews had previously asked Ms. Robinson about coming to a support group he ran for family members of children on the unit, but she had refused. Now he repeated that he understood that this was a trying time in her life and that her family was not giving her all the support she needed. He asked if her sister and her mother made it hard to come to the meetings. She nodded but added that she could not tell them not to come. He was silent for a moment and then asked if it would help her if he did not always provide transportation for them. "I don't mind taking the blame. If you like, I can tell you that you can't have the vouchers—maybe on days when you're here for the family group, say?" Ms. Robinson laughed. Mr. Andrews thought some of her laughter was from relief, although he did not ask her to explain it. "Okay," she said. "It's a deal."

When Mr. Andrews talked about his thoughts about Ms. Robinson to his supervisor, he made contact with his own mix of feelings about her request. When he said

what he understood to Ms. Robinson, even though he did not offer any insight-oriented comments about her predicament, his understanding helped him communicate something important to her. He empathized with her feelings while also offering help setting limits on one of the external triggers of some of Ms. Robinson's acting-out behavior. Not only did she respond with gratitude and agree to try the support group, but the next day, when she got angry at the doctor for something, she went back to Mr. Andrews for help. "You understand," she said to him. "I thought you could help me know the right thing to say to the lady in charge."

The Role of Theory

Theory is by definition a premise or a hypothesis, not a fact. Good theory is not static, but is an ongoing process. Research and the demand for evidence have become an important part of the theoretical world of psychotherapy, and both can be extremely helpful in professional practice. Yet even research is not finite, but is constantly unfolding, developing and contributing new data to existing stores of information. It is always interesting to me that colleagues, students and supervisees, including many clinicians I interviewed in the process of writing this book, often use statistics as a way of substantiating personal experience. I have seen professionals who have had good experiences as clients in therapy follow their therapists' style of practice and find research to validate their approach (see Wallerstein, 2000; Wampold & Brown, 2005). Similarly, I have seen clinicians turn to research that supports a very different approach from their own therapists.

Johnson (1999) notes that personal experiences can be both powerful instruments and significant problems in our clinical work. Personal knowledge of the difficulties a client is encountering and the long hard road to recovery can make a clinician both empathic and optimistic, which helps some clients through the more difficult parts of therapy. However, if the professional believes that the way he overcame a particular problem is the best way, he may struggle to provide appropriate assistance to a client who, for whatever reason, needs to follow a different path. The integrative approach described in this book suggests not only that diverse theoretical and technical interventions can be useful for the unfolding stages of therapy, as well as with varying groups of needs and issues, but also that two individuals with similar symptoms may not respond in the same way to a clinician's actions. A clinician working from within this framework can devise a therapeutic approach based on each client as a unique individual. Additionally, as I have mentioned, one of the central themes of the integrative process is that every clinician must think about and articulate her own thinking, beliefs and values in the context of her work. This interaction of clinician and client as entities is an important part of the therapeutic work, no matter what approach a clinician takes.

While no single practitioner can—or should—know about or use all of the approaches available to them today, just knowing that there are many approaches

underscores the idea that there is no one "right" way to practice. Any form of therapy will unfold based on a number of different factors. A client's temperament, history and current situation; a practitioner's experience, knowledge and personality; the setting in which the work takes place and even current events all influence any therapeutic process. Most clinicians take these elements into account without thinking about it and thereby, without conscious consideration, engage in an integrative approach. Many contemporary clinicians use the term "integrative" to describe their practice of choosing interventions based on what a client needs at a particular time, rather than on a specific theoretical perspective. Even Freud recognized the need for practical intervention before psychodynamic change could be considered. He famously fed the "Rat Man" against his own "austere technical precepts" (Gay, 2006, p. 267), and brought him into his personal circle in a way that would be frowned upon today. Yet clients are best served when pragmatism is integrated with theory. How does one decide when to gratify a client's concrete needs and when to ask a client to delay gratification in order to explore psychodynamics? A consciously integrative practice provides clinicians with a solid base from which to make such a decision.

The plethora of theories of psychotherapy can be overwhelming, making integration feel like an impossible task. As a way of organizing the ideas contained in these widely ranging approaches, I have broken down therapy types into four major categories: psychodynamic, developmental, structural and body-mind. Each of these categories contains a number of different concepts. Unfortunately, putting these complex concepts into categories without oversimplifying them is in itself difficult, if not impossible. For this reason it is important to remember that many of these techniques should only be practiced after a clinician has been trained in the methodology. However, a grasp on the ideas behind these approaches can be useful when a clinician is working with a client who, for example, also seeks help from other experts. An integrative team might offer clients medication in conjunction with supportive psychotherapy, family and individual work and a Dialectical Behavioral Therapy (DBT) group. A bio-psycho-social model offers a broad integrative perspective in which psychodynamic exploration might be integrated with medication and nutritional advice, requiring the client to have a full medical workup.

Therapeutic Models

The following is a brief description of some of the therapeutic models that will be discussed in this book. The overall lens through which all of these models will be viewed sees human behavior as complex and complicated—a function of a variety of influences, including genetic and biological, psychological, socio-cultural and family factors.

Psychodynamic Models: Relational, Intersubjective, Ego and Supportive psychologies

Psychodynamic models are based on the idea that change comes with understanding of some of the psychological forces that motivate actions. This understanding is called "insight" and is based on the idea that behavior and feelings in the present are responses to experiences from the past. Relational and intersubjective theories have emerged as contemporary ways of thinking about some of the ideas presented by Freud and his followers. Instead of viewing all behavior as motivated by an underlying sexual and/or aggressive drive, today's psychoanalysts believe that much of human behavior is motivated by the need for relatedness. Ego psychology, an early offshoot of classical Freudian theory, paved the way for supportive psychotherapy. Although many forms of therapy today have a supportive component, the goal of supportive therapy is to offer a safe setting in which individuals can develop more of a sense of their own abilities. Often there is not an exploratory or insight-oriented aspect of supportive therapy, which utilizes reassurance, advice and encouragement.

While psychodynamic theory is most often practiced as individual therapy, some of the premises can also be applied to group, family and marital work.

Developmental Models

Developmental psychology is interested in the ways that humans change over the course of their lives. The range of developmental issues considered include attachment; cognitive factors, such as problem solving and conceptual comprehension; motor skills; acquisition of language; morality; capacity for interpersonal interaction; sense of self; and identity formation. Some theories focus on infancy and childhood, while others concentrate on adolescence or different stages of adulthood. Perhaps more than any of the other categories in this discussion, developmental theories integrate biological, social and psychological factors, although some to a greater and others to a lesser degree.

Structural Models: Cognitive and Behavioral Theories and Related Techniques

With therapies that include Dialectical Behavioral Therapy (DBT), Acceptance and Commitment Therapy (ACT), Rational Emotive Therapy (RET), Assertiveness Training, Systematic Desensitization and related methods, CBT has been increasingly used in recent years for working with a variety of populations. Because it is both directive and time limited, many clients find it more attractive than some of the

longer-term, more abstract forms of therapy. According to one group of authors, (Dobson et al., 2008) three fundamental propositions are the basis of CBT: (1) cognitive activity affects behavior; (2) cognitive activity can be monitored and altered; and (3) desired behavior change can come from cognitive change. Although there are differences in technique and focus, CBT therapists and clients generally work together to identify irrational beliefs and illogical thinking patterns associated with symptoms and behaviors without delving into meanings or historical precursors. Dialectical Behavioral Therapy (DBT) and Acceptance and Commitment Therapy (ACT) both focus on helping patients observe and label their emotional reactions without attempting to analyze, judge or change them. ACT therapists suggest that acceptance of feelings leads to choices in behaviors. DBT clinicians attempt to help clients find a balance (or dialectic) between acceptance and change. Some approaches use primarily group therapy, while others practice with both groups and individuals.

The Body-Mind Connection

Through Freud's earliest work, psychodynamic theories have long recognized the interplay of body and mind, but they focused more on the mind's influence on the body than the other way around. (The controversial radical psychoanalyst Wilhelm Reich was an early exception to this generalization.) In recent decades, complex connections between body and mind have been recognized and become an increasingly significant focal point for therapy. Gordon, Staples, Blyta, Bytyqi, and Wilson (2008) note that the body and the mind are inextricably linked and constantly influencing one another through the brain and peripheral nervous system, the endocrine and immune systems and a variety of chemical interchanges. Body-mind therapies attempt to change problematic feelings and behaviors by altering interactions between body and mind. Growing bodies of research, as well as practical experience, indicate many psychological and physiological benefits of meditation, mindfulness training, yoga and other body-mind practices. A partial list of such practices from the National Center for Complementary and Alternative Medicine (NCCAM) includes behavioral, psychological, social, expressive and spiritual concepts such as meditation, prayer, yoga, biofeedback, tai chi, qigong, relaxation, guided imagery, hypnosis and art, music and dance therapies. Patient support groups and cognitive-behavioral therapy may also be used in conjunction with these practices. Many therapists include some of these ideas in their work, either consciously and purposefully or without realizing that they are integrating body-mind practices. This can be done directly, as when mindful breathing is brought into a psychodynamically oriented therapy or a client is encouraged to seek a movement therapist in conjunction with behavioral work, or indirectly, as when a therapist suggests that there might be a connection between an emotional and a physical state (Table 1.1).

Table 1.1 Therapeutic models and theories

Model	Main concepts	Focus of theory	Theorists	Practice applications
Psychodynamic	Change comes with an under-standing of some of the psychological forces that motivate actions	Insight and under-standing	S. Freud Winnicott A. Freud Bowlby Kohut Stolorow Mitchell Fonagy	Understanding and insight, thinking about and explaining personal motivation
Developmental	Human beings change and develop over the life cycle	How and when change occurs	A. Freud Erikson Piaget Mahler Bowlby Beebe and Lachmann M. and H. Steele Fonagy	Understanding problems of childhood and adolescence, understanding how problems of earlier development affect adult experience, understanding adult difficulties as part of adult development
Structural	Thoughts affect behavior and feelings	Behavior can change when thoughts are changed	Skinner Ellis Burns Linehan Chapman Hayes	Looking at thoughts that affect behavior and feelings, altering/accepting/ balancing those thoughts and feelings
Body-mind	The body and mind are constantly influencing one another	Intervene to improve both body health and awareness of body to improve emotional and mental health	Reich KabatZinn Thich Nhat-Hanh Linehan Hayes Chapman Somers-Anderson Knoblach Brown Brennan Kornfield	Enhance the mind's positive impact on the body and the body's impact on the mind to improve physical health, emotional well-being

Many contemporary clinicians have discarded the traditional "medical model" of psychotherapy, in which a client passively accepts treatment offered by professionals. (Even in modern medical practice, patients are encouraged to take a more active role in their own treatment than they were in the not-too-distant past.) Today clients are expected to actively participate in the therapeutic process, both by engaging in the work and expressing their feelings about it. Even therapies that do not view the relationship between clinician and client as a focal point recognize the importance of a working alliance between the two in order for the work to go forward.

Therapeutic Relationship and Working Alliance

I have found, perhaps not surprisingly given the research on the subject, that an important factor tying together many clinical theories is the relationship between clinician and client. As we will discuss in the chapter on assessment, part of any decision about what sort of therapy will be most effective is each individual's personality and needs. But recognizing the significance of the therapeutic relationship—broadly defined as the "collaborative and affective bond" that develops between a therapist and a client (Martin, Garske, & Davis, 2000)—is important to integrative thinking. In a detailed review of studies from 1936 to 2007 of treatment effectiveness, Wampold (2001) finds that the evidence points to the therapist as an extremely significant factor in the therapeutic outcome. When asked to explain why they improved, clients emphasize the relationship with their therapists rather than a particular type of psychotherapy or method of treatment. Carr (2011) suggests that different therapies include different ingredients to help clients change. Like Pine (2006), Carr notes that human beings are extremely complex, which is one reason there are many ways to help someone with emotional distress. He adds, however, that research shows one common theme: all techniques work best when a clinician is both genuinely interested in a client and is also able to form a solid therapeutic alliance with her (Carr, 2011). Yet every therapeutic relationship is complicated and may undergo changes over the course of therapy. A theoretical model can help a clinician navigate and make important choices about interventions and interactions. We will discuss this process more fully in later chapters, but for the moment, let us note here that a working alliance is part of a therapeutic relationship. Hersoug, Hogland, Monsen, and Havik (2001) have delineated four dimensions of a therapeutic working alliance:

1. A client's capacity to work purposefully in therapy
2. A client's affective bond to the therapist
3. A therapist's empathic understanding and involvement
4. Agreement between client and therapist on treatment goals and tasks (Hersoug et al., 2001, p. 207)

In a series of extensive interviews, Wallerstein (2000) found that what a client finds helpful is not always the same thing the clinician thought was helpful. Yet, like Carr, he suggests that a sense of a therapist's empathic understanding, professionalism, experience and knowledge is often important for a client to enter into a working alliance. However, in some forms of psychotherapy, recognizing and acknowledging negative feelings about a clinician are also an important part of the work. Psychoanalytic and psychodynamic theories focus on the relationship itself. Clients are encouraged to put into words not only positive feelings, but also anger, hostility, frustration and/or disappointment in a therapist. The idea is that these feelings may be rooted in early, unformulated and/or unresolved experiences from childhood, particularly in relationships with early authority and attachment figures, who are often a client's parents. A working alliance with genuinely positive affective ties allows client and therapist to examine childhood distortions and conflicts (Freud, 1914; Greenson, 1967).

In his review of a number of studies, Wampold (2001) states something that clinicians learn through experience:linking past with present is meaningful only when it has affective meaning in the here and now. What appears to be most important to the alliance in terms of efficacy of any treatment is a client's sense that his therapist's interventions are directed towards his specific, personal and experienced needs and affective states at a given time (Horvath and Greenberg, 1994). In other words, no one wants to feel that he is viewed as part of a theoretical equation. This finding fits well with Kohut's idea that the most important part of any therapeutic endeavor is the client's sense that the therapist is genuinely trying to understand his feelings (Kohut, 1984). Surprisingly, it can also affirm the opposite view, traditionally taken by many behavioral schools, that talking about the therapeutic relationship can interfere with and/or avoid the actual therapeutic work.

How can two opposing ideas be confirmed by the same research? An integrative perspective offers some insight into this apparent contradiction. What appears to be most important is that a client feels that her needs and concerns are being directly addressed by his therapist. Behavioral therapists may not view the therapeutic relationship as a central topic for discussion, but by addressing a client's immediate concerns, they promote a therapeutic alliance between themselves and their clients. For example, in a discussion of the use of Dialectical Behavioral Therapy (DBT) to treat a heroin addict with borderline personality disorder, Ekblad, Chapman, and Lynch (2010) speak of helping a client learn to work with the paradox of acceptance and change, using the illustration of a therapist saying "I understand why you want to use drugs—they reduce your shame and anger" (p. 15). The point of the understanding is to help the client accomplish the task of managing both his feelings and his behavior. On the other hand, Mitchell (1993), one of the founders of the relational theory of psychoanalysis, suggests that cognitive-behavioral and directive interventions are useful tools for looking at a client's characteristic patterns of relating to others. Understanding how a client engages in relationships is key, he believes, to change.

Managing Contradictions and Conflict

Numerous authors have discussed the importance of contradictions (e.g. Bromberg, 2001; Davies, 1998; Linehan, 1993; Mitchell, 1999; Pizer, 1998) both within any therapeutic process and in life itself. Much of Freud's theory is based on the psychodynamic impact of intrapsychic conflict (e.g. Freud, 1937), but many non-Freudian theories also often view symptoms and problematic behavior as the result of oppositional pulls—for instance, an addiction or an eating disorder may be at least in part the result of a conflict between a wish to feel better (self soothing) and a wish to harm the self. Poor impulse control, mood dysregulation and a lack of self-awareness can make it impossible for an individual to manage these internal conflicts in a healthy or productive way. A variety of therapeutic approaches offer tools for managing these contradictory wishes. On one end of the spectrum of techniques is the psychoanalytic practice of allowing clients to sit with unpleasant feelings in order to learn to both understand their origins and manage them. From this perspective, insight and change comes from allowing uncomfortable and/or unacceptable thoughts and emotions to emerge into conscious awareness. Behavioral approaches view insight as unnecessary for change to occur. Other approaches (e.g. a number of body-mind, developmental and contemporary relational theories) consider that insight comes after a client has learned to tolerate the feelings, and understanding what triggers them is not a prerequisite for change to occur.

Developing the capacity to manage and tolerate internal conflict, bringing with it the concomitant ability to live with strength and vulnerability in oneself and in others is an unspoken goal of many of these different approaches. To this point, I have found that one of the most difficult contradictions for clients and their therapists to manage is the issue of parent blaming. Many approaches to clinical work include developmental theories that look for parental failure, neglect and/or trauma as the cause of clients' difficulties in adulthood. Less often discussed is the role of the same parents in helping their offspring develop strengths, some of which probably make it possible for those individuals to enter therapy. Management of this contradiction is a subject that will be woven through many of the chapters of this book.

And like parents, clinicians must often make decisions about what intervention will be most appropriate and most useful for a given client at a given time without full knowledge of what is happening inside. The best parenting books, in my own experience, offer both theoretical and practical guidance while simultaneously making room for parents to formulate their own ideas about what may be going on with their child. Parents often comment that they have to relearn everything about child development with each subsequent baby, because no two youngsters develop the same way. Erikson once commented that in the process of bringing up children, parents get brought up as well. Children are excellent teachers, and parents learn how to parent by listening carefully to what children "say" both in words and in actions. The same can be said about the therapeutic process. Clients tell us, in behavior and in language, what they need from us.

Neuroscience

Meissner (2007b), responding to criticism of contemporary thinking about and research in neuropsychology, suggests that the reason for learning about neuroscience is not because it necessarily scientifically informs clinical technique, but because it provides yet another way of talking and thinking about what we do in our work with our clients. I would suggest that the same statement could be made about every theory discussed in this book, as well as many I was not able to include. As I address ways of assessing when, why and how to bring in different tools with different clients, I encourage readers to think in terms of these ideas not as a rigid set of guidelines to follow with each type of disorder, but as models of how one can make clinical decisions using an integrative approach. My goal is for readers to learn a process rather than a specific technique.

In numerous interviews with clinicians in a wide variety of settings in cities, towns and communities across the United States, I found this to be one of the most compelling reasons for this book. When clinicians in agencies, clinics, schools, hospitals and other organizations described the specific structure and treatment approach of their settings, an approach for which they often expressed enthusiasm, they still almost universally echoed a longing for, and often actively sought, training in other ways to understand and work with their clients. “It just seems too narrow to think in only one dimension,” said one clinician, whose words reflected those of almost everyone I interviewed.

Weaving concepts from one theory into another in practice is part of integrative work. Helping clinicians find ways of thinking and talking about this process is one of the central goals of this book. Choices do not have to be—and in fact should not be—random, but can come from important principles that should guide a clinicians’ selection of interventions. I am both a clinical social worker and a psychoanalyst. My shift away from traditional-format psychoanalysis reflects the development of my integrative thinking. If I were to come across a client who I felt would do better by lying on a couch and not looking at me, I might still consider using this technique, but most clients who come into my office tend to need help in the areas of affect regulation, self-knowledge and relationships. In these areas, I have found that face to face interactions allow a client to interact with a therapist as a whole person. Facial expressions and body language are part of the therapeutic process, not something to be filtered out.

What has remained with me from my analytic training is a deeply felt interest in meaning. What does a particular behavior represent for a client? Why this behavior? What thoughts and feelings emerge in relation to a particular event in a client’s current life—and what do those feelings and/or thoughts mean? The integrative approach I present in this book offers the interested clinician an opportunity to explore the idea of meaning from a number of different perspectives.

Jane’s experience with Alyssa is a good illustration of how this can work. Alyssa was in her early 30s when she began seeing Jane, a therapist, because she had trouble managing her anger at work. In the first meeting, Alyssa and Jane set up a plan

for 10 weeks of DBT. In almost every session, Alyssa told Jane that she could not do this "the way you want me to," and that Jane was "pushing too hard." At first Jane tried to understand what this meant to Alyssa and adjust the work in some way, but gradually she realized that their discussions about Alyssa's feeling of being pushed were, ironically, derailing the therapy. She also realized that this was probably a very good example of what was happening at work. Early in the next session, Jane said, "Before we go over the exercises for this week, I think we have to pay attention to what is happening here. I'm trying to do something that I think would be helpful for you. You don't like it, so you get angry at me, which gets me to stop pushing you." She went on to explain that this had a very specific meaning. "You have learned that getting angry helps you avoid things that you don't want to do." And she added that she thought this might parallel what was going on at work. Alyssa said it did, and wanted to talk more about the specifics of the problems at work, but Jane suggested that this was a good motivation for following through on the tasks that were part of the therapeutic process.

This is just one approach a clinician could take. A psychodynamically oriented psychotherapist might look for a different way of expressing and exploring what was happening in the work. While she would also be interested in the probable parallels between what was happening in the therapeutic relationship and Alyssa's difficulties at work, she would likely ask Alyssa to join her in looking for historical and unconscious dynamics that were being played out in this instance. From a developmental perspective, this behavior might be understood as a repetition based on particular unresolved developmental conflicts, while an ego-, self- or resilience-focused therapist might support Alyssa's ability to articulate that she felt "pushed" as an effort to adapt and/or to protect herself. A clinician might express both empathy for the feeling and a desire to understand it better, or he might communicate a desire to respond in a way that would work better for Alyssa. If Alyssa was unable to access any information about the feeling of being pushed or angry, mindfulness techniques might be employed. If she could not manage the emotions without missing appointments or becoming agitated or distraught, self-soothing practices might be taught and implemented.

Perhaps most important of all to an integrative approach is a growing body of data suggesting that many different psychotherapies are useful for a variety of disorders and needs, that even when medication is necessary, psychotherapy improves its effectiveness, and that the therapeutic alliance and the sense that a therapist both understands and is helping is highly predictive of positive outcome (Carr, 2011; Wampold, 2001). In the following chapters we will examine just how this information can be utilized by clinicians who want to integrate different ideas and approaches in their own practice.

Chapter 2
Contemporary Psychodynamic Models

Keywords Psychodynamic approach • Exploration • Meaning • Personal narrative • Clarifying meaning • Integrative practice • Different approaches • Unarticulated or unconscious meaning • Latent • Manifest • Behaviors • Symptoms • Flexibility • Short-term psychotherapy • Long-term psychotherapy • Insight • Cognitive approaches • Behavioral approaches • Prejudice • Blind spots • Integrative social work • Evidence • Research • Mindfulness • Body-mind • Clinical illustrations

Perhaps one of the hardest tasks facing a clinician developing an integrative practice is choosing when and how to incorporate different approaches into the work with each client. How does one develop an overarching approach to guide these choices and bring them together into an organized and complementary whole rather than a mix of a little of this and a little of that? As I noted in Chap. 1, from the beginning, most clinicians have a silent, often even unrecognized frame of reference for our professional work that reflects our personal principles and beliefs. This frame, or base, is often an important but unarticulated part of how we make clinical choices. Putting these principles into words is an important part of developing an organizing theory to guide an integrative practice.

Not surprisingly, theory that supports our personal values and beliefs tends to be the most appealing. As previously noted, these principles often influence our interventions more than we realize (e.g. see Schachter & Kächele, 2007), which is one of the reasons it is important for us to make use of every possible tool for developing self-awareness and managing inevitable prejudices and blind-spots. But it can also be extremely useful—although a bit harder—to think about and incorporate ideas that do not automatically fit into one's professional comfort zone. For example, many of us practice the type of therapy that our own therapists practiced, that is, the kind of clinical work we have experienced as clients. We also model our work on that of supervisors and teachers with whom we feel most comfortable. Yet some of our most powerful learning experiences may come from someone who operates outside of that frame. For many clinicians, a psychodynamic approach seems to be

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outside of our personal and professional belief system. Yet even for clinicians with no interest in long-term, exploratory or insight-oriented work, psychodynamic thinking can aid in the development of an integrative practice.

Psychoanalysis has long been criticized for being overly complicated, time and money-consuming, and useful only for a small number of people. The theory, or more accurately *group* of theories is complex and the language often overly complicated. Adding to the difficulty, today there are a number of different schools of psychoanalytic and psychodynamic thought with sometimes contradictory and often confusing approaches. Still, psychoanalysis today has little to do with the stereotypical image of a client lying on a couch and talking to a silent doctor four or five times a week. And psychodynamic theory has a great deal to offer to an integrative practice, even when a clinician's primary approach is not psychodynamic. Furthermore, a growing body of evidence (e.g. Leichsenring, 2005; Leichsenring & Rabung, 2008; Mishna, Van Wert, & Asakura, 2013; Roth & Fonagy, 1996; Schachter & Kächele, 2007; Shedler, 2010) points to the efficacy of psychodynamic work, on its own and in conjunction with other techniques. Because the term "psychodynamic" has different meanings for different clinicians, let us take a moment to define the term. Then we will focus on two concepts from psychodynamic thinking that can help organize an integrative practice: (1) the idea that behaviors, thoughts, symptoms and even feelings can have unconscious or unrecognized meaning and (2) the significance of the therapeutic relationship. These ideas can be useful tools for thinking about and organizing an integrative practice, even for a clinician whose primary interventions are non-psychodynamic in nature.

What Is Psychodynamic Thinking?

Psychoanalytic thinking today is a way of learning about oneself and of using that knowledge to both manage difficult feelings and experiences and enrich one's life. Numerous psychodynamic psychotherapies integrate psychoanalytic concepts, such as exploration of unrecognized reasons for overt behaviors and symptoms, with other approaches, including symptom-reduction and motivational interviewing. Like many of my analytically-oriented colleagues, I have found that psychodynamic exploration can be done very effectively in the context of less frequent sessions and with clients sitting facing their therapists rather than lying on a couch, two of the traditional techniques associated with psychoanalysis. In fact, Schachter and Kächele (2007) make a compelling argument for a revised version of psychoanalysis which integrates a wide range of contemporary techniques. The central goal of psychodynamic exploration, which runs across most psychoanalytic theories, might be said to be to bring together unintegrated aspects of the self in order to allow an individual free access to a wide variety of sometimes contradictory aspects of her internal world. Mitchell and Black (1995) tell us that psychoanalytic thought helps

clients bring together different realms of their experience, such as thoughts and feelings, past and present, words and images. Thus psychodynamic theories themselves can be said to have an integrative goal (see Holmes, 1998).

In this chapter, and throughout this book, when we use the term "psychodynamic," we will be referring to the idea that behaviors, symptoms, feelings and thoughts often have more than one meaning, and that some of those meanings may not be manifest, or apparent, at the present time. Exploring unrecognized or latent meanings with a client is only one possible use of this understanding. Simply recognizing the possibility that behaviors, symptoms and even feelings have more than one meaning can help a clinician think differently about what interventions make the most sense at a given time. Here is one example of how that works.

Mr. Nolan came to an outpatient clinic for help with a long-term depression that was interfering with his ability to do his work. His therapist, Ms. Bluen, soon discovered that Mr. Nolan was also an alcoholic whose wife was threatening to leave him if he did not get his drinking under control. Mr. Nolan expressed a commitment to changing his behavior and said that he had begun attending Alcoholics Anonymous already. However, he said, he did not think AA was the right program for him, since he did not feel that he needed to stop drinking altogether. Ms. Bluen, who was a psychodynamically-oriented psychotherapist who specialized in addictions and utilized an integrative approach to the work, considered several possible approaches to the problem. First, she recognized that the client might have a point. Not everyone has to give up alcohol completely in order to become sober. Second, she also knew that he might be wrong, but not yet ready to accept the reality that he did have to give up alcohol forever. And third, she thought that there were probably other reasons for resisting the program, including what she was beginning to see as his fear of feelings that might be emerging as he stops drinking and an intense hatred of feeling controlled by someone else.

Taking these possibilities into account, Ms. Bluen decided to do some educative work about the physiological and neurological impact of alcohol on the brain and the body. She explained that to interrupt what she described as a chemical chain reaction that occurred in his brain every time he drank, he needed to be abstinent for the moment. Utilizing a harm reduction approach, she told him that she thought there was a possibility that in the future the client could begin drinking again in a more manageable way. Motivational interviewing helped them focus on reasons that Mr. Nolan wanted to change his behavior—e.g. to improve his relationship with his wife and his capacity to do his job. Since research has linked addictive and impulsive behaviors with affect management difficulties (Christenson et al., 1994; McElroy et al., 1995, 1998) she also immediately began to address his difficulty tolerating feelings and introduced him to some behavioral, mindfulness and relaxation techniques for managing the unbearable emotions that triggered his drinking and others that would emerge during the process of becoming sober. She also explained that this was one of the benefits of attending AA daily. "They have lots of tools for helping you handle the impulse to drink and the feelings that will make you want to stop being sober." Besides hoping that these tools would help Mr. Nolan

get some control over his drinking, Ms. Bluen believed that they would help him stay in therapy long enough to build the internal (ego) strengths that would ultimately make it possible for him to become a "recovering" rather than an active alcoholic.

Although it is generally accepted that insight and exploration is not the treatment of choice for overcoming addictions, especially in the early stages of the work, a psychodynamic perspective can provide a useful frame for this integrative process. For example, as Ms. Bluen worked with Mr. Nolan, she began to hear information that led her to wonder if his complaints about AA were at least partly driven by an unconscious fear that he would fail at the task of abstaining altogether. In such cases, there can be a danger that a client will drop out of therapy in order to protect his self-esteem, so that a therapist might want to address the issue directly. However, clients like Mr. Nolan may not directly present his anxiety about failing, but instead may appear defiant, resistant, and/or as though he just does not care. Based on her knowledge of this population and in response to Mr. Nolan frequently blustery behavior, Ms. Bluen decided not to make a psychodynamic "interpretation" about his fear, but instead spoke in a general and educational way about the idea that drinking often is a way of protecting a person from feelings of embarrassment and shame about not succeeding at tasks that seem ridiculously simple to accomplish. She added that unfortunately the drinking itself also often made those tasks even more difficult, but she said that in her experience people often do fail in life, and that those who stuck with AA and learned the techniques she and he were working on learned to manage those ups and downs in a healthier manner.

In this way, Ms. Bluen made use of a psychodynamic frame to help her decide what aspects of Mr. Nolan' material she should address and how she might best address it. Psychodynamic understanding also led her to the realization that Mr. Nolan was conflicted about the work, even about whether or not he wanted to become sober. Ms. Bluen was able to remind herself and also explain to Mr. Nolan that recovery from an addiction is a process, not something that happens overnight. Even when he stopped drinking, there would be work to do. "You'll need new tools and muscles for coping with the world that you see around you without alcohol," she told him. "It's like working out at the gym. One workout does not give you strong muscles." For an integrative clinician, what is perhaps most helpful about psychodynamic theory is the idea that most behaviors, thoughts, feelings, symptoms and other aspects of experience have meaning (or multiple meanings) that is not immediately obvious, and that efforts to understand some of those underlying or hidden meanings can be key to almost any kind of therapeutic work.

Acknowledging the different aspects of a client's experience can enhance the development of trust in a clinician and at the same time diminish shame and feelings of isolation. Psychodynamic theorists have described this part of the work as providing a holding environment (Winnicott, 1965), selfobject functions (Kohut, 1977), or a "corrective selfobject experience" (Bacal & Herzog, 2003). In all of these situations, the experience of being with an attuned and actively engaged professional is in and of itself therapeutic.

Organizing Principles and Concepts

Psychodynamic thinking has undergone major changes over the years since Breuer and Freud (1957) first described the "talking cure." Numerous schools of thought have diverged from Freud's early conceptualization of conflict over psychosexual and aggressive impulses as the cause of psychological difficulties. Some authors have suggested that psychodynamic thinking today is by definition integrative (see Eagle, 1995; Frank, 1999; Parish & Eagle, 2003; Roth & Fonagy, 1996). Because the human psyche is tremendously complex, Pine (1990) suggests that different schools of thought help us to understand different aspects of experience, which he divides into four major categories: drives (and conflicts), ego, object and self. Today we will want to add other categories. Relational and intersubjectivity theories explore many new issues that emerge in relationships. Current research in attachment, neuroscience and affect regulation have also added to the mix.

Most psychodynamically oriented practitioners, however, would agree on certain basic tenets:

1. Provide a setting in which a client feels safe
2. Help clients recognize ways they avoid distressing emotions and learn to tolerate and become comfortable with a range of feelings
3. Be aware of the importance of relationships
4. Be aware of a client's sense of self and sense of agency
5. Pay attention to the therapeutic relationship
6. Look for patterns of behavior and expectations that have been repeated over time
7. Think about and explore unconscious meaning

Psychodynamic psychotherapy is, of course, "talk" therapy, which means that communicating and listening effectively is an important part of the work. Interestingly, research has shown that simply putting thoughts and feelings into words to another person can be therapeutic over time (see Busch & Sandberg, 2007; Schore, 2003; Siegel, 1999) and can actually make observable changes in brain functioning (Buchheim et al., 2012). Psychodynamic clinicians focus on three central aspects of affects: (1) recognizing, (2) expressing and (3) understanding their conscious and unconscious meanings. Yet for clients who are overwhelmed by feelings or unable to manage them, opening up these emotions prior to building the skills for managing them can be more destructive than helpful. Thus psychodynamically-oriented clinicians learn to listen for resistance and defenses, and to understand these aspects of the psyche as self-protective, not as antithetical to therapeutic progression. Understanding and supporting defenses against feelings can be an important part of psychodynamic thinking, even when it looks like these protective responses are interfering with therapeutic progress. (We will return to this topic when we discuss resistance in Chap. 9).

Self, self-organization, self-representation, and self-esteem are all considered carefully by psychodynamic theorists. Psychodynamic theories are generally focused not only on the inner self, but also on interpersonal relationships. Patterns of interaction and behavior that begin in the past are often repeated in the present

and affect current behavior, as well as the ways that new interactions and experiences are understood and responded to. Most psychodynamic psychotherapists attempt to help clients identify and recognize recurring themes and patterns in their lives. There is frequently discussion of both present difficulty and past experiences and attempts to understand what themes link the two.

In my own experience as well as the findings of numerous researchers (e.g. Couch, 1999; Farmer, 2009; Frank, 2005; Freedman, Hoffenberg, Vorus, & Frosch, 1999; Meissner, 2007b) any therapy relationship is important on a variety of different planes. It can, for example, provide what Kohut (1971) calls a corrective emotional experience in which old hurts are repaired and new development takes place. It can also offer clients what Winnicott (1965) calls a holding environment in which difficult or previously unarticulated material can be explored in relative safety. And it can be a setting in which interpersonal difficulties are repeated and worked through over time. By making the therapeutic relationship part of the subject of inquiry, a therapist communicates an interest in understanding feelings and thoughts as they emerge within the therapeutic space as well as outside it. In this way, a clinician provides a safe space for observing and experiencing previously unformulated, dissociated or unthought intrapsychic and interpersonal components of a client's life. I am not suggesting, however, that all of a client's dynamics must or even can be played out within a therapeutic relationship. In my experience, a good therapeutic partnership simply makes it possible for manifest and latent material to be examined, whether it emerges from within the transference or outside of it.

Transference and Countertransference

A therapist's own dynamics are also significant, for example at those times when countertransference may provide information about unconsciously received communications from a client. (However, as I will discuss further in later chapters, I do not agree with theorists who suggest that a clinician's response to a client *always* informs about unconscious or dissociated aspects of the client's experience.) Following the thinking of interpersonal theories, many contemporary practices see each therapeutic relationship as impacting clinical process (e.g. Hoffman, 1996). Mitchell (1988, 1993) suggests that each therapeutic dyad is different, thus questioning the traditional belief that a client has specific dynamics that will emerge with any therapist. From a relational perspective, both manifest and latent meaning continues to be explored through fantasies, dreams, and daydreams.

They are also found in what Sullivan (1953) has called a "detailed inquiry" into the particulars of a client's life (see Barth, 1998; Kanter, 2013). As I have already noted and will continue to discuss throughout this book, I believe that detailed inquiry into all aspects of a client's experience is key to an integrative approach. These details are like the colors and images in a painting, or the background data that gives a reader a rich sense of a character in a novel. The often unnoticed minutiae of daily life not only offer a therapist a special window into a client's reality, but

also provide a client an opportunity to put "unthought known" (Bollas, 1989) into words to another person. Numerous studies have suggested that the simple process of saying things to another person can lead to psychological change (e.g. Damasio, 1999; Rustin, 2013; Schore, 2003; Siegel, 1999). The small details, much more than the big ones, are what make each of us who we are.

Some psychodynamic theories still consider that particular material will emerge with any clinician. It has been my experience that certain themes appear consistently throughout an individual's life, but that any relationship, whether with a therapist or another person, will also have unique characteristics related not only to the chemistry of the two individuals involved, but also to the time, place and circumstances in which that relationship unfolds.

When to Use Psychodynamic Thinking and Psychodynamic Interventions

While there are no definitive answers about who responds best to psychodynamic interventions (see Roth & Fonagy, 1996; Milrod et al., 2007; Watzke et al., 2010), it is generally agreed that in order to benefit from psychodynamic exploration a client needs to have enough psychological strength to tolerate the feelings that will emerge during the exploratory process. Some research (see Roth & Fonagy, 1996; Shedler, 2010; Wampold, 2001) indicates that psychodynamically-oriented approaches work best with clients with some self-awareness and psychological-mindedness. However, the presence or absence of these traits cannot always be determined in the beginning of therapy. For example, as I describe elsewhere (Barth, 1998), sometimes highly verbal, thoughtful and apparently insightful individuals are unable to use their apparent self-knowledge for their own psychological well-being. This is sometimes the result of alexithymia, or an inability to process certain kinds of experience with language (Krystal, 1988; McDougall, 1989); but it may also be the result of defenses, personality organization and cognitive impairment. The opposite may also be true, that is, someone who appears to have no capacity for or interest in insight may turn out to be very responsive to a therapist's gentle exploration and offering of possible new ways of thinking about patterns that may have begun in the past and are being repeated in the present. Symptoms of depression and anxiety, inability to enjoy life, and repeating patterns of behavior that limit one's choices have all been shown to respond to these interventions.

Clients who cannot tolerate their feelings, who are in crisis or highly symptomatic, who cannot pay attention to their own thoughts and actions or do not have what is called an observing ego, and who cannot tolerate a developing relationship with a therapist are often not good candidates for psychodynamic exploration, but they often respond to a combination of supportive work and approaches that help them manage these feelings. Some clinicians fear that trying to understand latent or hidden meanings and historical reasons for problematic patterns of behavior will interfere with taking active steps to change behavior. However, understanding meanings can

sometimes enhance interventions focused on behavior (see for example Connors, 2006; Frank, 1999; Wachtel, 1997). Kohut (1984) goes so far as to suggest that the simple act of a clinician trying to understand what a client is experiencing is probably more important than an interpretation of unconscious meaning. A number of authors (e.g. Connors, 2006; Frank, 1999; Stern, 1997; Wachtel, 1997) suggest that some active, symptom-focused interventions can be viewed as early stages of psychodynamic work. They may make it possible for a client to begin to feel both hope and trust that therapy and this particular therapist can make a difference in his life.

The following chart can help a clinician decide when to work within the frame of psychodynamic thinking, and when a more active intervention is necessary (Table 2.1).

There are many times when psychodynamic interventions are not indicated, yet psychodynamic thinking can help a clinician make decisions about what is going on and what might be an effective approach. Here is another example of how this can work.

Anna Louise had been hospitalized for a severe depression. She had been stabilized with a combination of medication, individual, group and family therapy. She was highly motivated to return home to her husband and two young children, and did well on a series of progressively longer home visits. However, one day shortly before her discharge Anna Louise began complaining that she was feeling depressed and suicidal again. Her treatment team began to consider the possibility that she needed a higher dose of medication, but her therapist suggested that she was struggling with tremendous ambivalence about going home. "She is afraid," the therapist said. "Here at the hospital she's gotten support and nurturing. When she gets home, she will have

Table 2.1 Psychodynamic interventions

Psychodynamic interventions can be useful when	Psychodynamic interventions are often not helpful when
A client is interested in understanding something about the reasons for their behavior, thoughts, feelings and symptoms	A client's symptoms need immediate intervention
A client can tolerate feelings and thoughts that emerge as the understanding work is going on	A client has little or no access to feelings and/or thoughts
A client who has been participating in a program, doing therapeutic assignments, or otherwise engaged in therapeutic activities begins to resist, withdraw from or otherwise stop engaging in the work	A client is not able to think abstractly (this can sometimes be a temporary condition due to symptoms, and should be revisited periodically in the course of a therapy)
A client has feelings about a therapist that appear to be related to previous relationships, repeat old relational patterns, or seem to reflect a part of the client's self	A client is not interested in understanding or exploring possible meanings of her behaviors, symptoms, thoughts and feelings
	A client is psychotic, confused or suffering from alexithymia (the inability to use language to process feelings)

high expectations for herself, and she will assume that everyone else will have equally high expectations. She will be facing the demands of two small children, a household that needs to be run, a family pet, and her extended family." The team agreed that Anna Louise was not consciously acting depressed and suicidal, but that these feelings had emerged unconsciously as a way of keeping her in a safe and secure environment. With this conceptualization of her dynamics, the clinical team began to work with her and her family to set up a nurturing support system, including having her go into weekly psychotherapy and attend an ongoing parenting support group for young mothers that would help her feel more secure without being infantilized. Anna Louise was able to leave the hospital as planned and moved forward in her life with the support of her family, friends, therapist and support group.

Questions to Ask from a Psychodynamic Perspective

Exploring feelings, the therapeutic relationship and a client's past can stir up many issues for a client and for a clinician, which is one reason that it is so important for every therapist to spend some time in personal therapy. It is also a reason that psychoanalytic training is so rigorous. The work of self-knowledge is an ongoing process, however, which means that every client and every clinician is involved in learning more about themselves in the course of their lives. Interestingly, as McWilliams (2004) has explained, clients also need to learn about the psychodynamic process. Assuming that a clinician has been and is currently working on understanding personal dynamics and feelings that emerge in the work, here are some questions that can bring psychodynamic thinking into almost any clinical contact.

1. Focus on affect and expression of emotion: How are you feeling right now? How are you feeling talking about this topic?
2. Exploration of attempts to avoid distressing thoughts and feelings: How do you usually tend to deal with these feelings? What ways of managing these thoughts and feelings work best for you? What have you tried that doesn't work?
3. Identification of recurring themes and patterns: When have you felt this way in the past? What have you usually done in this kind of situation?
4. Discussion of past experience (developmental focus): What are the similarities between this situation and similar times you've experienced these feelings and thoughts? What makes you think this situation is the same as that one? Are there some of the differences?
5. Focus on interpersonal relations: what is happening in this interaction, with this person, and what does it mean to you? What do you think it means to them? What makes you think this?
6. Focus on the therapy relationship: Am I understanding what you're trying to say correctly? Does this feel helpful? Can you tell me if some of these feelings and thoughts that we're talking about with other people are also occurring in therapy?

Some clients are not able to accept or make use of exploration of their internal conflict and/or confusion. In these instances, even when they are in supportive, cognitive-behavioral, structural or medication therapies, they may enact some aspect of their difficulties and/or behavioral patterns, drawing a therapist into a living experience of their emotional world. As we will see in other chapters, sometimes thinking about possible meanings of the dynamics in which a clinician has become involved can be helpful without necessarily exploring them with the client. In order to do this, discussion with a supervisor or one's own therapist can help untangle a clinician's dynamics from those of a client.

Traditional psychoanalytic theory, often called "one-person" theory because it focuses on the intrapsychic or internal world of a client as the source of all enactments, encourages therapists to push a client to look at these feelings and behaviors as reflective of something about her own history and personal conflicts. The concept of therapist as participant observer (Sullivan, 1953) who unconsciously and frequently unknowingly influences the situation or person she is observing paved the way for contemporary recognition of a clinician's role in the development of any transference dynamic. Our personalities, individual dynamics and history color how we listen to and participate in a client's transference enactments. Mitchell (1993) likens this way of looking at transference and countertransference as going to a party and accepting an invitation to dance. At some point it is a therapist's job to ask, "Why are we dancing this particular step? Why did we choose this music?" Contemporary psychodynamic theories offer a wide continuum of approaches to a clinician's exploration of her role, ranging from a clinician's silent observation of her own thoughts and feelings, to requests that a client articulate what he understands about his therapist's feelings and thoughts, to a clinician's revelations to a client of aspects of her internal world.

A Word About Training

There is a reason that psychoanalytic training takes a long time. Clinicians are asked to understand their own psychodynamic thoroughly, to be able to use themselves easily in the therapeutic process, and to be able to think about and recognize psychodynamics from a variety of theoretical and clinical perspectives. Many analysts and analytically-oriented psychotherapists today consider that a therapist's reactions to a client contain useful information about the internal world and relational patterns of both client and clinician (see, for example, Davies, 2006). Because a clinician's psychodynamics also inevitably impact the therapeutic work, it is crucial to understand one's own dynamics in order to keep them from interfering with the exploration of a client's dynamics—especially in those inevitable moments when a client's struggles, personality or dynamics trigger something in a clinician. Even therapists not interested in doing long-term, psychodynamically oriented psychotherapy can benefit from being in that kind of therapy for a period of time. Given the research showing the importance of the therapeutic relationship to the success of

any therapeutic endeavor, it would seem that a therapist's commitment to self-understanding would enhance any kind of therapeutic approach and perhaps should be a requirement in all psychotherapeutic training. That said, however, even the most experienced psychoanalyst continues to evolve and to understand things differently over time. Similarly, psychodynamic theories are continuing to develop as new research and different issues emerge in the culture. They are not finished products that are ready to be applied "out of the package" to each clinical situation. Instead, each moment in clinical practice is an opportunity to explore and learn something new.

Evidence

Until recently, psychodynamic or "insight-oriented" psychotherapy and psychoanalysis were perhaps the least studied forms of psychotherapy, with much of the evidence of their impact coming from anecdotal descriptions and case studies. In a critical evaluation of psychodynamic theories, Eagle (1989) writes that one issue relevant to evidence-based research is that, "psychoanalytic writers attempt to employ clinical data for just about every purpose but the one for which they are most appropriate—an evaluation and understanding of therapeutic change." Recently, this has begun to change. For example, Wallerstein's (2000) study provides fascinating, in-depth data about the experiences of a group of men and women in long-term psychoanalysis, including how successful the treatment was and what the analysands themselves believed to have been the change factors.

It has not just been a lack of research in the field that has led many clinicians and clients to reject a psychoanalytic approach. Shedler (2010) notes that potential clients are often put off by historical images of arrogant and authoritarian psychoanalysts. Others are disturbed by the idea of an analyst sitting in silent judgment as they pour out their inner turmoil. The commitment of both time and money to long-term therapy has also been a problem for many clients and clinicians. Yet despite these negative characterizations of psychoanalysis (and by extension, talk therapy), there is growing evidence that psychodynamic psychotherapy helps many people get better. Some studies have shown that while a number of short term, "evidence-based" techniques have greater immediate impact on clients. Changes that occur in long term therapy (which is usually talk therapy) have a more permanent effect on the individual. For example, Leichsenring (2005), Leichsenring and Rabung (2008), Roth and Fonagy (1996), and Shedler (2010) have reviewed and evaluated research on a wide range of psychotherapies, including a number of both cognitive behavioral and psychodynamically-oriented psychotherapies. Their findings have been consistent: that longer term therapy appears to have longer-lasting results, especially with individuals with personality disorders, and that a variety of therapeutic interventions are effective with different symptoms and difficulties. Further, individuals undergoing long-term psychodynamic psychotherapy showed changes in brain functioning that did not show up in control participants. These changes were accompanied by changes that indicated a lifting of their depression.

According Roth and Fonagy (1996) the belief that specific clients and symptoms respond better to specific therapeutic interventions is not based on hard evidence as is sometimes believed. They write that the evidence about what therapies work for what disorders and groups of clients provides very little consistent guidance for clinicians to go by. Many of the studies have been, they suggest, too small to provide statistically useful results, but even large scale trials (e.g. Crits-Christoph, 1996) have not always been definitive (see also Seligman, 1995). However, like Wampold (2007) and numerous other researchers, they have found that a client's sense of a therapist's knowledge and experience, and interest in what a client is actually experiencing, can play a more important role than the specific therapeutic approach.

Conclusion

Putting thoughts into words out loud, to another person, can sometimes give us a chance to think about our own ideas differently, and leading to growing self-awareness and concomitant psychological change. A psychodynamic approach does not always involve what has traditionally been seen as interpretation or insight. Instead, as numerous contemporary psychoanalysts have suggested (see for just some examples, Bromberg, 2001; Fonagy, Gyorgy, Jurist, & Target, 2003; Frank, 2004; Hoffman, 1996; Holmes, 1996; Mitchell, 1993; Wallerstein, 2000) psychoanalysts today recognize that thoughts, feelings, behaviors and symptoms often have meaning that is not immediately clear either to a person experiencing them or to an observer. Such unspoken, unarticulated or unconscious meaning can play a role in ordinary daily behavior as well as in dreams and impulsive and unexplained actions. They can also impact how a client responds to therapy and therefore how a client uses any interventions, including those that are not psychoanalytically-based. Striving to understand these unspoken and unrecognized aspects of a client's everyday life, as well as those manifested in psychopathology, can be an important clinical intervention itself. This information can also help a clinician decide what other intervention(s) might be most useful for a client at a given time in their lives and in the therapeutic process.

Chapter 3
Developmental Models

Keywords Erikson • Epigenetic • Development • Developmental theory • Integrative practice • Cultural • Psychological • Social • Cognitive • Physical • Biological • Cognitive development • Psychodynamic development • Attachment theory • Emotional development • Teamwork in psychotherapy • Clinical team • Integrative team • Parents • Children • Integrative social work • Clinical illustration • Evidence • Research

Introduction

It is widely accepted today that a child is born with some basic abilities (e.g. the capacity to breathe, to suckle, and to cry) and with many other potential capabilities that will unfold over time. How he will develop will be the result of a series of interactions between that child's genetic makeup and the environment in which he lives. Educators, social scientists, parenting specialists and medical and mental health professionals bring, either implicitly or explicitly, theories of development into their work every day, with every client. However, to many people the idea of development is more theoretical than anything else. For instance, educators and parents alike may fall into a trap of expecting children to be more mature than their chronological or psychological development makes possible. Understanding that development is an ongoing interactive process is useful for both identifying difficulties and formulating an overall approach to a client's therapy. Developmental theory offers an integrative clinician a framework for thinking about the specific life issues that a client is facing (for example, how a college student is dealing with age appropriate issues like separation and identity). This frame, or outline, is not a rigid set of rules, but instead offers a way of organizing one's thinking so that interventions can be chosen thoughtfully. Yet the overwhelming number of developmental

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theories in existence today can make it difficult for a clinician to know what areas to focus on.

Developmental theory today cuts across cultural, psychological, social, cognitive and physical/biological fields and is based on extensive studies and observation of children and adults of all ages and at all stages of life. The range of data gathered from infant and child studies in recent decades no longer supports a "blank slate" theory. These studies show that from the moment of birth a child actively engages with the world. Childhood is a time of tremendous physical, cognitive, social and emotional development. Yet clinicians who closely observe and study these processes do not always agree on what they see or understand. In fact, so much has been written on these issues that it would be impossible to summarize in a single chapter (for further elaboration, see Austrian, 2008; Beebe, Jaffe, & Lachmann, 1993; Beebe & Lachmann, 2005; Gedo, 1991, 1997; Piaget, 1969; Rustin, 2012; Schore, 2003).

Because developmental progression does not follow a rigid path and has a wide range of normal variables, it is useful for a clinician to make an effort to become familiar with different developmental and lifecycle theories (see Austrian, 2008, for an excellent summary of developmental concepts that affect an individual's psychological makeup throughout the lifecycle). A practice can also be enriched by the availability of consultants with expertise in a wide variety of issues, including developmental theories. As we will discuss in throughout this book, and specifically in Chap. 9, a team can be formal or informal. In either case, it is useful for an integrative practitioner to have access to other clinicians whose knowledge augments and complements his own.

Understanding developmental theory helps an integrative practice in three different ways. First, it provides a frame for thinking about issues directly related to a client's chronological age. Second, it offers a way of thinking about the psychological themes that emerge at different developmental stages. And third, it helps us think about themes that develop in the course of therapy.

In my own work I have found Erikson's (1980) psychosocial developmental stages useful as a way of formulating developmental themes that are significant in a client's life. Seligman and Shanok (1996) describe in detail ways that they find Erikson helpful in integrating contemporary developmental thinking, including attachment theory. Goldberg and Gedo (1973), Pine (1985, 1990) and Stern (1985) also offer cohesive yet flexible, interactive and epigenetic models of ongoing psychological and emotional development from birth to death. Although many aspects of his thinking are no longer applicable, Erickson's table offers a way of organizing contemporary thinking about attachment, affect regulation and separation throughout the lifespan. Separated from drive/conflict theory, this approach does not privilege one stage of life or one particular set of dynamics or issues, offering instead a conceptualization of continual growth and development throughout the lifespan. As in therapy itself, an individual often revisits and re-works certain themes throughout life. Thus dynamics that are primary in one stage may run through an individual's life and may need to be worked on at various times and within the context of other developmental needs.

Themes and Life Stages

This conceptualization fits with contemporary attachment theory as well as with epigenetic models (e.g. Goldberg & Gedo, 1973). Mitchell (1993) suggests that the unfolding of dynamics both within therapy and throughout the life span can be viewed as alternating figure-ground, that is, that at times a theme plays a central role, and at times it is a background to other material. Similarly, Stern (1985) suggests that certain organizing themes, such as difficulties with attachment or separation, run through an individual's life, albeit in different forms at different developmental stages. Contemporary attachment theory (e.g. Bowlby, 1973; Cassidy & Shaver, 2008; Eagle, 1995; Goldberg, Muir, & Kerr, 1995; Holmes, 1996) and neuroscience research (Bjornsson, Didie, & Phillips, 2010; Lacy & Hughes, 2006; Rustin, 2012) offers tools for thinking about some of these themes.

In this chapter, we will focus on three themes that are frequently re-worked in different stages of development: attachment, separation-individuation (or, as we will discuss, attachment-individuation), and self-regulation, including management of affects and impulses. We will consider these themes as they unfold in three areas of the therapeutic encounter: in a client's past, in his present, and in the therapeutic relationship.

While there is not an exact one to one correlation between interventions and dynamics, a good rule of thumb is that issues related to early developmental issues like impulse control, affect regulation and object constancy require active, symptom-focused interventions, such as behavioral and structural, self-soothing and relaxation techniques. Problems that are tied to attachment insecurity and anxiety often require trust-building and understanding as well as symptom-focused interventions. Clients who are capable of tolerating difficult affects and examining their own thoughts and feelings can frequently make use of insight-oriented, psychodynamically-oriented interventions.

In the late 1930s, ego psychologists (see Hartmann 1939) were aware of and writing about the interplay of psychodynamics and cognitive-developmental processes (see Piaget, 1952, for further elaboration). Erikson introduced the idea that psychological development does not stop, as was once believed, with the "resolution" of oedipal conflict. His thinking that there is an ongoing process to development, with psychological, emotional and social tasks being accomplished at different ages of life throughout the human lifespan, can be a useful tool for an integrative clinician.

Developmental theory posits the existence of distinct developmental tasks that an individual needs to accomplish through the lifecycle. Erikson suggested eight stages of psychosocial development that lead us from birth to death (Table 3.1). While there are several ways in which the theory behind his stages is no longer applicable, including the conceptualizations of male and female development on which some of his thinking is based, contemporary clinical thinkers can still find it a helpful tool for thinking and talking about a client's developmental themes. For example, while most clinicians no longer closely adhere to the psychosexual conceptualization of

Table 3.1 Erikson's eight stages of development

Erikson's stages of development:
1. Trust vs. mistrust (oral-sensory, birth-2 years)
2. Autonomy vs. shame & doubt (muscular-anal, 2–4 years)
3. Initiative vs. guilt (locomotor-genital, preschool, 4–5 years)
4. Industry vs. inferiority (latency, 5–12 years)
5. Identity vs. role confusion (adolescence, 13–19 years)
6. Intimacy vs. isolation (young adulthood, 20–24 years)
7. Generativity vs. stagnation (middle adulthood, 25–64 years)
8. Wisdom: ego integrity vs. despair (late adulthood, 65-death)

development that informs Erikson's early stages, themes of Trust vs. Mistrust can be found in early attachment, and Autonomy vs. Shame and Doubt are useful ways of helping clients understand difficulties related to the initial forays of a young child into separation and individuation (or *attachment* and individuation, as Lyons-Ruth, 1991, calls it). Similarly, while adolescence is today often considered to extend through the 20s (see Amundsen, Borgen & Tench, 1995; Levinson, 1986), some of the crucial issues of this period of life continue to coalesce around identity, role confusion, intimacy and isolation. At the same time, Erikson's model can be used to integrate theories of cognitive development, cultural dynamics, and attachment issues. As Eagle (1995) points out, each theory can also elucidate different aspects of the developmental process.

In an epigenetic model such as Erikson's, development occurs according to genetic potentialities which are constantly interacting with and modified by environmental influences. Each stage is influenced by the way that the stage before it was managed, and also influences the form of the stage to follow. Similarly, issues of development in different realms are mutually impacted by one another: for example, cognitive development influences psychosocial stages and attachment, and vice versa. Each can have an impact on the progression of another. Issues that are primary in an early stage may take a backseat in a later period of life, but they will continue to be worked on and to influence the stages that follow. In clinical work, we often see themes repeating themselves in client's attempts to live their lives. The three themes described at the beginning of this chapter (attachment, separation-individuation/attachment-individuation, and self-regulation, including management of affects and impulses) often recur throughout an individual's life and affect how he engages in his current developmental stage.

Developmental Themes and Developmental Trauma

It is sometimes suggested that a client who shows signs of struggling with particular developmental themes may have been traumatized during the childhood stage associated with that particular theme. Diagnoses are sometimes also made on the basis

of a client's developmental themes. However, years of clinical practice have led me to question such one to one correlations, and a growing number of researchers have begun to address these supposed links (see Dozier, Stovall-McClough, & Albus, 2008; Roth & Fonagy, 1996). Although insurance companies often demand that clinicians work within a somewhat rigid frame of diagnosis and treatment requirements, it can actually often be helpful for a clinician to think about developmental issues and interventions from this broader, more integrative perspective without adhering to a rigid one to one correlation between diagnosis and treatment.

Here is an example of how this can work:

Margaret is on the staff of the counseling office in a large university. She loves her work, although she admits that she had imagined it quite differently than it actually is. "I thought I was going to be having deep intellectual discussions with smart young people who were trying to figure out the meaning of life. Instead, I have crisis sessions with depressed youngsters who cannot do their schoolwork, scary encounters with young women who are starving themselves to death or binging and purging several times a day because they think that to be successful and beautiful they have to be a certain body weight, or I'm dealing with a young man who has been hospitalized for the second time with alcohol poisoning but refuses to accept that he has a drinking problem. These are life problems, alright, but we don't have the luxury of exploring what they mean. We are always putting out emotional, psychological and physical fires."

Viewing these symptoms as reflective of developmental themes helps Margaret understand her clients, formulate interventions and also explain their struggles to them and their families.

"These kids are frightened, angry, hurt, sad, depressed, lonely…the behaviors are ways that they have found to manage these feelings and to cope with the very questions I wanted them to be asking in our sessions." These youngsters were struggling with separating from their parents and becoming independent adults in a world that was different from the one in which Margaret and many of her colleagues had grown up. "They have had a different set of pressures and a different set of goals that are part of the high pressure, high achievement world in which they live. Many of them have been so busy trying to get into the 'right' college that they didn't have time to wonder what they might like to do with their lives." College is where many youngsters today do some of the experimenting with identity and roles that high school students did in previous decades. Understanding drinking, eating, gambling, and other problematic activities in this context helped Margaret think more clearly about immediate interventions, which often had to be crisis, symptom and behavior-oriented. It also gave her a frame for addressing longer term goals, including developing a healthy sense of self separate from (although also connected to) family, a capacity to engage in meaningful intimate relationships, and an ability to find meaningful and productive work.

Immediate symptom-focused interventions include referral for medication evaluation, entering a student in a structured psycho-educational or cognitive group, teaching coping mechanisms, including relaxation techniques, addressing the need for nutrition and sleep, and at times making a referral for hospitalization. "I seldom

have the opportunity for long-term work with these students," Margaret notes. "But I consider my job to be helping them to get back on a healthy, age-appropriate developmental track. And I also hope that I give them a good experience of therapy, so that they will be comfortable coming back, either to me or to someone else, when and if they need some help at other stages of their lives."

Developmental theory helps parents, educators and government funding sources recognize and address the need for intervention during childhood and adolescence. Attachment research, for example, has been utilized to support government and private programs to aid distressed families in providing an early secure base for their children (see Slade, 2006; Steele, 2008). Other research has shown the importance of active intervention at certain stages of adolescence to help prevent disorders typical of those stages. For instance, Gilligan and Machoian (2002) found that adolescent girls are at highest risk of suicidal behavior in their 13th and 14th years, at the stage of development during which they begin searching for relationships with boys. This is a time when they are feeling hopeful and simultaneously extremely vulnerable.

Attachment and Separation

Although extremely popular, attachment theory is far more complex than is often recognized. Holmes (1996) notes that it is actually not a single theory but is instead an umbrella heading for a number of approaches that privilege the need for secure attachment in the development of a healthy psyche. What has become clear, however, is that attachment is not only a significant early process, but it is a theme that continues to be significant through the lifecycle. It is also amenable to change. Current research also suggests that the separation-individuation process does not stop at a specific point in childhood, but continues to be reworked throughout the life span (see, for example, Bowlby, 1973; Kohut, 1971; Stern, 1985).

Based on observation of infant and toddler and parent dyads, Lyons-Ruth (1991) suggests that we reframe the concept and the tasks involved in what Mahler, Pine, and Bergman (1973) call "separation-individuation." Lyons-Ruth offers the name "attachment-individuation" instead, suggesting that the goal of psychological health is not the development of separateness, but the capacity to be attached to another while also respecting one's own individuated self. Although this is a stage of early development, my experience working with college aged adolescents leads me to agree with Blos (1967) and others that the struggle to separate from and connect to parents in new ways, and simultaneously to develop new relationships in which one is both attached and separate, is a central one in adolescence. While both physical and psychological separation have long been viewed as crucial to the process of individuation and identity building, I, like Lyons-Ruth, have found that it is frequently important to integrate and underscore the importance of healthy, albeit changing, attachment to parents and family as an adolescent becomes independent (see Barth, 1989, 2003). Understanding these themes can be part of an integrative approach in

helping young clients and their families recognize and manage separation with connection (see also Chodorow, 1999).

According to Lachmann (2001), one might consider Mahler's view of separation-individuation in a similar light. He suggests that she does not view separation-individuation as a final destination, but rather as part of a process. Similarly, Bowlby, the "father" of attachment theory, writes that attachment itself is a process that goes on throughout life (1973)—an idea reiterated by Kohut (1977), who says that human beings need what he called selfobjects—that is, other people who can understand our thoughts and feelings, and can help us soothe ourselves and manage stressful emotions—just as we need oxygen—from birth to death. Thus, while these developmental issues are part of childhood, they are also revisited and reworked throughout an individual's lifetime. For an integrative clinician, this formulation opens the door to thinking about interventions from a here and now perspective as well as within the context of a client's history. For example, working on attachment needs in the present may be enough to help restore a client to healthy functioning.

Developmental issues of attachment, object relations, affect management and impulse control are often seen in clients with diagnoses in the areas of addictions, impulse control and certain personality disorders (e.g. borderline personality disorder), as well as in some discussions of bipolar disorders (see, for example, Bateman & Fonagy, 2004; Gabbard, 1991; Goldstein, 1999; Linehan, 1993). These formulations do not have to identify historical reasons for a client's current struggle, but thinking in terms of developmental concepts can help a clinician formulate an appropriate intervention. For example, in the case of Mr. Nolan, who was struggling with alcoholism, his therapist decided that he needed help managing his impulses and dealing with his shame about his difficulties. Locating these struggles in the arena of autonomy vs. shame and doubt in Erickson's model helped Ms. Bluen formulate useful interventions that would provide her client with support as he developed the capacity to maintain himself in recovery without causing him undue shame about not being able to do it on his own. They did not, however, mean that Mr. Nolan was stuck at the psychological age of 2–4 years, since over the course of his life he had worked through many of the developmental tasks of both adolescence and adulthood.

Thinking in terms of both ongoing process and managing opposites can seem daunting, but is actually useful in terms of choosing an appropriate intervention. If a client needs help with the kinds of functions usually provided by a secure attachment figure, e.g. self-soothing, time management, coping with overstimulation, and managing emotions, a clinician's first interventions should be directed at shoring up these self-organizing and self-regulating functions. Behavioral, directive and educational interventions might be most appropriate at these moments. Providing food and clean clothing (if appropriate within a specific setting), helping a client find housing, coping with an angry partner, paying bills and finding adjunct services to help with cleaning (for example in the case of a depressed or hoarding client) can be seen as offering not only a "holding environment" as described by Winnicott (1965), but also some of the selfobject functions described by Kohut (1977), as well as some of the attachment functions described by Bowlby (1988).

Table 3.2 Types of issues, interventions, and corrective experience

Type of issues	Interventions	Corrective experience
Early developmental issues: impulse control, affect regulation and object constancy	Active intervention like behavioral and structural, self-soothing and relaxation techniques	Holding (facilitating) environment, containing, corrective selfobject experience
Attachment issues	Trust-building, active interventions, and understanding	Holding environment, containing, affect regulation, corrective selfobject/attachment experience
Issues related to unconscious meanings and repeated patterns in clients able to tolerate emotions and self-examination	Insight-oriented, psychodynamically-oriented interventions	Holding environment, corrective selfobject/attachment experience, new understanding

It is tempting to assume that developmental issues seen in an adult or adolescent client indicate childhood difficulties at a specific age and developmental stage (Table 3.2). Similarly, it is currently common practice to conclude that certain symptoms in adults and adolescents indicate the presence of childhood trauma. While the tremendous amount of work on trauma has added a great deal to our knowledge and understanding of the impact of previously unrecognized or unacknowledged horrors in the lives of many young people, it is also important to remember that other factors may also play a significant role in the unhappiness and problematic behaviors of many clients (see, for example, Mitchell and Black, 1996). For a clinician working to build an integrative practice, the variety of developmental theories available can be a potent reminder that no approach should be applied rigidly or followed blindly. As in every aspect of this work, these concepts are tools for helping us listen to and think about what our clients are communicating to us. As we sort out the verbal and nonverbal messages our clients send, we can select from a wide range of tools to address the specific needs of a client at a given time.

Developmental Organizing Themes

Developmental Organizing Themes are those dynamics from earlier stages of development that a client brings into therapy, no matter what his or her age. For example, for many different reasons, a 29 year old man may come into therapy for help dealing with his dating life. It would appear that he is struggling with issues related to the stage of life Levenson (1989) refers to as transitional, with changes in life structure related to settling down, marrying, starting a family, and moving

forward on a chosen career path. But it gradually becomes clear that this young man is struggling with issues related to self-control and autonomy, which emerge each time he begins to move towards a more committed relationship. Developmental organizing issues from early childhood and adolescence color his ability to manage the stress of his actual age-appropriate developmental process.

However, from an integrative position, one would attempt to think in terms not only of developmental and family systems issues, but also in terms of what is actually happening with a client at a specific time in the work. Sometimes it can be helpful to identify repeated patterns as, for example, a struggle between control and autonomy in order to determine what approach might be most useful at a given time. As described by Connors (2006), Frank (1999) and Wachtel (1997), a clinician needs to assess a client's level of discomfort, capacity to tolerate that discomfort, and capacity for self-soothing. When the symptoms are interfering with life functioning—e.g. anxiety that cannot be tolerated, depression that makes it impossible to get out of bed, an addiction or compulsive behavior that is dangerous to physical or emotional life—active, structured interventions are most appropriate. Similarly, if a client is psychotic, acting out, uninterested in exploration or incapable of tolerating or engaging in discussion of these feelings and their antecedents, active work in symptom-reduction is important. For example cognitive behavioral tools can be directed specifically at helping clients gain more of a sense of independence and self-confidence. Mindfulness techniques, ego enhancing work, and some emotional focusing are also helpful.

Interestingly, from the perspective of an integrative approach, Roth and Fonagy (1996), who have reviewed a tremendous amount of research data on the correlation between interventions and symptoms, found that the specific intervention is less significant than a sense that a clinician has confidence in the technique and believes that it is appropriate for what is troubling a particular client. Thus, it is important for a clinician to be trained and supervised. However, even a beginning clinician has access to one of the most powerful techniques possible: trying to understand what a client is feeling and what he needs goes a long way towards helping (see Kohut, 1977; McWilliams, 2004). Like other integrative clinicians I have found that many clients need help learning to soothe themselves and manage emotions before they are capable of exploring distressing feelings. Clients who have been pushed into painful and intolerable feelings without the tools to manage them may become more symptomatic, or may simply leave therapy in order to protect themselves.

On the other hand, having developed the capacity to soothe painful emotions, some clients are able to move more deeply into self-exploration, while others have accomplished what they want from therapy and are ready to move on. Basch (1980) emphasizes the importance of supporting a client in achieving his own goals, even when they are not precisely the same as his therapist's. We will consider this issue further in the chapter on endings. In either case, whether clients are interested in moving more deeply into material or not, helping them learn to manage and structure feelings is, in developmental language, comparable to soothing a crying child. In most cases, a sobbing youngster, no matter how verbal, cannot say what is upsetting about until the crying stops. The pain must be addressed and the child's feelings

re-equilibrated before trying to determine what caused the upset. Once the emotions are regulated, the cause may not even be important, but several developmental steps will have taken place: the child will have done some work on developing the capacity to tolerate and the skill to manage the affect the next time and will also have learned that another person can be trusted to help with self-soothing.

Exploring Client History and Current Reality

Developmental concepts offer both clinician and client a way of talking and thinking about some of the difficulties with which a client is struggling. As noted earlier, however, it is important to recognize that there is not necessarily a one to one correlation between the concepts and a client's actual experiences. Instead, thinking in terms of developmental issues can help a clinician formulate interventions that target particular issues. It can be a useful way to talk about dynamics with clients, although it is also extremely important for a clinician to clarify that this does not indicate that a client is acting in a childish manner. Here is an example of how this can work.

After her discharge from the hospital, Anna Louise (who we met in Chap. 1) began to work with Lisa, a psychodynamically-oriented psychotherapist in a clinic affiliated with the hospital. Relatively quickly it became clear that Anna Louise held herself to an impossibly high standard of performance, getting very angry at herself for even the smallest mistakes. She often talked about herself as though she were an imbecile and called herself a variety of names. Lisa silently wondered if she treated her two small children this way as well. There had been no indication of any difficulties with the children—in fact, Anna Louise's husband described her as a wonderful mother—so Lisa decided that she could wait before addressing this question. Still, she carefully considered the most tactful yet direct way to help this sensitive client begin to explore her constant self-criticism. After expressing some curiosity about the ongoing negative descriptions that Anna Louise used to characterize herself, Lisa asked if being so mean to herself helped her get the work done. After a surprised silence, Anna Louise said she had never thought about that. It was just what she did when she was acting so stupid. Lisa said, "You sound like a frustrated mother with a toddler, calling her names because you can't understand that she's really just not capable of managing that task right now." Anna Louise burst into tears and said that exactly captured how she felt about herself. She added that she sometimes felt that way about her children, which made her feel like she was the worst mother in the world.

Since her client had opened up this issue, Lisa took the opportunity to explore a variety of parenting issues. Although Anna Louise worried a great deal about being a bad parent, it sounded like she was doing a pretty good job. Her husband and in-laws confirmed this conclusion, but because of her client's worries, and also as a means to help her develop a support network of peers, Lisa encouraged her to participate in a parenting group as well as her individual therapy. In her individual

sessions, Lisa asked about childhood memories. Were her parents critical of her? "Oh no," Anna Louise replied. "My parents are very, very loving. Very gentle and kind." The response may have been a defense against intolerable memories. It may have been a valid description of Anna Louise's parents, although in general descriptions of anything as all good or all bad are seldom complete: few things in life are absolute. Lisa wanted to ask questions to open up who had spoken to Anna Louise in that way, and to suggest that she was treating herself and her children as she had been treated. There are dangers with such a construction, however, since it can be an oversimplification of a complex developmental process and an isolation of a single memory, or cluster of memories. It is important for a clinician to keep in mind that these thoughts exist within the context of a complicated reality. Schafer (1994) calls such formulations "constructions" of history because they are constructed in the here and now and are not necessarily accurate depictions of an individual's past. Mitchell and Black (1995) note that the question of causality of symptoms—childhood trauma or internal conflict—is one of the major controversies for psychotherapists today. Gedo (1991) suggests that the answer is even more complicated: biology, history and conflict are all part of the picture. Even tools like the Adult Attachment Interview, which is often utilized to determine areas of attachment difficulty, need to be assessed with care. Slade (2006), for example, notes that in fact human beings often fall into more than one attachment classification, and furthermore that attachment patterns can change over time.

Attachment themes often contain within them "models of relationships" that clients have learned in early interactions with parental figures, and have carried with them into later relationships. These models lead to both expectations that certain patterns of interaction will be repeated in other relationships, and also to behaviors that may elicit these patterns. Understanding these constructs can help a clinician find a way to talk with a client about both interpersonal and intrapsychic difficulties. For example, it offers an opportunity to begin to talk about a client's implicit, or unarticulated constructions of experience—for example, that to be loved means to be criticized. Talking about Erickson's stage of mastery can help a client understand why certain patterns are repeated without being overly critical of self or of parents, thus maintaining a connection while also developing a separate and healthy sense of self.

Memories and Organizing Themes

A client's memories can be useful tools for thinking about how a client is experiencing and psychologically organizing any interaction. For example, Margaret, the college counselor, routinely asks her clients about previous experiences that might in some way have been painful, difficult or traumatic. For example, she has learned that while some homesick students have struggled throughout their lives with issues around separation—perhaps having been homesick at camp or having problems leaving their mother on the first day of school—it can be helpful to discuss

how they managed to master the experiences rather than to focus on their difficulties with separation. If finding a supportive adult or making a new friend helped in the past, the client might be encouraged to think that a similar capacity for mastery will emerge in this process as well. Discussing ways that a client might manage the feelings is another key to the process of both mastery and gradual movement towards a new experience of this ongoing theme. Margaret offers her own ego as support in the process, working together with each client to come up with ideas about managing difficult feelings. One client, for example, might find it useful to become involved in volunteer work organized by a campus group; another decides to have more frequent contact with her parents; while yet another decides less contact with her parents and regular sessions with Margaret would help; and yet another decides that it would be helpful to join a support group at the counseling center.

I have said this before, but it bears repeating: because developmental progression does not follow a rigid path and has a wide range of normal variables, it is useful for a clinician to make an effort to become familiar with different developmental and lifecycle theories. A practice can also be enriched by the availability of consultants with expertise in a wide variety of issues, including developmental theories. This does not mean that members of a team need to be rigidly structured or organized or even consulted in every case, but it is useful for an integrative practitioner to have access to other clinicians whose knowledge augments and complements his own.

Developmental Stages of Therapy

Just as in life, every therapeutic experience is a process that evolves over time, that is, the process of therapy is itself developmental. As questions of basic trust are tested and resolved (and often tested again), old attachment themes are repeated and reworked, leading to an opportunity to find new ways to be connected and separate. Repetition of old organizing themes allows a client to work toward greater security, self-confidence and connection to others. Whether the frame is two sessions of hypnosis, a 12 week course of DBT or a 3 year psychodynamic psychotherapy, there will always be at least three phases of the work: beginning, middle and end, and the work at the beginning will be different from that at the end. Developmental thinking is a useful tool for making decisions about interventions that are appropriate to each phase of therapy. In the beginning of any therapeutic encounter, therapist and client must get to know one another, agree on mutually defined goals, and establish the format in which the work to attain these goals will be done. This introductory phase may include educational instruction from a therapist or be focused on taking information from a client. In some way or another, however, either formally or informally, therapist and client begin the work. In this early stage, a therapist will be looking to see how well a client can tolerate the emotions that go along with engaging in a new activity and learning a new way of thinking.

Connors (2006), Frank (1999) and Wachtel (1997) have each noted that in this stage a therapist often needs to assess the need for immediate and/or structured intervention. Research has shown that clients tend to stay in therapy when they feel that they are getting something from the work (Roth & Fonagy, 1996) and to leave when they are not. Often in the early stages of the work, when symptoms are overwhelming or distressing, it is helpful for a clinician to be more active, directive and/or structured than he might be later in the work, when a client is less symptomatic and has learned some of the techniques and how to apply them. This may also be a time when medication is helpful.

In the middle phase of work, a client is encouraged to try to engage in therapeutic work with some independence. A clinician may continue to offer education and guidance during this period. Sometimes modeling, showing how we might try to work with certain dynamics, whether by exploring the psychodynamic meaning or by suggesting a specific behavioral or mindfulness technique, can be the most useful intervention we can make. If a client has been less symptomatic or has been acting out sporadically, the middle period can be a time for examining some of the triggers of these behaviors, and can also be a time for supporting the strengths that have made it possible for the symptoms to decrease during this time frame.

The final phase of therapy, or the termination phase, is, like the other stages, contingent in part on the type of therapy being done. One of the great benefits of short term, symptom-focused work is that it gives a client a sense of accomplishment. Clinicians who routinely practice longer-term, less focused therapy might do well to incorporate this technique into ongoing work. Basch (1980) says that too often psychodynamically-oriented psychotherapists run the risk of undoing important work they and their clients have done by focusing on work a client still needs to do rather than on the successful achievements already made. As one young client who had participated in a 12 week program of DBT put it, “I really have accomplished so much. I know what to do when I’m having these feelings. I know how to prioritize my activities. And I know how to ask for help when I need it.” She was also highlighting a further aspect of the termination phase: to anticipate ahead of time what a client might do should some of the symptoms recur.

Using Developmental Thinking to Help Clarify and Manage Resistance, Defenses, and Issues That Emerge in a Therapeutic Relationship

As noted in Chap. 2, concepts from psychoanalytic theory can be useful for a clinician no matter what approach they are using. Let us return to Margaret, the college counselor, for an example. Margaret found herself struggling with students who resisted her suggestions so often that she sought supervision to see what she might be doing to stir up this resistance. What she discovered was that in many cases, the apparent

resistance was developmentally appropriate, if problematic. Many college students, working on the developmentally appropriate issues of individuation and personal agency, are not particularly interested in becoming engaged in a new and dependent relationship to another adult, no matter how much they may like, admire and appreciate that adult. They therefore may forget appointments or avoid making them in the first place. Or, despite being symptomatic and in some psychological pain, they may not seek help because they feel that they should be able to take care of the problem themselves. Understanding this dynamic, a clinician can make a gentle comment about the difference between asking for help and being dependent, to see if a client can engage in a discussion of the issues. Or a clinician might directly address the developmental conflict, for example, "I think you are working hard to be an independent adult, and feeling like you might need help makes you feel like a child again. I wonder if we can work out a way that you could get the help you need without losing a sense of your independence and competence."

It is also common for a clinician to want to "know how the story ends." For those of us who, like Margaret, work with children and adolescents, this desire is often especially difficult, but it also affects clinicians who see adults. While this wish is both normal and comprehensible, it can interfere with the process of helping clients work on issues of separation and self-development. Not only can these endings awaken feelings from a personal developmental stage in which we felt abandoned or rejected, but we may also be left "holding" loving feelings while a client moves on, much as parents sometimes feel when their children work on individuation. Clinicians can feel "stuck" with the caring feelings, while the objects of their attachment get help and move on. Some clients want to move on without feeling that their therapists are trying to hold them back, but others feel more comfortable leaving when a clinician communicates not only positive feelings about the work they have done together, but also good feelings about the client as well. From a developmental perspective, even the ending is part of the process of therapy, helping clients get back on the developmental track and towards achievement of their life goals. We will discuss the complexity of this process more fully when we speak about endings in therapy. For now, let us simply note that this is one of the moments in which an integrative approach offers a range of possible responses, rather than a single technique that is assumed to be correct at all times.

Conclusion

Not surprisingly, sitting with clients as they work through developmental stages relating to attachment and individuation can open up a clinician's ongoing attachment needs. As we discussed in the last chapter, this is one more way that our own personality and psychodynamics can impact our work. For instance, a desire to help others is often accompanied by a desire to make caring connections. I have found that these wishes, which often make us want to stay connected to clients when clients are eager to break the link, can be part of a healthy developmental process in

some therapies. Clients sometimes need to know that their therapists will think about them in the future, and will care about how they are doing, even if they are no longer in touch. While I agree with Basch that it is important to support a client's accomplishments, I have also consulted in numerous situations in which it is helpful for a client to know that a therapist believes there is more that can be worked on before they end therapy. Some of these clinicians have agreed to stop the work, despite their professional judgment that it was not the best time to do so, because they did not want to hold on to clients inappropriately. In order to best help each client determine what will be most therapeutic for them at a specific time in therapy, it can be extremely useful to draw from different assessment tools and theories. Let us turn next to bringing cognitive and behavioral interventions into an integrative frame, and then we will talk about assessment as integrative tool not only in the initial phase but also in *any* ongoing therapeutic work.

Chapter 4
Cognitive and Behavioral Models

Keywords Cognitive therapy • Behavioral therapy • CBT • Psychodynamically-oriented psychotherapy • Integrative teamwork • Conjoint therapy • Multiple models • Integrative psychotherapy • Integrative social work • Dialectical behavioral therapy • DBT • Acceptance and commitment therapy • ACT • Mindfulness based cognitive therapy • MBCT • Mindfulness • Self-acceptance • Symptom-focused • Affect regulation • Evidence • Research • Clinical examples • Psychodynamics • Mindfulness • Developmental theory • Assessment • Termination

As I was preparing this chapter, I was also teaching a class on integrating theories to a group of experienced therapists. As we read about some of the contemporary cognitive therapies, one psychoanalytically trained group member commented that she had been practicing some similar techniques for years. "But I always felt like I was looking over my shoulder for someone to accuse me of stepping outside of the analytic frame," she said. "Like it was sacrilege to make a suggestion about a way of coping with certain feelings instead of trying to understand the meaning of those feelings." Another therapist quickly spoke up. "That's pretty funny," he said. "I was trained in Cognitive Behavior Therapy, but there have been many times when I've stopped the training to look at the meanings behind some of the behaviors. And I always felt like the CBT 'police' might come in at any minute and tell me I was breaking that frame!" My own experience and feedback I get from supervisees and students, that most of us integrate many of these techniques without necessarily recognizing that we are doing so, is reinforced by research reported by Roth and Fonagy (1996). I have come to think that there are several possible ways of integrating: (1) to train in more than one form of work and formally practice each of them with the same client; (2) to thoughtfully integrate concepts from different models without formally utilizing the overall practice; (3) to work conjointly with another therapist who offers a different model from one's own; (4) to utilize practices from one model to enhance work in another.

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It has been my experience that many clinicians who practice a wide range of therapies integrate cognitive behavioral techniques, either intentionally or unintentionally. In addition many cognitive behavioral theories now integrate not only mindfulness practices, motivational interviewing and other techniques, but they also bring in some previously rejected psychodynamic factors, including concepts such as resistance and consideration of the therapist-client relationship. Traditionally, it has been less acceptable for clients to see more than one psychotherapist at one time, but in contemporary practice more and more clinicians not only accept, but even encourage clients to work with other professionals who can offer them more tools for symptom management. Let us turn to a brief example of one way that cognitive behavioral work has been integrated with other approaches, and then we will discuss some of the theory that informs these interventions.

Clinical Illustration

Ms. Robinson (the mother of the ill child described in Chap. 1) was struggling with feelings of inadequacy and anxiety. As her social worker, Mr. Andrews, got to know her better over the course of her son's illness, he became convinced that her difficulties preceded the illness and were in part due to a number of difficulties she had managing her thoughts and affects. The hospital offered Dialectical Behavioral Therapy (DBT) groups for clients who were having difficulties managing some of the feelings related to their children's illnesses. However, many clients found it useful for dealing with other, longer term issues as well. Mr. Andrews felt that the group, which he ran, would provide some tools that Ms. Robinson might find helpful for managing the often disruptive anger that seemed to explode in her household. With his encouragement, she began coming to the group and found herself enjoying the sessions tremendously. She liked the contact with other parents, the sense that she was appreciated and even admired by some of them, and the feeling that some of the things she had to say to them were helpful. She also found that the tools the group had to offer—including beginning to find words for feelings, paying close attention to her own thoughts, feelings and physical sensations, as well as breaking down large difficulties into smaller segments—were all extremely helpful.

Despite having to travel for over an hour and take two buses and a train to get to her sessions, Ms. Robinson initially got to the group meetings on time or even a little early. After a few weeks, however, she began arriving at least 20 min late, which of course cut into the work and left her, the group and Mr. Andrews feeling frustrated. A psychodynamically-oriented therapist might have examined her reasons for being late and perhaps explored unconscious motivations. An integrative perspective would lead a therapist to ask whether such an exploration would be the most effective. Because Ms. Robinson had shown little interest in or ability to explore her own psychodynamics, and also because the behaviors were having immediate negative consequences that Mr. Andrews did not want to see reinforced, he chose to meet with her individually for a few sessions to try to stop the pattern.

Not surprisingly, Ms. Robinson arrived late for her appointment. Using a combination of what cognitive behavioral therapists call chain analysis and motivational work, and what Sullivan (1953) calls "detailed inquiry," Mr. Andrews asked her to go over what had happened from the moment she began thinking about getting ready to come to her session to the moment that she actually got on the first bus. Ms. Robinson explained that she had been getting ready to leave when her mother called to her from a back room and asked her to bring home some bread from the grocery store on her way back from the hospital. Ms. Robinson was upset with her mother for stopping her, but she also knew that they did need bread and a few other groceries, so she stopped to check to see if she had any money in her wallet. She discovered that she did not have money and had to go into her mother's room to ask for some. Her mother then began to criticize her for always needing cash. Ms. Robinson began to defend herself, which delayed her departure even further. By the time she got out the door she was too upset to immediately get on the bus, so she stood outside for a few minutes trying to pull herself together.

After Ms. Robinson described this incident, Mr. Andrews empathized with her frustration and said that it made sense that she had been late. He asked if this kind of interaction with her mother happened often. At first she said no, but then, as they continued to unpack her tardiness, she acknowledged that she was late to many activities, and often felt so ashamed of being so late that she did not even attend events and activities that she had been anticipating with pleasure. Mr. Andrews asked if she could think of any other ways to deal with her mother's frequent last-minute requests. As they came up with some possible responses, Ms. Robinson spontaneously commented that she thought that her mother was jealous of all of the attention she was getting at the hospital. "It's crazy," she said. "I don't want to be coming here. I want my baby to come home." Fonagy, Gyorgy, Jurist, & Target (2003) view the process of imagining what someone else is thinking and feeling (what they call "mentalizing") as an important step in the development of the self. Mr. Andrews integrated this idea into his work as well, asking Ms. Robinson to talk a little bit more about how she understood what her mother was feeling. As a result of both understanding her mother's feelings and simultaneously becoming more comfortable setting limits with her mother (with Mr. Andrews' support and specific suggestions), Ms. Robinson began to feel that she had more control over the process of leaving the house and began arriving on time for her appointments. Furthermore, she spoke of feeling more comfortable setting limits with her boyfriend and with her children, something that had been an unspoken problem for her.

One day Mr. Andrews walked into the boy's hospital room and found Mrs. Robinson and her mother, the child's grandmother, engaged in a quiet although intense conversation. Her mother spoke pleasantly to Mr. Andrews, then left the room, giving her daughter a hug. Ms. Robinson looked at the clinician. "We could never have done that before," she said. "I don't know exactly what has happened, but I feel like a very different person from when my son came to this hospital." She hesitated for a minute, then said, "That's not quite right. I think I feel like myself—only more." When Mr. Andrews encouraged her to say more, she said, "It's kind of hard to put into words. And it feels a little silly to say. But I sort of feel like I know what I'm

feeling now, and I know what to do with those feelings. And that means…I'm just more okay being who I am. I don't have to defend myself to anyone anymore—not to my mother, not to my sister, not even to you. And I guess that makes me less prickly. And makes it easier to be me."

Integrating these different approaches sometimes seems almost spontaneous, which is one of the reasons integrative therapy is often called eclectic. However, it often only takes a moment for a clinician to recognize why he has "shifted gears" with a particular client at a particular time. Understanding why we make some of these spontaneous shifts can lead to a practice in which we make thoughtful and well-reasoned decisions to bring in a different technique at any given time. Let us turn briefly to an overview of the major cognitive behavioral therapies in order to see more clearly how and when they can be utilized in an integrative practice.

Overview

There have been several phases of development in cognitive and behavior therapy, which have been an important part of the therapeutic community's repertoire since the 1950s (for an extensive discussion of the development of and similarities and differences between these theories, see Hayes, 2004). In a very general way, cognitive therapies are based on the idea that thoughts can influence feelings and that emotional responses to a situation can come from thoughts about that situation, including how one might interpret or explain it to oneself, while behavioral theories tend to view problematic thoughts and behaviors as the result of reinforcement from a person's environment. As we consider the history of these approaches, it becomes clear that an integrative process has been going on in the development of contemporary cognitive and behavioral techniques. Early behavioral therapy focused on altering the results of this spontaneous or accidental rewarding of behavior (Skinner, 1957). Critical of a psychodynamic search for unconscious meanings to explain problematic behavior, early behavioral therapists suggested that psychological problems could be understood as the result of positive and negative reinforcement (see Bandura, 1986). Thus behavioral therapies tended to focus on helping clients try new behaviors and to stop allowing negative reinforcement to dictate how they act and what they do. However, Ellis (1961), with his Rational Emotive Behavioral Therapy, or REBT, integrated cognitive concepts aimed at helping clients change critical and self-defeating thoughts and behaviors through recognizing the problematic beliefs that are linked to these thoughts and actions. For example, an REBT therapist would try to help a client change thoughts that he "should" or "must" do certain things or "be" certain ways into thoughts of self-acceptance and self-empowerment. Following Ellis, Beck (Beck, 1976; Dozois & Beck, 2010) developed Cognitive Therapy in the 1960s. There are many similarities between REBT and CT, including the attempt to identify what Beck calls "automatic thoughts" that contain distorted and problematic information which contributes to depression, and to change those thoughts into more realistic and self-empowering ones. Beck (1976)

also discusses the importance of "core negative thoughts" that are often part of the automatic thought process and that lead to depression. Such thoughts may include things like "I'm a failure" or "I am stupid," that a client may automatically think in response to disappointment and other problematic experiences. In other words, clients may blame themselves for something for which they actually bear no responsibility, thus adding to a sense of depression and self-defeat. CT today uses a combination of behavioral approaches to improving self-care and building confidence and verbal techniques for changing negative and automatic thoughts into more realistic and positive concepts.

Integrating Cognitive Behavioral Therapies

In what Hayes (2004) calls the "second wave," the focus turned more specifically to the maladaptive thoughts instead of problematic behavior. In his classic book on cognitive behavior therapy (CBT), Beck (1976) elucidates how altering certain maladaptive ideas and beliefs can lead to changes in behavior which then leads to improvement in both mood and self-esteem. Focusing initially on depression, Beck (Beck, Rush, Shaw, & Emery, 1979) suggested the disorder was often preceded by a series of negative thoughts. He found that by first identifying and then questioning the validity of these thoughts, clients could learn to change habitual patterns of cognition that led to the depressed state. Beck and his followers (e.g. Burns, 1999) continued to critique insight-oriented work as both inefficient and also based on invalid assumptions. From their perspective, trying to explore psychodynamic meaning could actually interfere with a client's therapeutic progress.

However, like Connors (2006), I have found that it can be extremely useful to integrate some of these ideas into a more psychodynamic approach. For example, a detailed inquiry (Sullivan, 1953) into the apparently insignificant and often concrete aspects of experience that a client feels are too silly to talk about can lead to a discussion of some of the assumptions a client makes about what certain behaviors—his own and those of others—mean. In a detailed inquiry a clinician engages with a client in a conversational and non-threatening manner in order to gather information about a wide range of features of that client's current and past life. Some assumptions that a client has made and taken for granted may be part of the reason that he feels self-critical, hopeless or anxious. A clinician can have a surprising impact on the chain of thought that leads to these feelings by commenting that he has a different perspective on the situation and asking if a client would like to hear it. Further, one can also expand a client's repertoire of reactions by bringing in the idea of mentalization (Fonagy, Gyorgy, Jurist, & Target, 2003). For example, asking for an elaboration of a client's understanding of what might be going on in the mind of the other person involved in a certain interaction can both help stimulate mentalization and also broaden a client's perspective on a situation.

However, clients cannot always simply "let go" of these assumptions. One of the difficulties with CBT as it was practiced during this period arose when clients felt

self-critical because they could not follow through on the assigned goal of changing problematic thoughts. For example, Elaine, who sought help for low self-esteem and difficulties in relationships, talked about crossing the street when she saw a colleague "so that he did not have to say hello to me." She also described phobias based on fears that she said she knew were irrational. The cognitive behavioral therapist with whom she worked helped her focus on changing the maladaptive thoughts that went with each of these symptoms. For instance, he suggested she tell herself that there was no evidence that the colleague did not want to speak with her, or that the elevator she was getting on would get stuck between floors. The therapist taught her to remind herself that her feelings of poor self-esteem or anxiety were due to problematic thoughts, not to facts or reality. Yet because she was unable to master her thoughts, Elaine became even more self-critical and despondent. "There's really something wrong with me," she said to herself. "I can't even get the assignment right."

Cognitive behavioral therapists now view such maladaptive thoughts as common and frequently difficult to alter. Because many clients like Elaine reported feeling even worse when they could not change their thinking as instructed, contemporary CBT techniques have shifted significantly.

Recent Developments in Behavioral and Cognitive Therapies

In what Hayes (2004) calls the third wave, which he says draw from both the cognitive and behavioral "wings" of the earlier approaches, therapists emphasize changing a client's relationship to his thoughts rather than changing the thinking itself. Dialectical Behavioral Therapy (DBT), Acceptance and Commitment Therapy (ACT) and Mindfulness Based Cognitive Therapy (MBCT), for example, have addressed some of these issues by integrating ideas about self-acceptance and mindfulness into the work of disrupting and shifting rigid thought patterns and concomitant behaviors and feelings. Problematic thoughts and feelings are now observed and accepted in a mindful manner as part of the change process. However, Dozois and Beck (2010) suggest that some form of acceptance has always been part of Beck's formulations of cognitive therapy and that despite some philosophical differences between mindfulness and acceptance-based and traditional cognitive approaches, the two styles are both compatible and complementary. Similarly, Burns (1999) proposes that by focusing on and labeling "automatic thoughts" one develops the ability to become aware of those thoughts in ways that are compatible with ACT.

DBT, which focuses on the dialectic between acceptance and change, was developed by Linehan (1993) in the 1990s to help people with Borderline Personality Disorder who are often overwhelmed by their emotions and find traditional therapies less than helpful for managing their feelings and their often problematic behaviors. Linehan added a number of emotionally soothing, self-accepting, and relationship-building practices to cognitive therapy, making the practice useful for clients with a wide range of symptoms involving difficulties managing intense emotions.

DBT is a highly structured approach that often integrates individual therapy sessions with skills-building groups (see Ekblad, Chapman, & Lynch, 2010). Mindfulness practices from the Zen Buddhist tradition are also integrated into a DBT practice. Although Linehan was one of the early leaders in this direction of integrating mindfulness with CBT practice (see also Kabat-Zinn, 1990), today some form of mindfulness practice is part of many CBT techniques.

Another recent addition to the CBT repertoire is Acceptance and Commitment Therapy (ACT) developed by Hayes (2004). Like Dialectical Behavioral Therapy, ACT integrates meditation-oriented mindfulness practices into a therapy which is aimed at helping clients observe what they are thinking without making judgments (acceptance) and learning to distance themselves from distressful and unhelpful beliefs (cognitive defusion) rather than getting caught up in the beliefs that accompany those thoughts (cognitive fusion). Mindfulness Based Cognitive Therapy (MBCT) (Segal, Williams, & Teasdale, 2012) offers an 8 week program for using mindfulness and other cognitive techniques to help clients with depression and encouraging mindfulness on the part of clinicians as part of the therapeutic approach.

Today CBT is often used as a broad or general label for a variety of focused and structured psychotherapeutic approaches for dealing with difficult emotions, behaviors and thought processes. These approaches often utilize specific activities and techniques to help clients identify and then make shifts in how they handle thoughts, feelings and actions that have created and maintained difficulties in their lives. In contrast to more exploratory, open-ended psychodynamic models, behavioral interventions tend to be activity-based and goal-oriented. They also focus more on the here and now than on a client's past.

Behavioral and cognitive therapy is currently utilized for a variety of conditions and diagnoses, including mood, anxiety, personality, addictions and eating disorders. It also frequently targets specific symptoms, such as phobias, fears, sleep problems and impulsive behaviors. The new approaches incorporate a contemporary understanding that clients often need help developing tools for regulating and managing disruptive emotions. One of the "dialectics" of DBT is actually shared by many integrative approaches: simultaneously helping clients begin to recognize and accept themselves and the reality of their lives (sometimes called radical acceptance) while also working to learn new ways to manage their own feelings and behaviors. Like a wide range of psychodynamic, Buddhist and mindfulness practitioners (e.g. Bromberg, 2001; Epstein, 2004; Kohut, 1971, 1977; Nhat Hanh, 1992), these clinicians have found that acceptance itself can actually lead to change.

Although many clinicians and theorists point to the evidence that cognitive behavioral therapies are highly successful treatment techniques, some recent research (e.g. Wachtel, 2010; Wampold & Brown, 2005; Watzke et al., 2010) has questioned whether contemporary beliefs that one treatment is more effective than another for specific disorders is completely accurate (Table 4.1). For example, although panic disorders were once believed to respond best to behavioral and medical interventions, Westen and Morrison (2001) report that a mix of interventions, including psychodynamic therapy, appears to be the most beneficial in the treatment

Table 4.1 Behavioral and cognitive therapies

Type of therapy	Basic concepts	Founding theorists
Classical conditioning	Introduced concepts of learned conditioned responses	Ivan Pavlov, John Watson
Behavioral therapy	Positive/negative reinforcement of behavior	B.F. Skinner
Rational emotive behavioral therapy	Through structured activities, change distress-producing beliefs to empowering new beliefs	Albert Ellis
Cognitive behavior therapy	Identify "automatic thoughts," recognize the distortions contained in them, and work towards developing more realistic and self-empowering new thoughts	Aron Beck, David Burns
Dialectical behavioral therapy	Through behavioral and mindfulness techniques find a balance (dialectic) between acceptance and change	Marsha Linehan
Acceptance and commitment therapy	Using self-acceptance and mindfulness practices, step back from thoughts and observe and accept them without buying into them	Stephen Hayes
Mindfulness based cognitive therapy		Zindel Segal

of these disorders. These findings fit far more closely with my own anecdotal and clinical experiences over the past 30 years in the field. From this perspective, rather than focus on a particular type of therapy as more effective than another, it seems that a more useful approach is to try to determine what interventions will work best for a particular client at a specific time (see also Stolorow, 1975)—and what interventions a particular clinician is most successful at using, Such a pragmatic, integrative and realistic approach would directly counteract the concerns I have heard expressed by more than one client over the years, but most succinctly by a client who said, "If this therapy is supposed to work so well, and I'm not getting better, then either you're a lousy therapist or I'm a lousy patient."

Of course, this is exactly the conclusion one hopes a client will not draw, yet at times it is true that a therapist may not be applying techniques correctly and a particular approach may therefore be compromised. Obviously, some symptoms can take far longer to ameliorate than others. A client's goals, motivation, compliance and capacity for change can dictate the speed at which they start to see differences. In other words, someone who wants to make deep personality change in the course of therapy will need to wait longer to see results than someone who has a specific behavioral shift in mind. However, it seems to me that any client should have a sense that *something* is happening in the therapy within 2–3 months, even if it is only a minor or small modification in their mood or circumstances. When this does not happen, both therapist and client should take stock together and separately to determine either what might not be working or what they might be missing. When it seems that the particular approach that a clinician is best trained for is not going to bring about change, at least without further help from other sources, a therapist may

refer a client to a professional who specialize in a technique that they believe will be helpful but that they do not practice themselves. When this occurs, both therapist and client need to agree on the way that they are going to integrate these approaches. In some cases, clients will stop seeing one therapist while working with the other. At other times, the therapists will work together as a team. In either situation, as we will discuss further in Chap. 9, both therapists will need to be sensitive to issues such as splitting and competition that can interfere with the therapeutic process, even in the best of teamwork.

Clinical Example

In the following example, all of the above difficulties emerged at different times, but because the therapists worked closely with one another, they were able not only to defuse a possibly explosive situation, but also to utilize their interactions with one another and with the client to enhance the therapeutic work.

Ms. Conrad, a primary school teacher, was in her mid-twenties when she sought help for her obsessional thoughts and compulsive, ritualistic behavior. For example, she had a morning routine of prayers, yoga and "checking" her house before she left for work. Initially a soothing way to start her day, the rituals had become so involved that she was often late for work. "I've tried getting up early to give myself more time," she said, "but I ended up adding another ritual to the routine. Instead of walking around the house three times, now I have to do it a fourth time. So I'm still late." She had been told that a combination of cognitive behavioral therapy and medication were considered the most successful techniques for the kinds of symptoms she was struggling with, and she felt lucky to have found Dr. Aikens, who was both a psychopharmacologist and a CBT practitioner. After doing a thorough psychosocial assessment and requesting that Ms. Conrad also get a complete physical checkup, Dr. Aikens started her on a low dose of the antidepressant Paxil and asked her to keep a record of some of the rituals and obsessional thoughts she had described as most problematic. He then asked her to choose one behavior that she would be willing to work on shifting. He gave her some assignments and worksheets to follow, and she eagerly began the work.

Ms. Conrad, who was charming, smart and very likeable, seemed to be trying her best to follow the routines. She filled out her daily worksheets and brought them to her therapy sessions without fail. She described her attempts to follow the routines. She did her homework. But she did not seem to be getting better. Dr. Aikens raised her Paxil, but Ms. Conrad hated how she felt on the medication. "I'm tired all the time," she said. "And I don't feel like myself." Dr. Aikens asked her to try to stay on the medication a little longer and to keep working on her homework assignments. Ms. Conrad did so, but complained that she was having difficulties concentrating. Dr. Aikens liked Ms. Conrad a great deal, but was becoming somewhat frustrated. He wondered if she was truly being compliant with her homework and with her medication. He had just decided to push her a little bit harder when she came into a

session and said that she was worried that she was not doing the work the right way. "I mean, shouldn't I be feeling better?" she asked.

"I'm sure it's something I'm doing wrong," she added. "You're wonderful, and I know I could be feeling better if I would work harder." Dr. Aikens asked her how she thought she might work harder. "I don't know. I was hoping you would have some suggestions." He asked if she was doing her homework. "Oh yes," she said. "But I know you must be feeling frustrated with me." Dr. Aikens attempted to look at some of the ways in which Ms. Conrad might be avoiding the work. Like Mr. Andrews, he worked to help Ms. Conrad be clearer about her motivation to change, and at the same time he attempted to unlink her thoughts and behaviors from the patterns into which they had fallen. But nothing he did seemed to work. He consulted with a colleague who suggested that Ms. Conrad did not want to get better. He thought this might be part of the picture, but he also thought that she did want to get better at the same time. Finally, he decided that it might be useful for her to work with a psychodynamically oriented psychotherapist to try to untangle her conflict about disengaging from her symptoms. When he presented this idea to Ms. Conrad, she initially expressed concern that she had disappointed Dr. Aikens. He told her that she had not, but that he was concerned that he was not helping her. He also said that, if she was willing to do so, he would like to continue to work with her as she worked with the new therapist. He could see her visibly relax as he clarified that he was not rejecting her, but that he was seeking further help for her.

Therapist/Client Relationship

Authors who have described integrating cognitive behavioral techniques with psychodynamically-oriented ones have focused on the importance of the relationship between therapist and client (Connors, 2006; Frank, 2004, 2005; Wachtel, 1997). As we have noted earlier, research (e.g. see Freedman, Hoffenberg, Vorus, & Frosch, 1999; Norcross, 2002; Roth & Fonagy, 1996; Wampold, 2001; Wallerstein, 2000) has also indicated the importance of this relationship in any therapeutic endeavor. Dr. Aikens' training had not focused on this aspect of the work, but he recognized that he had become important to Ms. Conrad and that her apparent resistance to the work was neither a rejection of him nor a commentary on the efficacy of the treatment technique. He referred Ms. Conrad to a colleague with whom he had both consulted and worked on other cases, a woman who he knew would focus on some of the issues that might be emerging in Ms. Conrad's feelings towards himself and, possibly, over time, towards her as well.

Connors (2006, 2011) describes a two-pronged approach based on the need for "self-regulation" and "self-initiated behavior change." I think of this as the need for help with self-regulation and self-soothing in order to do whatever other work one has in mind—whether it is exploration of meaning (psychodynamic), acceptance (mindfulness), body work, motivational interviewing, harm reduction, group or family therapy, or compliance (with medication, clinic or agency rules and

regulations, therapeutic goals, etc.). Wachtel (2010) integrates the relational aspects of the therapeutic interaction with specific cognitive and behavioral tasks, and Frank (2001) describes integrating understanding and exploring with behavioral techniques. Mitchell (1993) offers an example of this, noting that he often gives clients concrete "homework" assignment that they do not complete. According to him, what is most important is not the work itself, but the use of it in a psychodynamic exploration of the reasons that they failed to follow through.

I have discussed integrative work with therapists who have many different perspectives on cognitive behavioral work. Among the therapists with whom I spoke, I found that many felt that they integrated a number of other techniques and theories into their work, including psychodynamic, mind/body, and mindfulness concepts. Often psychopharmacological intervention is considered an adjunctive treatment as is working as part of a team with clients who were being seen for long term psychodynamic work as well. I also found among psychodynamic, body/mind and developmentally-oriented practitioners that behavioral techniques were often integrated into the work. It is often difficult for a clinician to tell whether the mixture of techniques is intentional or pragmatic. In fact, it is sometimes only after the fact that one realizes that one has been working behaviorally or educationally or psychodynamically at all. In my own work, I have found that offering cognitive and/or mindfulness techniques or even simple suggestions for self-soothing—such as going for a walk, listening to music, taking a bubble bath, calling a friend, watching a TV show—brings the question of managing affects into the therapeutic conversation in a concrete and manageable way. In much of the work in which psychodynamic work is integrated with behavioral techniques, the relationship is considered to be a crucial component of the work even though, as discussed above, when it comes into cognitive behavioral work it is generally considered in very specific ways.

One study (Westra, Aviram, Barnes, & Angus, 2010) found that clients often are surprised by aspects of their CBT experience. According to the study, 84 % of respondents said that they had expected more direction and less responsiveness from a therapist and were pleasantly surprised by their therapist's interest in making it a collaborative experience in which they could choose the therapy's direction rather than being told what to work on. These respondents also were pleased that their therapist was less judgmental than they had expected. In other words, clients were more comfortable with the process and learned more than they had anticipated. There was also some sense that it could be helpful to discuss the past, even though many clients were happy to focus only on the present. The majority of respondents also said that they had worked harder in therapy than they had assumed they would.

Most cognitive behavioral techniques, however, focus on helping a client become capable of doing the work him or herself. While in psychodynamic approaches, delving into the relationship with a particular therapist is considered an important part of the therapeutic process, in cognitive behavioral work the relationship is important in that it aids a client in learning new ways of thinking about his own ideas and feelings. Traditional techniques that focus on a client's distorted thoughts

about therapy or his therapist can rupture the work by damaging the therapeutic alliance (Castonguay, Schut, Aikins, & Constantino, 2004). In both cases, the relationship is a tool, but the ways in which that tool is used are somewhat different. We will discuss this in more detail in Chap. 8 when we look more closely at the role of therapeutic relationships, but for the moment let us note that these different approaches each have value in an integrative practice. Sometimes it can be useful to explore some of the thoughts and feelings a client has about her therapist, but sometimes to do so can interfere with the work, even in a psychodynamically-oriented approach (see, for example, Bromberg, 2001; Kohut, 1977).

One place that these two approaches can converge is in the area of resistance. Working to build a strong therapeutic alliance, and utilizing both motivational interviewing (that is, helping clients recognize why they might want to change), acceptance (change is hard), and specific tools for making those changes, cognitive behavioral therapists work to manage this resistance without focusing on a client's history or unconscious conflicts. Resistance, or therapy interfering—behavior, such as failure to do assignments or to show up for sessions, is an important part of the process for cognitive behavioral therapists just as it is for psychodynamically-oriented therapists. When a client fails to carry out assignments or to follow through on activities or is consistently late for appointments, a psychodynamically-oriented therapist might ask questions meant to open up why the client might be behaving in this way, and a cognitive behavioral therapist might use motivational interviewing techniques to open up why the client wants to change. A DBT approach is also to highlight the behavior and then do a chain analysis, which Chapman (personal communication) calls "talking the behavior to death." This is a minute and detailed discussion of what led up to the moment—a "mini-analysis" of the events and experiences that led up to an incident. The idea, from both ACT and DBT, is that one talks the incident to the point of removing the instigating factors from the equation (see Hayes, 2004) so that a client begins to do the necessary tasks, to get to therapy on time, or to do the homework. In motivational interviewing, however, resistance is believed to be the result of a disparity between a client's current stage of change (DiClemente, 2006) and a clinician's expectation or belief in how ready that client is or "should be" to change. A clinician's task is to deal with this disparity separately from the therapeutic work—for example, when a therapist is feeling overburdened by too many client phone calls, bored or simply not invested in the process, it is the therapist's responsibility to work on those problems, perhaps by going for further training or by using some of the therapeutic tools personally.

Interestingly, although there are philosophical, theoretical and technical differences between a chain analysis and Sullivan's (1953) detailed inquiry, there are also many similarities. More importantly, many of these ideas can be integrated in order to work with different aspects of a client's needs at different times—or with different clients with similar symptom pictures but different personalities. For instance, when a client is either consistently acting out or having difficulty moving more deeply into the therapeutic work, a clinician may ask for specific details about where that client lives, what his living situation is (e.g. who else lives with him), how he gets to work, what time he has to get up in the morning to get to work on time, and what his morning

rituals consist of. As I have described elsewhere, such detailed inquiry into the daily activities of someone with an eating disorder or other addictive or compulsive behavior can reveal useful data about how a client manages affects and what routines (or lack thereof) complicate her life (Barth, 1998). Kanter (2013) notes that a detailed inquiry offers a therapist an opportunity to begin to note patterns and inconsistencies that can help in the formulation of interventions and tools that will be most useful to that client. And as we have noted throughout this book, an integrative practice is a practice that attempts to match therapeutic interventions with client needs and clinician's abilities.

Chapter 5
The Body-Mind Connection

Keywords Body-mind • Alternative therapies • Mindfulness • Cognitive • Behavioral • Development • Therapeutic openness • Therapeutic curiosity • Clinical illustrations • Research • Evidence-based • Acupuncture • Yoga • Drug addiction • Headaches • Somatic complaints • Hypochondria • Defense • Couples therapy • Referrals • Teamwork

The intricate interplay between a human body and the mind that inhabits it perfectly illustrates an integrative process in action. Although at times they have been viewed as distinct and separate entities, today we consider body and mind to be mutually influencing, collaborative components of an overall whole. Physicians, mental health clinicians and clients themselves have become increasingly aware of the relationship of body and mind in both physical and psychological health and distress (e.g. Eccleston, 2001; Wolsko, Eisenberg, Davis, & Phillips, 2004). Almost two thirds of patients seeking aid for neurological distress like migraines also try "alternative and complementary medicine" (Wahbeh, Elsas, & Oken, 2008, p. 2321). Barnes, Bloom, & Nahin (2008) provide a chart (reproduced below) of the ten most common alternative treatments sought by patients. These included natural alternatives, breath work, meditation, chiropractic and osteopathic, massage, yoga and diet-based therapies, progressive relaxation, guided imagery and homeopathic treatment.

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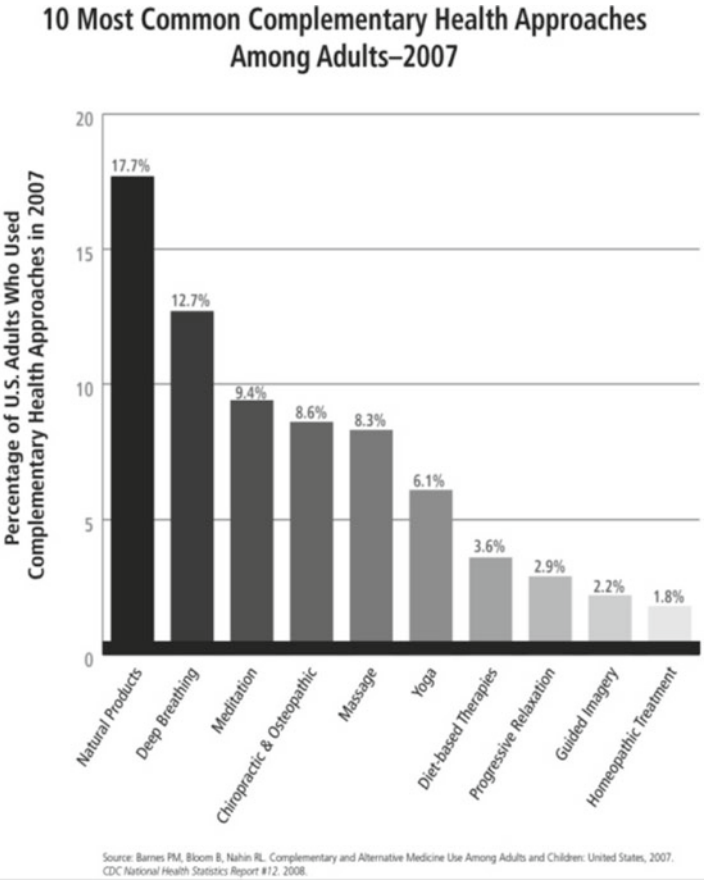

Although investigations into the impact of some of these interventions on psychological disorders are not extensive enough to be definitive (see Roth & Fonagy, 1996; Wachtel, 2010), there is certainly enough research and anecdotal evidence indicating that alternative or mind-body interventions have an impact on a number of aspects of physical and psychological disorders (e.g. Astin, Shapiro, Eisenberg, & Forys, 2003; Brown & Gerbarg, 2012; Barnes, Bloom, & Nahin, 2008; Damasio, 1999; Levine, 1997; Linehan, 1993; Rustin, 2012; Schore, 2003; Siegel, 1999) to warrant our thinking about these ideas in our clinical work. Straker (2006), for example, writes that helping clients learn to notice and listen to their bodies can be extremely helpful for suicidal clients. Stolorow's (1975) idea that self-harm can be an attempt (among other things) to make contact with the physical self has interesting implications in terms of working with this population (see also Gilligan & Machoian, 2002).

This does not mean that we need to actively engage in these alternative forms of treatment ourselves. In fact, as is true with other techniques discussed in this book, one should be trained in any intervention that one makes with any client. An integrative practice makes room for a client to explore alternative possibilities, with a clinician

finding ways to be both interested in and curious about what these adjunct therapies might mean to our clients. Here is a brief example of how this can work. I was seeing a businessman in his forties for traditional psychodynamic psychotherapy. As a result of some family issues, he also began working with a DBT clinician, who taught him some mindfulness techniques. He was particularly impressed by the idea of taking a moment to pay attention to his physical experience. "I never in my life thought to simply stop and ask myself what I was feeling in my body," he told me as we discussed the experience. This man had a history of impulsivity which we had been exploring in his individual therapy. I asked him if he thought he could use the mindfulness technique he was learning in DBT in his individual work with me. Hesitant at first, he found that it was extremely useful as we opened up material that had previously been too overwhelming for him to tolerate and that had sometimes led to impulsive acts after a particularly difficult therapy session. Like many clinicians, I had long been aware of the importance of encouraging clients to pay attention to physical manifestations of emotions, but this was a reminder that sometimes clients need to be taught simply to pay attention to their physical experiences as a goal in and of itself. I would suggest that this is one of the crucial and often unarticulated components of integrating body and mind in clinical work: that is, the body is not simply a metaphor or a symbol, but is also an actual meaningful reality. Let us turn now to some ways that a clinician can think about and organize the integration of both symbol and reality of body and mind into clinical work.

It is outside the scope of this chapter to try to detail all of the body-mind therapies available today. Putting aside homeopathic and alternative medications as being outside the purview of this discussion, we will look instead at five general groupings suggested by the alternative therapies listed above: (1) breathing and relaxing techniques; (2) direct body-based intervention; (3) diet and nutrition; (4) exercise; and (5) meditation and mindfulness. There are a number of ways in which these categories overlap with one another, but taken together they provide a useful outline for exploring the integration of body and mind in clinical social work practice. Much of the evidence that we have discussed throughout this book points to the role of several key themes in any therapeutic process: affect regulation, self-awareness, supportive relationships, self-esteem and a sense of security and safety. In this chapter we will look at some ways that body-mind issues can help enhance therapeutic work with these issues.

It is my hope that the chapter will help clinicians become more comfortable discussing a variety of the links between body and mind that are not always brought into talk therapy. Referring clients for adjunct work—e.g. yoga, meditation, acupuncture, nutritional advice and so on—is already part of many clinicians' practice. In this chapter we will consider ways to make use of these experiences—to paraphrase Freud (1893–5)—to bring both body and psyche into the therapeutic conversation (p. 296). Helping clients talk about nonverbal and/or physical experiences that they may not have previously considered part of their psychological or emotional experience can be an extremely important integrative practice. For example, a clinician's encouragement for a client to exercise, get massages or even to take a warm bath to self soothe in times of physical and emotional stress underscores the

link between the physical and emotional aspects of experience. Discussions not only of possible ways of utilizing such activities for self-soothing, but also of a client's sometimes surprising resistance to these suggestions can be can be an invaluable addition to any therapeutic process. In some cases these conversations can awaken old and deep connections between body and psyche. In others, new skills for self-management become quickly integrated into a client's emotional repertoire.

Another brief example, this time from my own initial foray into therapy, illustrates that a clinician doing "nothing more" than talk therapy can integrate body-mind material into the therapeutic process.

I was a recent college graduate with a low paying job. I wanted to start psychotherapy but had no idea about how to find a therapist I could afford. A new roommate offered a key not only to that door, but also to another unmet wish that I did not, at the time, realize was connected to the first. She told me about a clinic near our apartment where she was seeing a therapist, and when I expressed an interest she encouraged me to call for an appointment. When I also expressed my admiration that she was taking a ballet class, she invited me to come with her to try one out. I was quickly hooked on both experiences, and although I did each only once a week, within a few months I told my therapist that I felt like I had received a blood transfusion, like blood filled with oxygen and nutrients was flowing through my body and my brain. "It's like I can feel the tips of my fingers and toes for the first time," I told her. My therapist asked about the feelings, and we talked about many different aspects of the dance classes, including not only what we actually did in them, but also many complicated feelings (e.g. of simultaneous admiration, competition, and envy) that emerged in relation to my classmates. Psychotherapy and dance soon became entwined components of my personal and professional therapeutic development even though they were never actually physically combined (I never did dance therapy, for example).

In the years since then, I have heard comments about the interaction of psyche and bodywork from many clients. One client who began psychotherapy, meditation and yoga simultaneously told me, "I actually feel like I can see colors and hear sounds more clearly, but it's more than that. It's like I can hear my thoughts and feel my feelings more distinctly…like I'm wearing internal glasses and things that were once blurry are now distinct and sharply outlined." Although I might have wished to take full credit for this experience, I believe it would have been a false assumption on my part. It seemed to me that her sense of clarity came from opening up channels of communication between her body and her psyche, and that the talk therapy, yoga and meditation had all contributed to this process. I would suggest that this is one of the goals of any body-mind work—to open channels of communication between body, mind and psyche. There are a number of ways that this can be done. As the previous examples suggest, the work can be done by a clinician who recognizes and verbally explores links between a client's physical and psychological or emotional experiences. But with some clients, it is also helpful if a clinician is familiar with some techniques for managing body-based affects in the clinical process (for some useful examples, see Connors, 2006; cancer.org 2008, 2011; Frank, 1999; Linehan, 1993; Wachtel, 1997).

Before turning to a discussion of some of the ways that an integrative practice can bring body-mind dynamics into the clinical work, let me address one other component that is crucial to all therapy, but that stands out as particularly significant when working with body-mind issues.

Boundaries and Training

As in all therapeutic work, it is extremely important that clinicians observe professional and ethical boundaries with clients at all times (see Gabbard & Lester, 1995 for further discussion of this extremely important issue). Not only must any hands-on work be completely professional, but it must be well-thought out and thoroughly discussed with a client before it is put into practice. It might seem that a tense and frightened client would benefit from a gentle massage of neck and shoulders, for example, but the contact could be experienced as a sexual overture and/or a potential repetition of childhood abuse to which the client has no recourse except to submit. Even when clients request body work, their current psychological state and past history must be thoroughly assessed and factored into any decision to implement such work (e.g. Craige, 2013). Ongoing discussion of a client's response to the therapy is also crucial in order to determine if he is having any sort of problematic reaction to any intervention.

Again, it is important for a clinician to be thoroughly trained in any area in order to integrate it into the work. As in my own experience of spontaneously integrating experiences from dance class into my work with a traditional talk therapist, and as I further discuss in Chap. 10, an integrative approach can consist of a clinician's active incorporation of different techniques. It can also be reflected in work with a more or less structured team which, along with a clinician, addresses different aspects of a client's dynamics and/or needs. Thus a referral to a specialist in body therapies, like a referral to a psychopharmacologist, nutritionist, art therapist, DBT or ACT specialist, can be viewed as part of integrative work.

Let us turn now to some of the different types of body work that have been integrated into talk therapy over the years. The following table will provide an overview of some of the major areas of thought in this area (Table 5.1).

Before turning to the specific headings in the table, let us discuss one topic that can be seen in almost all of the categories: trauma theory.

Trauma Theory and the Body

Trauma theory looms large in any discussion of body and mind therapies and techniques. It is the one area in which body and mind are most commonly and regularly brought together in clinical work, and the recent expansion of and focus on trauma

Table 5.1 Body-mind concepts and therapies

Model	Basic concepts	Focus of theory	Theorists	Practice applications
Breathing and breath-work	Breath is the "portal" to the body-mind system (Brown & Gerbarg, 2009)	Using breathing to change open inner awareness	Brown & Gerbarg; Chapman & Linehan; Descilo, Vedamurtachar & Gerbarg, et al. Hayes; Raja; Connors; Wachtel; Ogden; Elliot	Breath counting and monitoring to relax, manage anxiety, aggression and other strong affects
Meditation and mindful-ness	Meditation opens the mind to all thoughts without judgment or criticism, mindfulness focuses the mind—both promote self-awareness and relaxation	Slowing down and becoming more accepting of self	Benson; Kabat-Zinn; Chapman & Linehan; Epstein; Hayes; Linehan; Siegel; Thich Nhat Hanh; Van der Kolk Kabat-Zinn	Meditation is used to help clients relax and become less critical of their thoughts and feelings. Mindfulness is used to help clients recognize feelings for what they are
Energy work	Various techniques for opening physical and emotional energy flow, which may be blocked because of fears, anxieties, and other causes	Releasing and rechanneling energies for healing mind and body	Alexander; Callahan & Trubo; Eden & Feinstein; Fehmi; Feldenkreis; Kabat-Zinn; Shapiro; Numerous others	QiGong, Reiki, Bilateral stimulation, Sensorimotor work, therapeutic touch, Feldenkreis, Alexander technique, Biofeedback, Acupuncture, Acupressure, Massage, Zero-balancing, lights (e.g. for depression), and a variety of other methods attempt to open blocked energy and rebalance the mind

Diet, nutrition exercise and movement	Nutrition, diet, & exercise have an important impact on mental health	Balancing physical well-being to help psychological health	Linehan, Hayes, McClintock Greenberg, Connors, Buyback, Blumenthal, Herman, Kari; Burks & Kelley; Strophe; Brown & Gerbarg, Numerous others	Some, such as DBT, theories of eating disorders, addictions, and other impulse and affect regulation disorders, and geriatric work actively integrate these ideas into the therapeutic process. Others, such as psychodynamic psychotherapies, discuss the links and encourage clients to make use of this knowledge
Physical manipulation of the body	Unexpressed Or unrecognized emotions are the cause of certain physical symptoms. The body "holds" unformulated or Unverbalized experiences		Feldenkrais; Janov; Levine; Lowen; Ogden; Reich; Rolf; Traeger; Numerous others	Alexander technique, Rolfing, Primal Scream, Traegerwork, Feldenkrais, Sensorimotor psychotherapy

theory (perhaps a sad commentary on the world in which we live) has ultimately brought body and mind work to the attention of many more clinicians. Almost all of the categories listed in the chart above have been integrated into some aspect of contemporary trauma theory. The treatment of trauma is an important specialty, one to which even a brief summary cannot do justice. Research into the most effective tools for working with a wide range of traumatic experiences is ongoing. For the purposes of this chapter, I will simply note that almost every theoretical approach to clinical work has addressed questions of trauma in some way (see also Brandell & Ringel, 2011). However, there are still ongoing controversies and questions about the best ways to address trauma (e.g. see Boulanger, 2007; Mischel, 2009; Shedler, 2010). Because research is not always definitive (see also Burks & Keeley, 1989; Carr, 2011; Gaudiano & Herbert, 2000; Roth & Fonagy, 1996), we are clearly in need of further data on the subject. Rather than try to summarize the wide range of thinking on the topic, what I will focus on in this chapter is that this is an area of clinical work in which integration, not only of body and mind but also of interventions, is recognized as paramount.

Bringing the Body into a Therapeutic Conversation

Most of us do not need research to convince us of what we have learned from experience: that diet, nutrition and exercise can have a positive impact on a number of psychological and emotional issues and disorders, ranging from depression to anxiety, to eating disorders to addictions and other disorders of affect regulation and impulse control, and from populations ranging from childhood to the elderly. There is, however, research underscoring this belief (see e.g. Babyack et al., 2000). Because these issues are also part of the popular culture, they are relatively simple to bring into almost any therapeutic conversation. Traditionally, when clinicians have addressed these issues they have had brief discussions about a client's exercise and eating habits. In more recent years, perhaps in part due to the growth of eating disorders, which may have made exploration of diet and exercise almost mandatory, clinicians have become more alert to the importance of more intensive exploration of these behaviors. Linehan (1993) offers specific suggestions of physical activities to be utilized for self-soothing, but a growing number of clinicians now integrate a discussion of how a client might begin to use exercise and food constructively in the management of psychological and emotional difficulties. What clinical knowledge adds to the mix is the understanding that following through on such commonsensical recommendations is not always as straightforward as one might expect.

This is how it worked for Mr. Nolan, who we met in Chap. 2. As his therapist, Ms. Bluen, got to know him better, she began to understand that it was extremely important to him to feel that he was in charge—at home, at work, and even in therapy. She learned that it was much more productive to ask him to explain his own thinking about himself than it was to try to tell him what she understood about him, even if she felt that she had something that might help him deepen his self-perception.

Like some of the clients described by Kohut (1971, 1977, 1984), Mr. Nolan needed her to operate as though she were an adjunct to him rather than a separate person. During one series of sessions, for example, he spoke of his difficulty getting any kind of exercise.

"I used to run," he said. "I really did enjoy it. But now I keep telling myself I'm past that. I don't need it. I don't know what that's about." Ms. Bluen knew from previous interactions with Mr. Nolan that this was not a request for her to give him her thoughts. At some point it might be useful for them to explore this dynamic, but for the moment Ms. Bluen thought it might be more productive to help him articulate his own ideas about this rather unusual idea, that he was "past that." She said, "I know you don't know, but do you have any guesses about what it might be about?" she asked.

"I know I'm a perfectionist," he replied. "I don't like to do anything if I can't do it right. And running…I used to do it really well. Now, I'll have to start from the beginning again…"

Ms. Bluen had several choices. She could have reflected back what she was hearing, that Mr. Nolan did not want to start at the beginning again. She could have asked what would make that so painful. Or she could have suggested that it might not be as painful as he was imagining. Instead of any of these, however, she chose to put what she heard as a dilemma into words. "You seem to want to run again," she said. "It sounds like it really makes you feel better, and maybe works almost as well as a drink to calm you down." He nodded and said, "Maybe better, sometimes." She continued, "But it sounds like to start at the beginning again would be so frustrating for you that it might almost make you feel like you need a drink!"

He grinned. "Bingo. That's the problem in a nutshell." He then went on to elaborate on the difficulties, again almost as though he had made the comments himself. Ms. Bluen encouraged him to talk more about how he felt when he was running, how his body felt, and what was the difference between when he was in shape and how he imagined it would be if he were to run now.

"That's interesting," he said. "My first reaction is that it wouldn't be so very different. One of the things I'm learning in here with you is that there is a process to things. That I can start in one place and gradually move to another. It makes it a little easier to tolerate that gap between what I want to do, what I think I should be doing, and what I can actually do at any given time."

He was silent for a moment and then added, "I have a kind of funny relationship with my body." Ms. Bluen remained silent, waiting for him to continue with his thought. "I don't always believe myself. I mean, sometimes, I think I don't feel so well. And then I start to think that I'm fine, I'm just making a big deal out of nothing. And then I think, 'well, but maybe it's not such a nothing.' Like when I have a headache and don't want to go to work. I'm not ever sure whether I should make myself go and work through it, or stay home and do what I've learned to do till it goes away. Which way will make it go away faster? Sometimes ignoring it is the best thing. Sometimes I'm dehydrated, and I need some quiet space and some silence, and then I'm good to go."

The Body as Container of Unarticulated or Unknown Emotional Experience: Talk Therapy, Breath Work, Energy Work, and Physical Manipulation

The idea that the emotions are influenced by unrecognized or unknown experiences within the physical self can be found in both Eastern and Western traditions. In traditional Ayurvedic practices from the Indian subcontinent, Chinese medicine, and in the work of the Greek Hippocrates, medical interventions took into account an accepted interplay and interconnectedness of people and the universe. Each links temperament, mood and health related to physical elements in the world—for example, air, earth, fire, water, wood and metal (the actual elements are different in different traditions) (NIH, 2013; Reichstein, 1998). Hippocrates believed that health, both psychological and physical, was based on the four "humors" that he considered the human manifestation of the four basic elements of the physical world being in balance (Hansell & Damour, 2008). These beliefs impacted Western treatment of emotional and physical disorders (e.g. the practice of bleeding an ill patient was derived from the theory of the humors). Ayurvedic and Chinese medicine practices have become more popular in Western cultures in recent years, although there are some serious concerns that some of the herbs used to balance the system can themselves be harmful when not properly monitored or prescribed (e.g. NIH, 2013).

An integrative approach recognizes that it is important for clients to process experience both verbally and nonverbally (see for example Connors, 2006; Frank, 1999; Hayes et al., 1999; Linehan, 1993; Greenberg, 2009; Wachtel, 1997). Meissner (2007a) makes the case that this is not a new idea even in the realm of talk therapies. He says that the body has always been and continues to be a crucial part of any psychoanalysis. Freud's ideas about drives were derived in part from his work as a neurologist and his deep belief in the subtle and often unrecognized mutual impact of body and mind (Sulloway, 1979). Not only did he believe that hysterical symptoms were the result of the mind's utilizing the body to avoid unacceptable memories and emotions, but in some of his earliest work on hysteria, Freud (1893) also described a client's body "joining" the therapeutic conversation (p. 296) when a clinician got too close to some of those intolerable feelings and thoughts. Although he was by no means the first to come to this conclusion (see also Gay, 2006, for further discussion of this phenomenon) he brought the idea to popular contemporary culture with his prolific writing, linking non-organically based physical symptoms such as blindness, lameness and an inability to feel or swallow with specific emotion-laden events. His early therapeutic work centered on bringing the unrecognized or unconscious emotions into conscious awareness by having a client talk about what had happened until it no longer remained buried in the body, leading to what his colleague Breuer dubbed "the talking cure" (Breuer, 1895).

Freud soon learned that the path from talk to symptom release was not always a straightforward one, leading to the theory of defense and resistance that has been further explored and elaborated on by numerous psychoanalytic thinkers over the years. Wilhelm Reich, one of Freud's followers, transformed these ideas into

a theory of body armor which both reflects an individual's basic personality and has to be pierced through physical manipulation in order to change a client's psyche (Reich, 2013). Although Reich took these ideas to an extreme, some of his ideas may have influenced numerous body-mind theories. The idea that the body is the site of unexpressed emotion is also significant in contemporary trauma theory. Sifneos (1996) and Krystal (1988) elaborated on the concept of alexithymia, or the inability to utilize language to process emotions created during a time of trauma. Levine (1997) further explored the idea that the body "holds" memories, thoughts, and feelings outside of conscious awareness, and numerous other trauma theories continue to explore these ideas. The assumption is that these aspects of experience are not verbal and that they affect a client's behavior and overall sense of well-being. They are part of the "unthought known" (Bollas, 1989) or unformulated or dissociated thoughts and feelings (Bromberg, 2001; Stern, 1997; The Boston Change Process Study Group, 2010).

Numerous techniques have been developed in recent years to help clients who cannot speak about or use words to help remember and/or process trauma contained in the body. These range from bodily manipulation to bilateral stimulation (e.g. EMDR, EFT), and also include hypnosis, meditation, mindfulness, yoga and breathing practices. While many of these techniques may offer hope of immediate change in symptoms, some of them can also open up unexpected material and distressing reactions in vulnerable clients, which again points to the need for a clinician to be well-trained and supervised and a client thoroughly assessed before undertaking these techniques. While many clinical theories have drawn attention to previously neglected nonverbal cues as a source of significant information, it is important to recognize that both verbal and nonverbal material can sometimes be misleading.

Nonverbal communication is not necessarily an accurate reflection of unconscious or unformulated material simply because it is not expressed in words. What we perceive, hear or think we understand about another person is not always what is being felt or communicated by that person, whether by verbal or nonverbal means. For example, in recent studies of interpretation of facial expressions, scientists have found that many factors can influence a client's facial expressions, including even something as simple as how many times a person blinks in a minute, which in turn colors how others interpret those expressions. Even trained observers can draw inaccurate conclusions based on movements of the face, body and extremities (e.g. Girard et al., 2013). It is therefore extremely important that a clinician constantly utilize both verbal and nonverbal exploration to try to clarify a client's condition rather than drawing conclusions on the basis of either set of "data."

Symbolic Meaning and Body-Mind

For an integrative clinician, it can be sometimes be enough to find ways to talk and think about a client's physical reactions in relation to his psychological and emotional experiences. Let us return to Mr. Nolan for an example of how this can work:

Mr. Nolan had suffered a serious illness as a child. He and Ms. Bluen had spoken about a number of different aspects of the illness. Now, in relation to his ongoing uncertainty about how he felt, both physically and psychologically, Ms. Bluen began to explore what he had understood and known about himself during the illness, from which he had taken nearly a year to recover. "I still don't even know if I was really sick," he said. "Was I just faking it? Could I have gotten better faster? Could I have gone back to school? What was really the matter with me? Was it in my head? Or in my body?"

While it was tempting to suggest that Mr. Nolan find out the "truth" about his illness, his medical records could only offer partial assistance to the work. A traditional either/or approach is captured by the phrase "it's all in her head," the implication being that physical pain is either "purely" psychological or "purely" physical (or, as it is technically termed, "organic"). Physical symptoms can take on a life of their own (for another interesting discussion of this issue, see Grzesiak, 1994; also Aron & Anderson, 2000). An integrative clinician's task is to help a client find ways to address both the realities of any physical experience (e.g. what does it feel like, what does it do to the body?) and, not necessarily simultaneously, the realities of linked emotional and psychological experiences. Only in this dual track, as it has been called (Connors, 2006; Frank, 1999; Wachtel, 1997) can a clinician address the idea that body and mind are not really separate entities, but are mutually influenced and influencing parts of the same bio-psycho-social system that makes up human experience.

The interplay of symbolic meaning and regulation of affect through physical experience is often central to our work, although it is not always spelled out so clearly. Connors (2006) provides some excellent examples of this process, as do Frank (1999), Freis (2012), and Wachtel (1997). I have found that an integrative approach offers a clinician the opportunity to work with both aspects of this equation. In my experience, when a client is not able to engage in exploring meaning, for example, it often signifies that they do not yet have the tools for self-soothing in the face of some of overwhelming feelings. Rather than focusing on resistance to knowing or feeling, I find it useful first to focus on how a client manages painful or distressing affect. In my work with clients with eating disorders, for example, I often find myself moving back and forth between concrete discussions of specifics like using exercise, diet and other body-related tools to manage physical and emotional discomfort, and exploring some of the reasons behind both areas of discomfort. However, sometimes in the initial phases of work, the main focus will be on the physical soothing of both body and mind.

An example of how this might work in therapy can be seen with Hank, a young emergency worker who came from a long line of emergency workers. His father, uncles, cousins and siblings were all first responders of one sort or another. Hank had learned from an early age to ignore both physical and emotional pain. Heavy drinking, hardy eating, physical action and good sex were antidotes to life's problems. However, shortly after assisting a colleague who had been badly injured, Hank began to suffer from debilitating back pains. He appeared to have strained his back slightly, but there were no clear organic explanations for the severity of his pain.

Hank's physician thought he needed psychotherapy, but also knew that it was unlikely that he would follow through on a referral, since psychotherapy was not part of his culture and would probably have been viewed as a sign of inadequacy or weakness on his part. However, she had learned of an organization that was offering an integrative approach to helping first responders with physical and psychological issues. This organization offered body work, including yoga and acupuncture, along with some psychotherapy for those who might make use of it. It had been recommended by Hank's union, which made it more acceptable to Hank, as did her statement that they would help him deal with the physical symptoms. Hank actually knew of an older colleague who had been there and found it helpful, so he accepted the referral without the resistance he would have presented to a referral for talk therapy. Still, with some reluctance, Hank began to take a yoga class at the center. The teacher explained that her focus was not only on helping her often physically powerful students relax and stretch some of their muscles, but also developing a different kind of muscle strength. She also explained that some of the work they were doing could help some of their muscle-related tension. To Hank's surprise, he found that within a short time of beginning the classes he was sleeping better. "I'm not sure how that works," he told the physician who had referred him. "But it's really nice."

Similar results can also be seen in clients who are making good use of talk therapy. For example, to return to Mr. Nolan, Ms. Bluen suggested that a yoga class might be worthwhile for him. A physically active man who regularly ran for exercise and pleasure, Mr. Nolan initially responded that yoga was not his kind of activity. "I don't think it can help me," he said. Ms. Bluen said that she did not want to pressure him into it, but asked if he could talk to her a little bit about his resistance. They did not spend much time on it, but in their brief discussion Mr. Nolan described not only his reluctance to participate in something "alternative," but a lifelong distaste for engaging in any activity that he would not be good at. This dynamic was obviously an important one, which they returned to over time in relation to a variety of different issues. At one point, Mr. Nolan decided to take a yoga class as an experiment, to see if it actually helped him calm down and also to open up more of the discussion about his discomfort with new things. Not only did it turn out to be an activity that over time gave him a great sense of comfort, but the experience allowed him and his therapist to further explore his anxiety about doing anything new, opening up a lifelong fear of failing that contributed to his feelings of isolation and loneliness.

Talk Therapy for Physical Issues

Clients with physical difficulties, whatever the origins of the problems, often benefit from a combination of interventions, including when appropriate, medication, biofeedback, acupuncture, meditation, physical therapy, exercise and massage, among others. Group and individual work together are often useful as well. It is therefore important that a clinician be sensitive not only to clients like Hank, who might do

better with physically oriented therapies, but also to the possibility that, as with Mr. Nolan, even talking about physically based activities can open up previously closed off areas of an individual's psychodynamics.

As I have discussed throughout this book, my use of Sullivan's (1953) concept of a "detailed inquiry" into the minute aspects of a client's daily life is part of my own integrative approach. Asking about small details such as where a client sat or stood to eat breakfast or even what color the room was painted, or who else was present and what time was it when bad news was received, can provide invaluable information about unarticulated experience. For instance, I have found that eating disorders in college students can be reflective of struggles to manage the sometimes contradictory and often confusing tasks of this developmental stage : finding a path towards independence, creating an adult identity, and simultaneously learning to be connected to others (Barth, 2003). Physical changes in the body, including both gaining and losing weight, can be symbolic, symptomatic and reflective of some of the emotional and developmental struggles in which these young people are engaged. Close attention to the details of a client's story can help a clinician determine what aspects of the difficulties to focus on at a given moment in the work. For example, Margaret, the college counselor we met in Chap. 3, has found that when she listens closely to the details of a student's daily life, she may find surprising reasons behind problematic eating. "Like one student who had grown up in a different culture and who was literally starving for her native foods, which we didn't have anywhere on campus—or even in town! I helped her make a phone call home and encouraged her parents to send care packages of food and to get other relatives to do the same. I'm not sure whether it was the food, or making her parents aware that she was feeling so fragile, or just my having understood her and being an ally. Maybe all of the above. But she started to get better."

A Damaged or Suffering Body Can Affect Psychological Well-Being

Not only does a healthy body promote a healthy mind, but a damaged or suffering body can affect psychological well-being (e.g. Greenberg, 2009) and can make it difficult for a client to heal emotionally. In my work with clients with eating disorders, for example, I have repeatedly seen evidence that starvation from both anorexia and bulimia can interfere with a client's ability to think or work productively in therapy. Similarly, in interviews with clinicians across the country, I heard repeatedly that it was crucial to take care of the physical needs of clients who were ill, dirty and/or hungry, as well of course as those who were physically debilitated by alcohol and drugs before psychological and emotional issues could be addressed. Not infrequently, as clients begin to pay attention to their physical experience, they may begin to exercise regularly and even pay better attention to their eating and sleeping habits without active guidance from a therapist. Some clinicians work directly with the body in the belief that emotional issues will begin to emerge and be

worked through in the body. Meissner (2007a) writes that even when the body is not part of the conversation, it is participating in the therapeutic process, since a clinician's empathy is in part due to unarticulated and unformulated physical attunements (see also Davies, 2005; Fonagy, Gyorgy, Jurist, & Target, 2003). An integrative clinician will not assume that all physical disorders have psychological causes any more than that they are all simply physiological. Sometimes doctors can misdiagnose a physical symptom as psychosomatic, or sometimes a physiologically based illness will have emotional ramifications (Greenberg, 2009) Even a psychologically-caused physical illness can impact the body's chemistry and physiology.

Integrating body and mind can sometimes be as simple as noticing that a client is hungry, dirty, tired or "strung out." Some of the clinicians I interviewed worked in agencies that provided showers, clean clothes and food for homeless clients. Clinical work was done both with the offering of these concrete physical comforts and also in the form of talking afterwards. As one worker put it, "You can't do any kind of insight therapy with someone who is starving or exhausted. But getting food in their stomach and making sure that they get a chance to sleep on a cot in a room where they feel safe does wonders for getting the therapy going."

Conversely, many clients who one might expect to be particularly aware of their bodies are surprisingly disconnected from their physical sensations. Athletes and dancers for example, are taught to play or dance through pain rather than to view it as a signal from their bodies to protect the injured body part. Cultural focus on thinness supports a general attitude of ignoring or misreading cues about hunger, and at times our punishing work ethic leads to sleep disorders, many of which are the result of ignoring the body's need for sleep, rest and relaxation. I have worked with many athletes, dancers and other physically active individuals who come in for a session after a big competition, a marathon or weeks of intense rehearsal for a dance performance and complain of feeling irritable and unhappy. Although there are often psychological aspects of their emotional state, of course, including let-down when an event is over, conflicts about both winning and losing, and so on, there is also a simple physiological component that many of them have missed. Many of these clients are taken by surprise when I ask what they have done to repair their bodies after putting so much stress on them. They are even more surprised when I suggest that some of their emotions may be the result of the toll taken on their physical selves.

As we discuss in Chap. 6, a clinician needs to include an ongoing evaluation of every client's physical condition and relationship to his body in her thinking about that client. A surprisingly large number of clients, even those with physical concerns, come into therapy not having consulted with a physician for an extended period of time. A complete physical checkup by a qualified physician is required by many agencies and is part of my own initial expectation of all clients. Explaining that making sure that a client's physical health is taken care of is part of an initial assessment process and also introduces the idea of important and often subtle links between psychological issues and the physical self early in the therapy. The discussion often also quickly flushes out some of a client's concerns and anxieties not only about seeing a physician, but also about his body. It also provides an early opportunity for

learning more about a client's exercise and diet practices, history of illness and general relationship with her body. Eventually this information will help a clinician determine what, if any, body-mind interventions might be most useful with a specific client at a given time in the therapeutic process.

Focus on Physical Health Can Also Be Resistance

Ironically, sometimes physical activities can block links between different parts of a person's self. Even healthy athletes may actually be using their bodies to shut out their feelings. In fact, exercise is an adaptive tool for managing emotions that clinicians often try to encourage clients to begin to use. But at times such behaviors are incorporated into resistance to actually experiencing important, albeit unpleasant, feelings. As we will discuss in Chap. 7, an integrative practice can be enhanced by a therapeutic team, whether formally or informally structured. In working with body and mind, nurses, doctors, psychopharmacologists, physical trainers, and a variety of professionals who teach and work with the body can become part of the therapeutic process. A clinician's task in such a situation is often to help a client integrate this varied team's input, even when it is contradictory and/or confusing.

Alexithymia

Feelings often occur without being named or thought about. Some people manage these kinds of feelings or sensations comfortably, but for others, this inability to know one's feelings in words is related to alexithymia, or the inability to use language to help process emotions (Barth, 1998, 2008; Bromberg, 2001; Krystal, 1988; McDougall, 1989; Sifneos, 1996). Some individuals who suffer from this difficulty are actually quite verbal and skilled at talking about their emotions and even explaining the historical precedents for them. Their apparent insight may give the appearance that they are able to use their often psychologically astute explanations to help them manage or regulate their feelings when this is actually not the case (Barth, 1998, 2008). It is important for a clinician to keep in mind that many verbal and intelligent clients suffer from this difficulty. Many of these clients have spent their lives disappointing others—parents, teachers, and so on—whose expectations were based on their high level of intelligence. Recognition of the presence of alexithymia can help a clinician choose appropriate interventions that reinforce a client's ego strengths and help build up areas of weakness instead of repeating these previous experiences.

This is how it worked with Anna Louise, who we met in Chaps. 2 and 3. As the therapist gently explored Anna Louise's feelings in a number of different situations, she concluded that the young woman was suffering from a very subtle form of alexithymia. Based on this conclusion, she began to work with her to develop a capacity

to recognize some of her internal emotional cues. However, there were several different aspects of this work. On the one hand, they needed to work on Anna Louise's capacity to tolerate the emotions she began to contact. On the other, because Anna Louise had a history of "not living up to" her potential, her therapist needed to be sensitive to both her possible embarrassment about what she might see as a failure and her anxiety about not living up to the therapist's expectations.

For many of us, even those without alexithymia, it can be easier to make contact with physical sensations than with emotional ones. Because she thought this was probably true of Anna Louise, who had always been physically active and therefore in some ways attuned to her body (although as with many individuals with eating disorders, the attunement was not complete or even always accurate), the therapist suggested they begin with some simple physical data.

"Close your eyes," she said, "and just sit comfortably." She waited till Anna Louise seemed somewhat comfortable. "Now, let your mind's eye wander around in your body. Pay attention to any physical sensations you might have. Breathe gently while you are noticing what you are feeling physically." Because Anna Louise was not used to paying close attention to many of the communications from her body, the therapist did not want to stir up any material that might be potentially overwhelming or distressing. She wanted Anna Louise to feel comfortable about this initial foray into the realm of her physical self, and hoped she might also learn something new about herself in the process. Not wanting to arouse too much anxiety, she did not ask Anna Louise to remain with her eyes closed for more than a few minutes. "Now slowly open your eyes," she said. She had her take some counted breaths—breathing in for a count of three and out for a count of three—and then asked her to return to breathing normally.

"Can you tell me what you noticed?" she asked.

Anna Louise smiled. "I could feel my heart beating," she said.

"Excellent," said the therapist. "Tell me all about it."

Anna Louise looked at her blankly. Gently, the therapist asked, "For example, did it seem to you to be beating fast or slow?"

"Oh…I'm not sure…slow I guess…"

The gentle questioning continued for a few moments, after which the therapist suggested to Anna Louise that she try doing this exercise—closing her eyes, breathing evenly, and paying attention to some part of her body—for a few minutes every day. "Let's just see where it takes us," she said.

Integrating body and psyche can sometimes begin with nothing more complex than a simple exercise like this one. In fact, Brown and Gerbarg (2012) call the breath the "portal" to the mind-body system. They are among a number of body-mind synthesizers who offer readers techniques for breath counting. They also describe some of the obstacles that can interfere with a client's use of these techniques. Clinicians also often feel uncomfortable bringing breath work into other forms of therapy. DBT and ACT incorporate some breathing and mindfulness tools into the work almost as a matter of course, but many psychodynamically-oriented therapists worry that it will interfere with the opening up of transference and other

unconscious dynamics. In my experience the opposite is often true. For Anna Louise, for instance, the breath work opened the door to a discussion of her dependence on her therapist and her fear that her therapist would eventually tell her that she was finished. "I'll have to leave. I'll be on my own. I won't know how to function without you."

As her therapist sensitively explored these ideas, Anna Louise began to sob and was once again unable to catch her breath. The therapist asked if it would be helpful to do the breathing exercise again. Anna Louise nodded. They went through the steps again. When Anna Louise was feeling more stable, the therapist asked if she could stand to think about other times in her life when she had felt so destabilized. Anna Marie was hesitant, but said, "If you'll help me when I get frightened. Maybe we could stop and do the exercise again each time?" The therapist agreed, and for months afterwards they gently probed and discussed memories and fears. At one point in the process, Anna Louise said, "You know what's incredible. I've started doing this myself sometimes! I got really upset the other day and realized that I could stop and breathe. And I did. And I felt much better!!!"

She then looked worried. "This doesn't mean I have to stop therapy, does it?" Her therapist replied, "Not at all. It just means that you're starting to take in some of the work we're doing and making it your own. That's terrific, but I think there are other things you'd like to work on, right?" Anna Louise nodded. "So we'll keep working on them," the therapist said.

A number of clinicians I interviewed in the process of writing this book told me that they use some of these techniques in their work with acting out, impulsive and sometimes cognitively impaired clients. They shared stories of clients who had historically become involved in physical fights and were able to "check" themselves and interrupt their own impulsive action by using breathing and body awareness techniques they had learned from therapy. One therapist told me that she saw a young man start counting his breaths with his fingers in a situation that would previously have devolved into a fight. "And when he stopped counting, he turned around and walked away!" she said. Another, whose client reported a similar situation, asked him if he could explain what had felt different in this case. He replied that he could not say, but that it was fun. He had never felt so powerful before.

Research has shown that talk therapy changes the brain (see Busch & Sandberg, 2007; Rustin, 2012; Schore, 2003) which in turn changes the self. Similarly, systems theory tells us that changes in behavior can impact the system in which a client lives (see Gitterman & Germain, 2008) which in turn reinforces the alterations in activity. Yet clients and clinicians often resist doing the work that leads to these changes. I have often found that clients reject my offer to teach them a short breathing exercise. When this happens, I try to respect their refusal while also asking if they can talk about what makes them uncomfortable about my suggestion. Exploring these obstacles can be extremely useful, providing surprising details about a client's internal world. One client, for example, told me she felt too vulnerable when she closed her eyes and followed my instructions. Like Anna Louise, this interchange opened up her fears of being dependent and abandoned. While exploration of the material can sometimes remove the resistance, it is important for a clinician to

accept a client's reluctance. In another case, a young man never did a breathing exercise I suggested, but our exploration of his discomfort opened up some important previously unarticulated areas of his struggles to manage his feelings in the presence of others. Sometime later, he told me that after our discussion he decided to take some classes in meditation, which he found very soothing and ultimately extremely helpful in dealing with his anxiety. Even though he had not wanted to do any breath work with me, he told me that the suggestion was what had inspired him to look into meditation.

Conclusion

An integrative practice is a balancing practice. One pays attention to different aspects of any client's experience and attempts to balance different needs with different interventions at different times. For example, there is evidence that psychiatric medications work better when a client is also in talk therapy (Busch & Sandberg, 2007), but sometimes resistance to one or the other of these interventions means that a clinician cannot integrate them. At these times, a clinician must decide whether to insist (e.g. if there is danger to a client or to others because he is refusing to take medication), or to work with the resistance in hopes of either removing obstacles to the integrative work or reducing the problem without medication. Similarly, a psychiatrist with whom I often work closely has a policy that all patients on medication must also be in talk therapy. When a client is unwilling to do so, this psychiatrist sometimes works with them on understanding their reluctance, or, if they have been in therapy for a long period of time and the work seems to have reached an appropriate conclusion, he will continue with medication alone. Thus his policy is integrative and also flexible, depending on the needs and dynamics of specific patients.

In conclusion, another aim of an integrative approach is to find ways to think and talk about the interplay of affective and physical experiences (see Anderson, 1998; Greenberg, 2009). This helps clients integrate into a whole (albeit not always smoothly functioning) system, rather than disconnected part-selves.

Chapter 6
Making Assessments and Choosing Interventions

Keywords Mental status exam • MSE • Evaluations • Assessments • Integrative tools • Multiple perspectives • Detailed inquiry • Ongoing process • Cognitive • Behavioral • Development • Clinical illustrations • Research • Integrative social work • Evidence-based • Acupuncture • Yoga • Drug addiction • Headaches • Somatic complaints • Hypochondria • Defense • Referrals • Teamwork

In order to decide how to best help a client make constructive change, a clinician must first understand not only the problems that client presents for help, but also what has created those problems, what clinical interventions can be most effective, and what kind of work a client is actually capable of engaging in. From an integrative perspective this means understanding something about a client's developmental needs and level of functioning, cognitive capacities, and self-awareness, as well as his external support system. One tool which has traditionally been utilized for making an initial assessment of a client's psychological state is the Mental Status Exam (MSE). Although not described as integrative, by asking for information about a variety of different aspects of a client or potential client's current and past psychological, social, cognitive and developmental functioning, this exam incorporates two keys to integrative work: detailed inquiry and an understanding of process. It can be given both formally, as is often required in an agency setting, or informally, as may be the case in private practice when a client details reasons for seeking professional help at that time. Some of the questions are not meant to be asked directly, but are general guidelines for clinicians as they listen to and observe a new client—for example, a clinician can note how clients hold themselves as they walk into the consulting room, whether or not they make eye contact, their general physical appearance and condition, and their initial social skills. Information about a client's history and environmental support system (e.g. family, friends, school, work, and living situation) is sometimes taken separately, as part of a social history. From an integrative perspective, this information as well as data about medical conditions and previous psychiatric interventions is part of a thorough initial assessment.

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It is important to remember that assessments require ongoing work on the part of a clinician. In my opinion, the central issues of a client's psyche are seldom revealed in a single interview. Every assessment is silently influenced by a number of other factors, not all of which are directly related to a client's presentation or needs. A clinician's experience and personal and professional biases, the setting in which the interview is done, and the treatments available at that setting are all factors in any assessment. The following is a somewhat extreme example of what can happen when an assessment is based on a client's appearance, intelligence and description of her needs:

Laurie, a young dancer, went into therapy for help with her eating disorder. She liked her therapist, Mrs. Herman, but she was concerned that because she was older and traditionally-oriented, the therapist would not quite "get" a performer with a cutting edge modern dance company. Mrs. Herman was kind and empathic, but in many ways the polar opposite of Laurie, whose "edgy" clothes, spiked hair, piercings in various parts of her face and body, and tattoos were open communications of her very different attitude towards life. Laurie did not take drugs, but deciding that her problem was "an addiction to dieting," she went to a drug treatment center to see if they could help her.

An inexperienced intake worker accepted Laurie without finding out exactly what disorder she was concerned about. This mistake could have been rectified by some simple questions about her symptoms, her history and her specific hopes about what therapy might do for her. Only when she was in her first group session did it become clear that she was not using drugs or alcohol and that her addiction was in many ways significantly different from those of other group members. The treatment team's creative response was to help her to integrate the work she was doing with her individual, psychodynamically-oriented psychotherapist with their treatment approach, which included cognitive behavioral, motivational and peer group work. Although some of the peer-counseling and confrontational group sessions were distressing to Laurie, her overall sense was of being understood and of having her needs and wishes recognized and reflected by the staff and other group members.

Many MSE protocols integrate a social as well as a medical and psychological history (see, for example, Lukas, 1993; Martin, 1990; Waldinger & Jacobson, 2001) and therefore are almost automatically part of an integrative process. Martin (1990), whose list of factors to be included in a MSE can be found below, calls the mental status examination "a structured assessment of the patient's behavioral and cognitive functioning" (Martin, 1990, p. 924). He includes factors such as a client's physical appearance and behavior, degree of attentiveness, motor and speech activity, mood, affect, ability to speak of his thoughts and perceptions, his attitude toward the examiner and his insight into his problems. Martin also considers an examiner's reaction to a client to be an important source of information about that client's current mental functioning.

Because there is much data to be gathered, therapy often begins before an assessment is completed. As the work progresses, further information can be utilized to help fine tune interventions to a client's needs. Even in long-term psychotherapy,

ongoing evaluations of a client's mental status and social functioning can help both clinician and client recognize where therapy is helping and where changes in therapeutic approach might be useful. However, the integrative approach begins the moment a client asks for help or is referred for assistance, whether by an authority, an agency or another individual. Clinicians immediately begin to assess both the specific request and that client's capacity to utilize the particular treatment requested. Putting together a rich, detailed picture of a client's condition, symptoms, and strengths helps clarify interventions that make sense for that specific individual at that point in time.

Following is a table of Martin's list of factors to be considered in a Mental Status Examination, which we will then discuss as guidelines for an integrative perspective (Table 6.1).

There are a number of thorough and detailed discussions of the elements of the MSE (e.g. Lukas, 1993; Martin, 1990; Waldinger & Jacobson, 2001). It is important to remember, however, that the MSE is an instrument, not a set of hard and fast rules. In this chapter we will look at how these concepts can be understood from the perspective of the four categories of integrative work. Some key concepts from each category can help a clinician begin to think about the elements of an MSE in an integrative process. We will look at each of these categories in more detail in later chapters (although readers are welcome to turn now to those four chapters and then to return to this one, or to consider returning to the discussion of assessment after having completed the other chapters). The following is a brief outline of concepts to be considered under each integrative heading, and a list of questions a clinician might ask from each perspective.

- A *psychodynamic perspective* alerts one to manifest and latent material. Manifest material is that which we know and can talk about. In a dream, for example, manifest material is what we remember about that dream when we wake up. Latent content is material that is hidden from our conscious awareness,

Table 6.1 Factors to be considered in mental status examination

Level of consciousness
Appearance and general behavior
Speech and motor activity
Affect and mood
Thought and perception
Attitude and insight
Cognitive abilities
Attention
Language
Memory
Constructional ability and praxis
Abstract reasoning
Examiner's reaction to the patient

Martin (1990, p. 924)

often containing psychological meaning that we are either unaware of or uncomfortable knowing. In a dream, it is the symbolic meaning of the dream's manifest, or known, content.

- A *cognitive-behavioral perspective* alerts a clinician to a client's potential capacity to modify behavior, to carry out instructions, and to delay impulse gratification long enough to do the work that will lead to behavioral and cognitive change. This framework is less interested in hidden meaning and more interested in motivating a client to carry out specific behavioral tasks.
- A *developmental model* is useful for both psychodynamic and behavioral interventions, in that it provides information about a client's current stage of psychological, emotional, cognitive and behavioral development. An assessment will also include information about a client's history, his highest level of developmental achievement, and experiences in his life that may have enhanced and/or interfered with his ability to move through the developmental stages leading to psychological and emotional health.
- *Body-mind models* pay close attention to the interplay between the physical and the psychological, emotional, cognitive and developmental aspects of an individual's life and functioning. For example, someone who is suffering from a debilitating physical illness or from a psychological disorder with physical consequences, such as an eating disorder or drug or alcohol addiction, may have difficulties accessing her potential developmental and cognitive skills, despite high levels of achievement and apparent capacities.

The following chart provides a simple list of questions a clinician might ask herself while making an assessment that includes all four of these perspectives (Table 6.2):

As will become clear, there is a certain amount of overlap in the elements, which an integrative approach takes into account. Because almost any form of categorization is, to some extent, both arbitrary and individual, readers may find themselves looking at some of these concepts from a different perspective. Indeed, to do so is not only desirable, but also part of an integrative process in which a therapist works to understand a client's dynamics. Our point of view is part of what helps each clinician determine what intervention might be most useful to a particular client in that situation and with that therapist. An integrative perspective recognizes also that these choices will be influenced by the policies and expectations of the institution or agency in which client and clinician are working and by the specific relationship developed within a particular therapeutic dyad and by the interactions that emerge between a specific client and clinician. Other factors, for example the gender, age

Table 6.2 Questions to ask from each of the four integrative perspectives

Psychodynamic: What is the underlying meaning of the behaviors, symptoms, feelings and thoughts?
Cognitive-structural: What thoughts and feelings are contributing to these behaviors or symptoms?
Developmental: What developmental issues are expressed in these behaviors, thoughts and feelings?
Body-mind: What are the links between physical and psychological symptom and behaviors?

and background of both participants, a therapist's training, experience and skill in different techniques, and a client's immediate need and capacity to experiment and/or tolerate uncertainty, as we will see, also play a role and must be taken into account in the assessment process.

A thorough assessment of a client's current and past psychological, social, physical and general functioning can be especially important to a clinician trying to choose from a variety of possible interventions for a specific client. An integrative assessment begins with the first contact with a client—a voice on the phone, a new face in the agency's waiting room, even an initial glance at a prospective client's folder. A clinician takes in and begins processing information almost without conscious thought—as in any social interaction with another person. Concrete and subjective information about a client's appearance—sex, age, race, and ethnic background, physical condition (e.g. under- or overweight, malnourished, sleep deprived, physically agitated, calm, etc.), hygiene and grooming, clothing (whether or not clothing is appropriate for the weather and for client's age and situation)—which is often registered automatically, contains important details for both initial and ongoing assessments. Is there good eye contact? Is affect, or expression of emotion, appropriate and consistent with what a client is talking about? It is extremely important to remember that assessment is a process. An initial evaluation tells a clinician a number of things, but what it does not reveal is how a client will appear on another day or at another time. Since assessment is an ongoing process as a client changes over time in the course of therapy, it is important to continue to integrate these spontaneous observations into a conscious and purposeful assessment of any client, whether it is the first or the hundredth meeting.

Despite the technical language, many of the concepts listed in both of these tables are already part of every clinician's day to day, automatic way of participating in any interactive situation. Even integrating the different perspectives into an initial assessment is part of our day-to-day vocabulary. Therefore a formal evaluation of a client from an integrative point of view is less complex than it may seem at first. For example, when I was recently introduced to a well-dressed young woman at a professional gathering, I was surprised and curious when we shook hands and I felt her rough, callused palms. Without even noticing what I was doing, I found myself doing a mental search for an activity that might cause such a texture. I wondered if she was a farmer, but discarded that idea, based on knowledge of where she lived—a large urban area—and her city style of dress (revealing an unrecognized preconception about farmers and their style. If she had been a client, I would have wanted to explored this response in order to see what impact it could have on the work.). I thought she might be a sculptor or potter, but again discarded the idea based on initial impressions. Such informally gathered data is an automatic part of the initial phase of any social or professional interaction, but a clinician needs to pay close attention to his or her personal and cultural biases which, if unexplored, can lead to unconscious parallels to "racial-profiling," in which spontaneous judgments about an individual's criminal intentions are based on such physical characteristics as skin color and apparent racial features (Gabbidon, 2003).

We will return to this issue when we discuss a clinician's response to a client in the Mental Status Exam. For the moment, however, let us turn to the table at the beginning of this discussion. Many aspects of a mental status exam can be evaluated at least in part through careful observation and attentive listening on a clinician's part. For example, level of consciousness (whether a client is awake or not, and how alert and aware of his surroundings he is), appearance and general behavior, speech and motor activity (how clear, organized and appropriate is his speech, and how well is his movement coordinated, and how comfortable does he feel in his body) can be initially assessed as a client walks into a room, responds to a clinician's greetings, and sits down in an appropriate chair. A clinician will almost spontaneously ask herself questions from each of the four categories while observing this early behavior, as I did with my colleague in the example I have just described.

For example, Lily was 10 years old when she was referred by her school for an assessment of possible sexual abuse. A normally quiet, well-behaved and unremarkable child, she had recently begun acting out in class and on the playground. Of particular concern were repeated demands that boys from her class kiss her on the lips and put their hands on her breasts. The referring guidance counselor had already begun the evaluation process by making the assumption that these behaviors had underlying meaning and wondering if they were signs of sexual abuse. Mrs. Warren, the intake worker, observed that Lily was a small but physically developed girl, with obvious breasts and hips. At the interview her thick hair was pulled back into a tight, uncomfortable looking pony tail and her clothes were noticeably too small and tight, as though no one had noticed that she was growing. Mrs. Warren asked herself if the clothing and hairstyle had meaning—for example, were they signs of neglect, poverty, a mother's dislike of her daughter, and/or a wish to simultaneously hide and reveal her daughter's sexuality. Mrs. Warren knew from years of experience that her evaluation of Lily would need to include Lily's mother and possibly other important people in her life, taking into account environmental and relational aspects of Lily's situation even as she began to observe and process the details of her appearance and behavior in the consulting room.

After making Lily and her mother as comfortable as possible, she asked what they understood about why they had been sent to her. She also asked how they felt about the referral. Listening carefully to their answers helped her deepen her initial ideas about what thoughts and feelings might have been behind Lily's recent behaviors. Lily's mother commented that she had a new boyfriend and that Lily had walked in on them having sex shortly before she began acting out at school. Mrs. Warren accepted the manifest, or concrete explanation of Lily's sexual acting out, but remained curious about how and why this experience might have led to these behaviors. As she continued to ask gentle questions and listened to both Lily's and her mother's descriptions of the new boyfriend, she was also taking note of how they spoke, how they interacted with her and with one another and how well they explained their ideas and thoughts. This information helped her begin to have an idea of the psycho-social developmental issues they were each dealing with as well as the underlying meanings and the thoughts that led to the activities that had created problems for Lily. She was also paying close attention to any information that

might give her some sense of both mother's and daughter's relationships with their own and one another's bodies, which could both inform her understanding in each of the other areas and also help her develop an appropriate plan for intervention.

This approach is derived in part from Sullivan's (1953) concept of "detailed inquiry," which we have been discussing throughout this book. Sullivan believed that we can never actually get into another person's mind and "know" what they experience, but by asking questions about the concrete details of an experience, the "who said what to whom" (see Mitchell, 1999), we can learn what an individual thinks and feels about different aspects of his life. Through this in-depth exploration of the obvious, a clinician can gradually begin to put together answers to each of the four questions listed in the table above. It is important to keep in mind, of course, that beginning to build a working alliance with a client is often as important to an assessment as is getting all of the details. An effective detailed inquiry requires that a client trust a clinician, and genuine trust only develops over time.

While conducting an initial interview, a clinician is also listening carefully to information about other aspects of a client's mental status. For example, mood can be viewed as the feeling a person has most of the time, and affect as the way a person shows the feelings (see Lukas, 1993, for further discussion of this distinction). Inappropriate affect involves a dissonance between a client's expression of feelings and what he or she is talking about, as when a client laughs while telling a sad story. Lily's silly grin while speaking to Mrs. Warren appeared to be an expression of inappropriate affect. Such behavior can represent any number of issues, ranging from serious emotional problems to nervousness or anxiety at a given moment. Most practitioners conducting MSE's automatically take an integrative approach, recognizing that both affect and mood can be affected by external and internal circumstances, and that an initial interview only provides a brief snapshot of a client's full emotional state.

Martin (1990) tells us that it is extremely difficult to assess a potential thought disorder. Because experience is one of the most useful tools in such evaluations, when one suspects a thought disorder is present it can be extremely important to consult with and perhaps have a client seen by a more experienced colleague. Seeking such counsel from others is not a sign of weakness. Conversely, it reflects a genuine capacity for this very difficult work. Disordered thinking, which may range from overt hallucinations and paranoia to severe confusion and disorientation, can signal the existence of severe psychiatric disorders such as schizophrenia and bi-polar disorders. Because the signals that a client is suffering from psychotic thinking can be subtle, it is not unusual for a clinician to miss them. The setting in which a clinician works may also influence his ability to recognize signs of disordered thinking. For example, in a clinic that treats mainly overweight women struggling to control compulsive eating behavior, a thin woman's complaints about her body weight may be seen as neurotic, but not seriously disturbed. The delusional nature of her thoughts may be missed because of her high intelligence, her high level of functioning and her articulate descriptions of her psychological state. A clinician with more familiarity with anorexia, however, will know to look more carefully for body dysmorphia and starvation-induced psychosis. The interviewer

will be on the alert for signs of such thinking, paying attention to symptoms of psychotic thinking as they discuss the need for weight gain, and gradually attempting to determine whether such thoughts are secondary to the anorexia or symptoms of a primary psychosis.

Because no clinician can be an expert on every diagnosis, consultation with other professionals and the development of a treatment team is an extremely important part of integrative work. The topic of teamwork is one that we will return to as we discuss interventions, as it has important implications for any integrative work. It can also be helpful to distinguish between process, which can be viewed as *how* a person thinks, and content, which is what a person thinks *about* (again, see Lukas, 1993, for elaboration of this difference). Thinking in these terms helps an integrative clinician understand another aspect of the complex mix of issues that can be creating problematic behaviors and symptoms that lead a client into a clinician's office.

An important goal of the initial interview is arriving at an empathic understanding of how the patient feels. When the clinician listens carefully and then communicates an appreciation of the patient's worries and concerns, the patient gains a sense of being understood. This sense of being understood is perhaps the bedrock of all subsequent treatment, and allows the clinician to initiate a relationship in which an alliance for treatment can be established.

Medical history and psychological reports, work history and family history are all extremely important in helping tease out what a client needs and what services and interventions would be most useful. A history of previous therapeutic experiences can also help a clinician determine what may be most useful in the current situation. For example, if a client has had a good experience with group therapy, but did not like individual sessions, it may be preferable to start them in a therapeutic group. Similarly, if someone has been in a rehabilitation setting for alcohol or drug use several times in the past and is currently being referred for the same problems, it can be extremely useful to do an extensive exploration of what helped and what did not in the previous settings prior to making a decision about what form of work to offer the client this time.

Let us turn now to a key element in the evaluation process: assessing a clinician's reactions to a client.

Clinician's Reactions to Client

As I have mentioned in earlier chapters, studies have found that the quality of a therapeutic experience can be a better predictor of a successful therapy than almost any other criterion (see e.g. Connors, 2006; Couch, 1999; Farmer, 2009; Roth & Fonagy, 1996; Wachtel, 1997; Wampold, 2001). What is important for this discussion is that this finding does not mean that a therapist and a client have to become best friends—or even to like one another. Salter discovered many years ago, for instance, that a good attachment object is not necessarily warm and friendly or even

obviously loving (Main, 1999). A good clinician is not a buddy. Changing habitual patterns of behavior and ingrained beliefs and attitudes is hard work, no matter what technique is utilized. From an integrative perspective, the therapeutic relationship can be seen as the scaffolding which supports the therapeutic process, or what Winnicott (1965) calls a holding environment that supports a client as he engages in the difficult task of changing.

To this end, the initial interview is not just for the purpose of evaluation, but can also help set the groundwork for a positive relationship with both a clinician and a clinic or agency. However, at the same time that we are working to both engage a client and make a preliminary evaluation of their current functioning and needs, a clinician will be paying attention to our own reactions to that client. Originally called "countertransference" by Freud (1914), such reactions were once viewed as the result of a patient's influence on a physician's unconscious. Freud and his followers saw these reactions as the result of an analyst's unresolved psychological issues and believed that they were problematic, because they interfered with an analyst's ability to be objective about an analysand's problems. Beginning with Jung (see Samuels, 1985) and Racker (1957) countertransference was viewed as having some positive components, including the possibility that it might actually help an analyst begin to understand something about an analysand's unconscious process.

While some analysts (e.g. Langs, 1981) took this concept to the extreme of suggesting that every reaction an analyst has is caused by an analysand and therefore information about the analysand's dynamics, most contemporary analysts agree that analysts have their own dynamics that must be understood in order to sort out what is happening in the interactive space. Contemporary psychoanalysts generally believe that therapy is an interactive process in which both parties play a significant role (see, for example, Davies, 2002; Mitchell, 1999). These theorists have looked for inroads to make use of this potentially rich interactive dynamic. Our reactions may therefore reflect something about ourselves and also about a client (see Feiner & Epstein, 1993; McWilliams, 2004, for extremely useful discussions of this subject). The process of separating one's personal feelings from information about a client is one of the reasons it is extremely important for a clinician to undergo a personal psychotherapy.

Clinicians learn, over time, to ask themselves questions about how they are feeling in the room with a client, whether or not they are following what the client is telling them or are feeling confused and disorganized, and whether their own mood has shifted in some way during the course of the interview. These and other internal communications frequently capture something significant about a client. An integrative approach requires that a therapist be alert to her or his own dynamics, as well as to unspoken or unacknowledged prejudices and cultural and religious biases that may color how a client's presentation and/or issues are perceived and assessed (see, for example, Burch, 1993; Campbell & Morrison, 2007; Ganzer and Ornstein, 2002).

Let us return to Laurie, who we discussed earlier in this chapter. Interestingly, she was able to use the support of Mrs. Herman, who turned out to be far less

conservative in her approach than Laurie had thought, to explore some of the issues that arose in the drug treatment community. It turned out that many of these experiences paralleled some of her conflicts and struggles with friends and family in "the real world." Interestingly, not only Laurie, but everyone involved in her treatment found themselves reconsidering an important part of the assessment process. As she put it one day in a session with Mrs. Herman, "I didn't turn out to be who they thought I was when they took me into the drug treatment program. And you didn't turn out to be who I thought you were. I guess we're all learning that it's really true that you can't judge a book by its cover…"

Assessment of Violence

It would be irresponsible not to discuss the potential for client violence in a chapter on assessment. Because aggressive and violent clients can be extremely difficult and in need of careful management, anyone working with potentially violent and/or aggressive clients needs to be specifically trained to deal with this population. Inexperienced clinicians sometimes feel badly about not being comfortable with certain clients, yet their discomfort may very well be a communication that there is something happening which they are not equipped to handle. This is not a sign of incompetence. In fact, asking for help when one is unsure about how to manage a difficult client is part of the teamwork approach that we will discuss in Chap. 10. A team, as we will consider in that chapter, may be made up of only two people: a clinician and his supervisor, for example. But asking for help is crucial not only to assessments but also to ongoing work. Here is an example:

For example, Margaret, the college counselor whose work I described in earlier chapters, sometimes has to assess students at a variety of levels of psychological functioning. Peter was a brilliant student who had been hospitalized for paranoid ideation and violent fantasies at the beginning of the winter semester. He had been given a leave of absence and was now requesting that he be allowed to return for summer school. His treatment team had been in close contact with Margaret and school officials and reported that he was doing better, but that he was still somewhat volatile and that they were not sure that he was being compliant with medication. Margaret requested that his parents come with him to the interview, but even with them present he seemed anxious and somewhat disorganized in his thought processes. Suddenly he started speaking in an increasingly loud voice, and then simply stopped talking and looked pensive. Margaret was concerned, but as an experienced clinician, she was able to help him calm down, speaking quietly and firmly with him about what she thought might be going on with him. When she told him that she needed to make sure that he was taking his medication and following through on all of his therapy, however, he became more agitated.

It turned out that he was hallucinating while Margaret was talking and had stopped shouting in order to listen to an "order" from one of the voices he was

hearing. Minutes later, he stood up, shouted obscenities and threw his chair across the room.

Margaret had prepared for this possibility by arranging to have a campus security guard wait outside her office during the interview. When he heard Peter's raised voice he quietly came into the room and asked if Margaret needed him. She turned to Peter and his parents and said that she had needed to call for backup help because of Peter's actions. The security guard stayed with them until an ambulance arrived to take Peter back to the hospital. Although Peter continued to speak to himself, he remained calm in the presence of the large guard.

When the paramedics arrived, Margaret told Peter that she hoped that he would start taking his medication regularly. "We want you to be able to come back to school," she said. "But we want to be sure that it will be a good experience for you. You need to be as healthy as you possibly can be." Peter was mumbling to himself and she doubted that he had taken in what she said. His mother was crying. Margaret said, "Please call me and let me know what happens. And let's talk about what the next steps should be."

Newhill (2004) offers an extremely useful perspective on violent clients in clinical settings. Providing a number of strategies and ideas about how to assess and work with potentially violent clients, she also encourages agencies where such clients are treated to provide their staff with ongoing training in risk management and assessment. She says that only when such agencies both acknowledge client violence as a concern and provide a safe workplace for staff, can clinicians actively provide help to these individuals.

Assessment of Strengths

Clinical assessments often focus on what is wrong in a client's life, however, from an integrative perspective, clients strengths can sometimes be even more important than their weaknesses. Theories that focus on resilience recognize the importance of a client's strengths, which may not always be evident in an initial assessment (see, for example, Gitterman, in press). Once strengths have been recognized and noted, it is also important to assess how best to make use of them in the therapeutic work (see Cowger, 1994; Martin, 1990). Cowger (1994) writes that looking at a client's strengths reinforces feelings of competence and agency. Paradoxically, recognizing a client's competence can sometimes interfere with a clinician's ability to identify a client's vulnerabilities. To see how this can work, let us return to Ms. Conrad, who we met in Chap. 4.

In her late twenties, Ms. Conrad had begun working with Dr. Aikens for problems with obsessional thoughts and ritualistic behaviors. Dr. Aikens had become frustrated with Ms. Conrad's difficulty in following through on her assignments with him. When he referred her to a psychodynamically-oriented clinician to work on the problems that might be causing her to resist the work, he made it clear to her that he was not rejecting her and that in fact he would like to continue to work with

her if she wanted to. He also told her that he would be willing to speak with the new therapist. When the other clinician did call, Dr. Aikens was surprised when she asked if he really was willing to continue to work with Ms. Conrad. When he said that he was definitely happy to continue with Ms. Conrad, but he felt that he was not getting through to her, the clinician said, "I think you've gotten through to her. She's very attached to you. But I have a hunch that her obvious strengths have made you expect more from her than she is actually able to do right now. I think that may be true in her life in general. I'm wondering if you would be able to keep working with her, and to help her start with smaller steps, smaller goals that she actually could accomplish."

Dr. Aikens realized that Ms. Conrad's competence had indeed hidden some of her vulnerabilities from him. Re-visiting her history and her symptoms, he realized that he had been expecting her to accomplish more than she actually could. He agreed with the other clinician that this might be true in other aspects of her daily life. Teaching her to break large goals into smaller, more easily achieved tasks would probably be very useful for her and might actually help with some of her symptoms. He knew that obsessive-compulsive symptoms were some of the most difficult to treat (Jakubovski et al., 2011) and wondered if he had actually overestimated not only Ms. Conrad's abilities, but also his own.

In his next meeting with Ms. Conrad, Dr. Aikens shared with her that he thought they might want to start with some smaller goals. She was distraught. "I've failed," she said with tears in her eyes. He tried to reassure her that she had not failed at all, but explained that they were simply working on things a little differently. "I'm so sorry," she said. "I'm making your work so hard."

Dr. Aikens suggested that her reaction was probably an example of one of the things that fed into her symptoms. "You're going from 0 to 60 miles an hour in nanno-seconds," he said. "Let's see if we can break this down into smaller increments. You are assuming that you have failed because I want to start with smaller goals. Maybe the problem is that you feel disappointed and you don't know how to manage that feeling?"

Ms. Conrad nodded and added, "Yes, and I feel like I've disappointed you."

Although in other circumstances Dr. Aiken might not have addressed this statement directly, not wanting to distract them from the work at hand, he decided in this situation to ask Ms. Conrad to talk about her thought that she had disappointed him. Encouraging her to mentalize (Bateman & Fonagy, 2004), he hoped to help her begin to find words for some of her own confused and distressing feelings when she disappointed someone and when she was disappointed herself. Becoming more comfortable talking about these feelings would be a step towards helping her learn to manage them with a variety of tools other than the OCD rituals that had been driving her life. At the same time, he did not want to let her get so caught up in the feelings that she did not take the next step towards managing them. After encouraging her to talk about these thoughts for a few minutes, he then suggested they try one of the exercises they had been working on. She had, he said, just been exposed to one of the experiences that he thought worked as a trigger—the experience of disappointment in herself and fear that she had disappointed someone else. Now he

suggested they try one of the cognitive behavioral techniques they had tried before. Ms. Conrad took a deep breath and nodded. As they went through the exercise, Dr. Aikens had a sense that for the first time in their work together, she was actually taking in the ideas he was trying to teach her.

Conclusion

In an integrative practice, assessment is an active, ongoing process that is part of every intervention. Humans are complex and complicated beings. The fact that we are capable of changing is what makes therapeutic intervention useful, yet this is also sometimes confusing. A client may change not only in the course of months or years, but even within the course of a single hour. In the following chapters we will discuss how integrative theory can help clinicians decide which of their therapeutic tools to use at any given time with any given client.

Chapter 7
An Integrative Approach to Therapeutic Relationships

Keywords Therapeutic relationship • Transference • Countertransference • Research • Evidence • Clinical examples • Psychodynamic • Integrative practice • Small steps • Detailed inquiry • Affect-regulation • Attachment • Developmental • Holding environment • Secure base • Integrative approach to therapeutic relationship • Teamwork • Termination • Ending

As I have noted throughout this book, a growing body of research has found that a relationship between therapist and client can be a key factor in therapeutic outcome, no matter what type of therapy a clinician is practicing (e.g. Bacal & Herzog, 2003; Eagle, 2000; Frank, 2004, 2005; Leichsenring, 2005; Parish & Eagle, 2003; Roth & Fonagy, 1996; Schore, 2003; Siegel, 1999; Wallerstein, 2000; Wampold & Brown, 2005). But this finding actually leads to more questions, such as what sort of relationship leads to change? Do clients with different diagnoses need different kinds of relationships? Do these relational needs change over time, as they do with children and their parents? How does a clinician go about providing the right kind of relationship for each client? And is it better to talk about the relationship or to allow it to unfold silently as a background to the work?

To answer these questions, I have found that clinical theory and research results must be combined with a close reading of an individual client's specific needs and experiences at any given time. Furthermore, the relationship between each client and each clinician is, as we now understand, based not only on a client's but also on a clinician's personality. Much has been written about various aspects of therapeutic relationships (for just a few examples, see Feiner & Epstein, 1993; Frank, 2005; Gabbard, 1995; Hausner, 2000; McWilliams, 2004; Meissner, 2007a, 2007b; Norcross, 2002; Novick & Novick, 2006; Parish & Eagle, 2003). In this chapter I will focus on some specific relationship issues that frequently arise in clinical work in order to discuss ways that a clinician might respond to them in an integrative practice.

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Interventions Based on Diagnosis

Although research seems to indicate that certain techniques are more successful than others with specific diagnoses, close reading of some of the data as well as anecdotal evidence underscore the idea that these findings are not necessarily as definitive as we might like to think (Goodman, 2013; Roth & Fonagy, 1996; Wampold & Brown, 2005). There are a number of reasons for this discrepancy, including both problems with measurement tools and with clear adherence to specific techniques (Goodman, 2013). In other words, even in research situations, clinicians often unintentionally integrate techniques and theories. While this may muddy the waters of the research, it contributes to our understanding that each therapeutic dyad will have both similarities to, and differences from, any other clinical relationship. Similarly, clients with the same diagnosis may still have personality differences and need slightly different interventions. An integrative approach takes into account research that suggests that certain interventions are more useful for certain diagnostic categories, but also pays close attention to each client's needs as they become apparent in the clinical situation.

For example, while there is evidence that clients with addictions need structured interventions to deal with their behaviors, there is also evidence that many of these clients have co-morbid disorders and therefore need a combination of interventions, including medication and social and psychological support, as well as structured tools, limit-setting, and motivational interviewing (Sonne & Brady, 2002; Weiss, Kolodziej, Najavits, Greenfield, Fucito, 2000). My own experience, both in my practice and with therapists I have supervised, has been that motivational interviewing and an ongoing relationship with a clinician who both sets limits and provides an opportunity for exploring issues that interfere with the work can enhance this process. Similarly, Goldstein (1999) and Goodman (2013) offer evidence that some of the preferred treatment techniques for Borderline Personality Disorder are in and of themselves actually integrative practices. In the process of setting limits and helping a client with self-regulation, a clinician offers a client an opportunity to work through old attachments and relational patterns and learn new ones (e.g. Connors, 2006, 2011; Frank, 2001, 2005; Goldstein, 1999; Goodman, 2013; NIMH, 2013; Wachtel, 1997).

However, while understanding a client's diagnosis can be extremely useful, thinking exclusively in terms of diagnostic categories can lead to problems in the therapeutic work.

Developing a Working Relationship

Clients come to therapists for a number of explicit reasons and often with an equal number of unformulated or unrecognized ones. Sometimes they have agendas that they purposely hide from a clinician—for example, court mandated clients may not

reveal that this is the reason they are coming for therapy (although, conversely, some will deny any need for help and will say that are only coming because they have to). Clients may hide symptoms, such as addictions and compulsions, and also the degree of their dysfunction until they feel safe with a clinician. While a client may not always be completely forthcoming about what he wants from therapy, it is part of a clinician's job to attempt to make sense of the request, as much as possible. Therapy begins when that clinician makes an honest attempt to both understand and respond to what a client is communicating.

Attempting to put into words why we might be doing what we are doing is an important part of any therapeutic work for several reasons, some of which we have already discussed. A clinician's attempts to talk about why a client has come, and what help the therapist is able to offer, can partially alleviate initial anxiety about asking for help as well as fears that a client's request will be misunderstood or rejected. By verbalizing and asking clients to confirm or further clarify what they are asking for, a clinician also models a process of communication that will be crucial to any ongoing work. This modeling also immediately invites a client to be a partner in the therapeutic process.

A client's engagement in the work is so important to an integrative practice that I choose to avoid the terms "patient" and "treatment" whenever possible, in order to avoid the implication that something is about to be done to them, or that they are passive recipients of my clinical interventions. Over the years some clients have struggled to find a better word to capture our relationship. They have told me that "client" does not work for them because it turns what is a deeply meaningful, personal and interactive process into a business association only. One woman who has participated in a very successful long-term psychodynamic psychotherapy with me suggests "therapeutic partnership," but this term also has problems, in that it implies an equality of sharing and expertise that in itself disguises the complex reality of the relationship. Although I am still searching for a term that captures all of the complexities and emotions that can be woven into even brief therapeutic partnerships, for the moment I am still using "client" as the operating term.

All of which is to say that making a contract with a client is often not as simple as the word might imply. I have written about an apparent contract change when clients share hidden symptoms after a long period of therapeutic work (Barth, 2008). I find that sometimes this contract change comes because a clinician has passed some important tests that a client sets, either consciously or unconsciously. Such tests can come in the very beginning of therapy—even in the first phone call. For example, years after she had started therapy, Laurie, the young dancer described in earlier chapters, explained why she had stayed with her therapist, Mrs. Herman, even while she was looking for a therapist who would focus more directly on her eating disorder. She was impressed in their first phone conversation, before they had even met, when Mrs. Herman expressed concern about Laurie as a real person. "You told me that you were going to a conference," she said, "so you couldn't see me right away. You asked me if I was okay waiting until you got back, or if I needed you to ask another therapist in the clinic to see me sooner." Mrs. Herman's openness about

the process, her clearly expressed concern about Laurie, and her invitation to her to express what she needed from the outset of the work set the stage for her to become a secure attachment object even before they met.

The story was somewhat different with Laurie and James, her primary worker at the drug treatment program. In their first few sessions, Laurie shared a great deal of personal information with James, which led him to believe that they were developing a good therapeutic relationship. Based on his initial assumption that she was an addict, James drew a number of conclusions about issues Laurie raised. Hearing that she was having some difficulties with other members of her dance company, he attempted to provide her with tools for managing her feelings and the often impulsive behavior that went with them, but she was resistant to almost any intervention he made. He then began to use motivational interviewing to try to help her formulate reasons she might want to make change, even though she was also resistant to it. He thought they were making some headway, when she called to tell him that she was canceling therapy for good. "This stuff is worthless," she said. James felt overwhelmed and incompetent at first, and later he began to feel angry with Laurie. "She's a borderline and an addict," he said to a colleague. "I guess I should have been prepared for her to act out on me."

Diagnoses are helpful tools in assessment of a client's dynamics and level of engagement, but they can also pose obstacles to the therapeutic work. Davies (2006) and Bollas (1989) both illustrate ways in which diagnostic categories can, ironically, be ways of avoiding painful material that is emerging in a client-clinician relationship. In a consultation with a colleague, James began to ask himself what might be going on for him in this process. He started to look into his own history for some personal factors that might be influencing his response, but his colleague stopped him. "Most of us have some kind of reaction to clients with borderline dynamics," he said. "But what's going on here seems to be that you're taking Laurie's response personally. That may be a problem you have in general in your life, and might be something you want to look at in your own therapy; but in terms of Laurie, if we just get you to step back and not take her behavior personally, what could we learn about what it means to her?"

Taking It Personally

James was struggling with a common dilemma. A therapeutic relationship is often simultaneously professional and personal. Part of a clinician's task is to recognize that behavior that appears to be directed specifically at a clinician is actually reflective of that client's patterns of interpersonal interactions. In some therapies, generally psychodynamically oriented ones, these patterns are often explored as they arise in the transference. Contemporary relational theorists (e.g. Aron, 1991; 1996; Bromberg, 2001; Davies, 2002, 2006; Mitchell, 1999) have also brought to our awareness the importance of the interplay of a clinician's psychodynamics with a

client's in any transference/countertransference interaction. On the other hand, there is ongoing dispute about how much the therapeutic relationship itself should be the focus of therapeutic exploration. While some clients find it useful, others find it disturbing and/or distracting from the "real" work of therapy. Novick and Novick (1998) caution against confusing a professional alliance, which has specific therapeutic goals, with a more general, personal relationship. Yet a therapeutic relationship is also an interaction between two people that can make both members of a therapeutic dyad feel vulnerable (see Gabbard & Lester, 1995).

Within the context of a professional relationship a client can and should feel seen (or recognized) and understood by her therapist. It is this feeling that clients often report when asked what was most helpful in their work with a particular therapist (see Wallerstein, 2000; Wampold & Brown, 2005). Some clients want to know more about their therapist as a person, and some prefer to have no extraneous information about her, even sometimes becoming irritated when something personal inadvertently enters the frame. The more clinicians know about themselves, the better able they will be to both recognize their roles in the mutual interaction and to simultaneously refrain from taking a client's responses to heart, and the better able they will be to explore what these responses mean to and about that client.

Recognizing our own role in any therapeutic encounter and the ways in which our engagement with clients may replicate old patterns of interacting for us as well as for them can lead to powerful shifts in our ability to choose interventions that will help clients work through some of their underlying issues. This does not necessarily mean sharing personal information with clients. It is important to have a colleague, therapist, or supervisor with whom we can explore these issues for ourselves in order to have more clarity about how to proceed with a client. Kohut (1971) suggests that clinicians need selfobjects in order to avoid making clients serve those functions. He further notes that clients respond to a clinician's genuine attempts to understand their experience. When we recognize that even a rejection by a client is not usually about us personally, it makes it easier to think about what the behavior means and thereby to understand it.

When James was able to ask himself what Laurie's rejection of therapy meant, he realized that she had exposed herself to him, a stranger, albeit a professional whose goal was to help her. He did not know a great deal about her history other than that she described her parents as overprotective and intrusive. She was not close with her older brother, who was often in trouble and who James suspected was a drug user himself. Her younger brother was autistic and Laurie was very close to and protective of him. When Laurie was a young teen her parents had put this brother into a residence for autistic children. She said that it broke her heart. "Why couldn't we take care of him at home?" she asked with tears in her eyes. This was when she began restricting her food intake and cutting herself. "No wonder she rejected me," James said after discussing this material with his colleague. "She was probably prepared for me to either hurt her or abandon her, so she beat me to the punch and rejected me first."

The Role of Understanding

Understanding alone is, in my experience, generally not enough to make change happen, but it is an invaluable tool in an integrative practice. One recent study (Goodman, 2013) underscores Kohut's (1984) belief that attempting to understand a client's experience from his perspective is a key—not often recognized—to a variety of different therapeutic techniques. One important tool in the work of understanding is to encourage clients to explain to us what they are thinking, and to ask them to tell us what they think we or another person might be experiencing. This is not only a tool for exploring transference and countertransference material, but also a practice of encouraging mentalization (Fonagy, Gyorgy, Jurist, & Target, 2003; Goodman, 2013) as well as an observing ego (see, for example, Gabbard, 1993). Renik (2006) has also pointed out that as clinicians try to put into words for clients what we understand about them and how we came to those conclusions—for example, based on what they have told us about their history, or in response to a particular facial expression or body position—we are modeling the process of self-reflection. Done in ways that are tolerable and manageable for each client, talking about what we understand and helping them put their own thoughts and feelings into words can be an important part of any therapeutic endeavor. Research in neuropsychology has shown that verbal clarification is one way in which therapy helps clients develop the capacity to both tolerate and manage their affects (Rustin, 2012; Schore, 2003; Siegel, 1999).

This explicatory process also has tremendously useful implications for a client and clinician's agreement about what they are working on and how that work will proceed. Although even at the beginning many clinicians do not overtly spell out what this agreement may be, therapy is a mutual agreement to work on particular issues in a particular way. But what each member of the therapeutic dyad has agreed upon may actually be quite different. Recognizing that there is a contract, albeit often unspoken, and clarifying what that contract might be is an important part of any therapeutic encounter. Often, such contracts are renegotiated several times in the course of therapeutic work—again, sometimes without ever being articulated overtly.

The Therapeutic Contract

Contracts are not always so easily made, nor are they always direct. Often, for a variety of reasons that neither clinician nor client can control, they have to be broken. It is the process of establishing and working within a therapeutic agreement that is important. The arrangement does not have to be formal (I am not speaking here of the kind of written contract that some clinicians have suicidal clients sign, which by their very nature need to be formalized). If a clinician models an open and honest attitude towards establishing an agreement of sorts with a client from the beginning of therapy, renegotiation is more manageable and in fact can be seen as

part of the work. A contract can therefore be both firm and flexible—one of the many contradictions present in life and echoed in the therapeutic process. By establishing and re-establishing what both client and clinician believe to be the goals of their work and the ways that these goals may be met, a clinician may be handed all of the tools she needs for making decisions about what interventions will be most useful at a particular time with a particular client.

This is how it worked, for example, with Hank, who we met briefly in Chap. 5. Hank was an emergency worker whose physician referred him to an agency that provided body work like yoga, acupuncture and nutritional guidance for first responders. The agency also provided psychotherapy, marital counseling, and help with addictions, including regular meetings of several twelve step programs. The intake worker listened carefully to Hank's request for help with his back and recommended acupuncture and yoga to begin with. She also explained the availability of other help, but quickly accepted Hank's rejection of everything other than those two approaches. She also discussed his doubts about both techniques and suggested that he talk to some of the other clients who might be sitting in the drop-in area, where coffee and pastries were available, to see what their experiences had been like. To his amazement, Hank found an older colleague in the lounge. When he told Hank that this place was terrific, that they had helped him with back troubles and also with problems sleeping, Hank was sold. But when the acupuncturist with whom he started working suggested that he might also consider talking to a therapist, Hank made it clear that he was not interested. She accepted this and worked with him for several months until his back pain diminished significantly and he stopped coming for help. Some months later he referred a colleague to the center, saying, "You won't believe how much they can help."

Manifest and Latent Material in the Relationship

As we discussed in the previous chapter, an initial assessment is extremely helpful to a clinician's decisions about what will be the most useful intervention for a particular client. Because clients have different relational needs and dynamics, it is useful for clinicians to be able to think about the specific needs of each client. For example, clients who are quite anxious or having difficulty managing their impulses may need a therapist to be actively engaged, asking questions, guiding the therapeutic conversation and offering suggestions and direction. Someone who is depressed or simply more methodical might prefer a therapist who acts more as a witness than as a guide. They may need a clinician who can sit quietly with them while they attempt to think their thoughts rather than one who makes suggestions or asks questions.

No matter whether or not one works directly within a therapeutic relationship, it is useful to have some understanding of how a client's feelings about his therapist can impact the work. Further, it is helpful to have some ideas about obstacles that might interfere with this relationship and thereby negatively affect therapy. Resistance, for example, may appear to be related to some aspect of the work itself,

but it may also be motivated by latent or unformulated issues from the therapeutic relationship itself. Such issues may derive from a client's history and/or background, of course, but they may also be related to a clinician's unrecognized or unarticulated dynamics. In an integrative practice a clinician keeps both sides of a relationship in mind, even though he may never bring a discussion of these dynamics into the therapy office.

For instance, both a person with borderline personality disorder and an individual with a generalized anxiety disorder may both need active intervention, including not only question-asking, but also guidance about what to talk about and even some limited self-disclosure from a therapist. For a person with borderline personality disorder the clinician's activity could help limit impulsive acting out, while an anxious person might use the interaction to help manage disturbing thoughts and feelings that he cannot yet handle alone. And while one person struggling with depression may want to sit with a therapist because, as one client once said to me, "it's the only time it's safe for me to think," another may long for input into what feels like a dark and empty space from which he cannot emerge alone.

An assessment of a client's specific developmental issues and conflicts, both historically and in the present, can also help a clinician consider how best to approach particular issues. This can include not only a client's history, but also the history of the therapeutic work. For example, many clients need more active intervention at the beginning of therapy. As they become more comfortable with a clinician and more familiar with the process of self-examination, they may require less activity from their therapist. Similarly, as we will discuss in the chapter on endings, a client who has been capable of self-initiated exploration but is preparing to leave a meaningful clinical relationship may need more support and guidance in this final period of the work.

It is crucial for clinicians to be attuned to our own dynamics as they unfold within each therapeutic relationship in order to avoid allowing these personal responses to interfere with the therapeutic process. These responses can also be clues about important, unarticulated material about a client. Mitchell (1998) offers the image of transference and countertransference as a relational "dance." Much of the therapeutic work, he suggests, involves being curious about why we and a client have chosen a particular dance step and music at a particular time. This sometimes means paying close attention to reactions which involve parts of ourselves that we do not like, or of which we are critical, ashamed or embarrassed.

These feelings can interfere with therapists' ability use our reactions to help us understand something about our clients' unconscious or unformulated experiences. They can also lead to an inability to manage our own unconscious and unformulated dynamics, important in order not to induce or project or issues in a client. Since, as Greenberg (1991) notes, we all have blind spots which by definition we cannot see, these events cannot be completely avoided. Handled with humility, empathy and tact, these situations can be powerful learning events in any therapeutic work, whether the frame is cognitive and behavioral, psychodynamic, body-based, medical, and so on. When ignored or suppressed, they can interfere with and derail even the most rigorously applied techniques.

Therapist's Self-disclosure

Numerous authors have explored the question of self-disclosure in the therapeutic process. Gerson (2001), Mitchell (1998) and Goldstein (1994) have made interesting cases for the significance of the inadvertent self-disclosures on the part of a clinician, including wearing or not wearing a wedding ring, changes in appearance due to aging, illness or life events like pregnancy. Like Wallerstein (2000), they suggest that clients are often quite interested in personal details about their therapists, but boundaries that maintain the professional relationship are crucial for therapeutic work to be done (see also Frank, 2005; Gabbard & Lester, 1995). Wallerstein (2000) suggests that often these inadvertent comments or revelations have far more significance to the outcome of therapy than clinicians generally recognize. Our being human is an important part of our being therapists and helps clients feel understood and recognized by another person. A willingness to listen to and think about clients' reactions to our personalities without always considering such reactions to be manifestations of transference issues is also extremely important (see Bollas, 1989).

It is important to know that a therapist's self-disclosure is not appropriate for every client or in every situation. For example, many clients seem to feel comforted by knowing that their therapist knows first-hand something about their experience—e.g. parents struggling with issues with their children like to know that a clinician has children of his own. In an attempt to overcome an addiction, it can sometimes be helpful to know that a therapist has overcome something similar. On the other hand, many clients feel intruded on by any information about a clinician and cannot tolerate a therapist's self-revelations, even of the most insignificant sort. Basch (1980) makes a case for listening carefully to the needs clients actually communicate to their therapists rather than imposing a theoretically bound or "experience distant" (Kohut, 1971) generalization on every client.

Similarly, Johnson (1999) and Bloomgarden (2000) suggest that therapists who have struggled with eating disorders may be particularly vulnerable in working with clients with these symptoms. He also believes that they can also be powerful role models and that they can sometimes understand some of the struggles more fully than someone who has not suffered themselves. He warns that a clinician needs to be clear, however, that just because something worked for her does not mean that it will work for clients, even those who seem very similar to the clinician in dynamics and symptoms. In such situations, self-disclosure can also be a double-edged sword: while some clients may be comforted to know that their therapist has struggled with and overcome these issues, others may feel that it is a command to them that they be able to follow a similar path. Still others may become frightened that this clinician is too vulnerable to help them. As always, our understanding of a client is one of the most powerful tools for deciding what will be the most useful for a specific individual at a given time (see also Thompson-Brenner, Satir, Franko, & Herzog, 2012). Goldstein (2007) makes a similar comment about therapists who are in mid-life working with clients at the same stage of their lives, noting as well that a clinician's narcissistic vulnerabilities can make it difficult be empathically attuned to a client's needs.

There is a growing body of research on another aspect of this issue, the experience of shared and secondary trauma on a clinician's part. Shared trauma occurs when client and clinician have both experienced the same traumatic event, such as a natural disaster or an act of violence or war occurring in their community. According to Tosone, Nuttman-Schwartz and Stephens (2012) secondary trauma phenomena or collective catastrophic events can have a powerful and often unrecognized impact on mental health professionals living and working in traumatogenic environments. Shared trauma occurs when clinicians are exposed to the same community trauma as their clients. They suggest that clinicians must pay close attention to and put into words their own trauma narrative, and must be assiduous about their self-care in order to provide appropriate help to clients. These shared experiences can be important aspects of a therapeutic relationship, but a clinician must be both alert to and cautious about any changes in boundaries that might result from intentional and unintentional self-disclosure around these experiences. Agencies need to be prepared to offer training, supervision, and support to help clinicians navigate the effects of both shared and secondary trauma. Clinicians in private practice should look for such settings in which they can receive additional assistance processing these experiences.

Understanding, Attachment and Affect Regulation in a Therapeutic Relationship

Silverman (1998) points out that attachments are one of the most important ways that we learn to regulate our affects, which explains one of the reasons that attachment to a clinician can be helpful, no matter what techniques he uses (see also Kohut, 1977). Schore (2003) describes neuropsychological research that underscores the importance of attachment experiences in the development of affect regulation. Thus it seems that it might be useful for clinicians to be as alert as possible to some of the issues that might arise in this area, whether or not we use this information directly in the work with a client.

In order to enhance these processes, a clinician has to manage his own affects and regulate his own self-esteem and attachment needs. This is especially true when work with a particular client triggers strong feelings. Such responses may be related to a clinician's personal history and dynamics or simply be normal reactions to this client's behaviors and emotions. In either case, a clinician's work—or lack thereof—on personal feelings will very likely have an impact on the therapeutic experience.

Some common problematic reactions from therapists include: anxiety, over-identification with a client, denial of the severity of symptoms, over-concern about the symptoms, over-simplification or over-complication of a disorder, frustration, anger, impatience, disgust, confusion, judgment, romantic impulses, and a desire to rescue a client. These feelings are not abnormal and are human responses to another person's vulnerabilities. What is important is how the feelings are handled and incorporated in the work.

Attachment, relational and neuroscience based theorists have for some time now been integrating a clinician's thoughts and feelings into the therapeutic work (see for just a few examples, Aron, 1991, 1996; Bollas, 1989; Bromberg, 2001; Boston Change Process Study Group, 2005, 2010; Davies, 2002, 2006; Fonagy, Gyorgy, Jurist, & Target, 2003; Hoffman, 1998; Stern, 1985, Schore, 2003). A clinician's responses have been found to be especially helpful as clients work through dissociated and/or unformulated material within a therapeutic relationship. Yet how can feelings of anxiety, disgust, and helplessness be useful? According to Kohut (1977), clinicians need to be careful not to use our clients to meet our own needs for self-esteem. Many of us become therapists precisely because of some of our personal and often unconscious needs to "cure" ourselves and our loved ones. How do we balance these different needs and interests in order to provide our clients with the best possible therapeutic experience?

I have found it particularly useful to heed Novick and Novick's (1998) warning that understanding something about our experiences with a given client does not mean that we know precisely what that client is experiencing. Instead, empathic responses offer us tools for beginning to explore what might be happening beneath the surface of an interaction. Attention to the details of these interactions provides an opportunity to sift through and understand a range of emotions and thoughts that a client experiences at a given time, and to differentiate those experiences from our own. Like Novick and Novick (1998), Parish and Eagle (2003) emphasize the difference between transference and the therapeutic alliance. They add that a theme that runs through these and many other aspects of any relationship between clinician and client is the issue of attachment. Using a clinician as a "secure base" (Bowlby, 1988), a client may explore his inner world or may "simply" learn ways to manage affects. Sometimes the therapeutic alliance is background to the ongoing work (see Mitchell, 1999) and should not be examined or otherwise touched. Kohut (1971) describes a phenomenon he calls a "silent idealizing transference" in this way, and suggests that it needs to be allowed to evolve without discussion or even open acknowledgement.

It may seem obvious, but it is well worth noting that one of the most important tools available to any therapeutic dyad is talking. While we have seen that words do not always communicate everything a person is feeling, they are a powerful method for exploring not only what someone else is experiencing, but also what we feel, think, need and want. This is, of course, one of the reasons parents and teachers exhort young children to "use your words." Again, clinicians often have to work hard not to take communications from clients personally. This means that we learn to listen to what a client says, even criticism of our work, as information about that client. Of course, they may also be telling us truths about areas that we need to work on. Like many of my colleagues, I have found that my clients are some of my best teachers. But even when what they have to say about me is a useful insight into my own dynamics, it almost always tells me something useful about them as well. Clients are often uncomfortable telling us things that they worry might make us feel badly. Part of our work is to help them understand that these communications can be useful to both of us.

Deciding when to open up a discussion about a therapeutic relationship or when to allow it to function quietly in the background depends on several factors. An integrative clinician will consider questions such as: Is the relationship working as a silent holding environment in which the therapeutic work is moving forward? Is something happening that is interfering with the work? Is it necessary to the process? A client's needs will help an integrative clinician determine what interventions will be most useful at a particular time. Untangling these needs gets easier with experience, but an understanding of some of the issues involved can improve any clinician's ability to make these distinctions and apply appropriate interventions.

From Understanding to Intervening

Familiarity with a number of different approaches is of course extremely important in an integrative practice. However, since none of us is capable of being an expert in every possible approach, it is also very useful to have a team of colleagues who are available for both consultation and/or referrals of clients when they need interventions that we are not qualified to provide. We will discuss teamwork from this perspective in Chap. 9. For the moment, however, let us focus on how understanding what a client is communicating can help us choose and integrate appropriate interventions.

In my experience, if we listen closely, without a personal investment in immediately changing a client, we can often find clues to the best intervention for that client. For instance, when I began working with anorexic clients many years ago, I was just finishing up my analytic training, where I was taught that to "gratify" either abstract needs for love or attention or concrete needs for physical care would interfere with the analytic process. However, as I listened to my clients, I realized that some of them were literally starving to death with no capacity to feed themselves. I discovered that a starving person cannot engage in any kind of self-exploratory work. I began to keep granola bars, fruit and yogurt in my fridge and found that, contrary to what I had been led to believe, a tremendous amount of exploration went on when I offered food to these young women (and occasionally men) in order, as I often put it, "to help them think." My offer was rejected almost as often as it was accepted, but it was almost always met with surprise, interest, and some curiosity. In many instances the relational meaning of the interchanges was only examined years later, when the symptoms were diminished, but that the action was meaningful from the beginning was apparent in the immediate thoughts and reactions it elicited.

Another example of how listening to what a client asks for, both verbally and nonverbally, can inform a clinician's interventions, can be found in the ongoing work with Hank, the young emergency worker. Months after referring his colleague to his acupuncturist, Hank called and asked if he could come in for a "refresher." He said that his back was just a little "out," and he thought it might be helpful to have a treatment to keep it from getting worse. She told him she thought that was an excellent idea and they set up an appointment. When he came in for the session, she asked

him about how things were going since the last time they had met. He replied that everything was pretty good, that his back had been fine, and that work was just its normal stress level these days. As she was setting him up on the treatment table, he thanked her for seeing his buddy and said that he heard she had referred him to a couple's therapist for some problems he and his wife were having. She told him she had been happy to help, and added that she thought couples therapy could be really useful for a lot of people.

When they were finished with the appointment, Hank again thanked her for referring his friend to the other therapist. Since he had rebuffed her first attempt to refer him to a therapist himself, the acupuncturist did not think she should ask him if he wanted a referral, but she had the thought that this might be the underlying message in his repeated reference to this friend. She said again that she thought that couples therapy could be really useful for a lot of couples. She added that she and her husband had done it at one point in their marriage and that they were very glad that they had. Hank said nothing more at that point, but several days later he called and shyly asked her for a referral for his wife and himself. "We've just got a couple of things we need to talk to someone about," he said.

Conclusion

What happened with Hank is a common occurrence in the therapeutic process. A connection to a helping professional can make it feel safe for a client to seek out further help (e.g. Bacal & Herzog, 2003; Frank, 2004, 2005; Leichsenring, 2005; Parish & Eagle, 2003; Roth & Fonagy, 1996; Schore, 2003; Siegel, 1999; Wallerstein, 2000; Wampold & Brown, 2005). It is not simply what a clinician offers, but how it is presented that is significant. Empathy and understanding are extremely important, but so are knowledge, experience, and an ability to recognize both our own and our client's limitations. A therapeutic tool that seldom receives its due is a therapist's tact, but the kind of thoughtful and sensitive response to a client's resistance shown by the acupuncturist working with Hank can go a long way towards building a working alliance, which is key to a therapeutic relationship. Setting limits is also important. Boundaries are not only important to protect a client, but also to protect the therapeutic work. We will discuss this aspect of the work in Chap. 8.

Chapter 8
Small Steps and Manageable Goals

Keywords Clinical interventions • Research • Clinical illustrations • Integrative practice • Rigidity versus flexibility • Individualized approach • Detailed inquiry • Small steps • Integrative social work • Reasonable goals • Manageable goals • Cognitive therapy • Behavioral therapy • Body-mind dynamics • Psychodynamic • Beginnings • Endings • Termination • Developmental process

Not only clients, but clinicians may be overwhelmed by the magnitude of the problems clients bring into therapy. I have noted in various chapters the importance of breaking both problems and goals into smaller, more manageable components. In fact, I see teaching clients how to take small steps towards manageable goals as one of the hallmarks of an integrative practice. In order to do so, clinicians also need to find ways to break down our own goals as well as those of our clients into manageable segments. It is not uncommon for us to want our clients to feel better immediately, but we also hope to help them make changes that will pave the way for happier and more productive lives in the future. In some cases, these goals are achievable; but we have to start at the beginning, which is often helping them manage painful feelings and circumstances in the present. Sometimes what seems to be a small intervention can lead to surprisingly large changes. Perhaps more often than we and our clients like, our task is not to take away painful emotions or change difficult situations, but to help clients learn to live with a degree of unpleasantness in the short term in order to make changes in the long-term.

Utilizing knowledge from a variety of different theories helps a clinician determine how to decide what steps to take at each point in a client's progression. For example, according to research conducted by Hersoug, Hogland, Monsen, and Havik (2001), clients report feeling most helped in the initial stages by a supportive and educative approach. (Interestingly, this study found that a clinician's experience and training can have a negative impact on the development of therapeutic alliance when it leads to a protocol that feels rigid and experience distant to the client). Prochaska, DiClemente, and Norcross (1992) outline a five stage model of change in addictive

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behaviors from the perspective of using small steps that is also applicable for other symptom pictures. Their stages are: *precontemplation*, *contemplation*, *preparation*, *action and maintenance*. Precontemplation is the period during which there is often no awareness of a problem and no intent to change. During the contemplation stage, there is an awareness and perhaps desire to change, but no commitment to a plan to create that change. Preparation usually includes a desire to change and some small, but possibly ineffective changes. During the action stage, a commitment to change and significant shifts in behavior are made. And the final stage, maintenance, is the ongoing process of learning to maintain and consolidate the gains. However, describing what they call "spiral patterns of change," these authors remind us that change in addictive behavior does not generally take a straight path. It is not a linear progression, but instead is usually a prolonged pattern of "relapse and recycling through the stages." (Prochaska et al., 1992, p. 1104).

These stages need little alteration to be utilized in an integrative practice with a wide range of clients. Given the extensive research showing that factors such as a client's level of functioning and psychological-mindedness have a significant impact on outcome of *all* therapeutic interventions (Norcross, 2002), I find it helpful to assess a client's state of mind on a regular basis not only at the beginning, but throughout any clinical work. These stages are useful tools for breaking the therapeutic process down into small, manageable steps. For example, these stages help us think about where a client is at any given moment in the work.

Recognizing "Where a Client Is"

Winnicott (1987) suggests that part of a clinician's job is to hold in mind where a client is able to go in the future. However, following the maxim of "starting where a client is" makes it more likely that he will succeed in making initial steps towards change. And as motivational interviewers remind us, feeling successful is a powerful impetus for further change (Rollnick, Butler, & Miller, 2008). Paying attention to where a client is can help a clinician set reasonable goals, recognize small but valuable accomplishments, and help a client begin building "feeling muscles" that will help him move to the next level of his development, even after therapy is finished.

For instance, let us return to Hank, the emergency worker who sought acupuncture and then asked for a referral for couple's therapy for himself and his wife. Hank and his wife Trish explained to George, the couple's therapist to whom they had been referred, that they needed help resolving a conflict about Trish's desire to go back to work now that their youngest child was in school. Although George quickly assessed that Hank was struggling with some latent insecurities and anger, he also accepted that asking for help was not high on Hank's agenda. He took into account not only Hank's characterological reluctance to ask for aid, but also his probable professional and cultural need to seal over some of his more vulnerable emotions. By asking for help with his marriage Hank could be opening a door for working on

other issues, but George did not want to scare Hank off by pushing him to work on these issues before he was ready to do so. Thus he accepted the couple's expressed desire to focus on a very specific goal. George knew that establishing a relationship in which he clearly respects a client's agenda, while at times acknowledging other future possibilities, can give a resistant client a positive experience of therapy, which might be the most valuable aid he offers.

In the first session, George helped both Trish and Hank talk about the conflict as openly and clearly as possible. He stopped each of them from interrupting the other, but it soon became clear that the problem was not between them, but between Hank and his father, who believed that women should not work outside of the home. When George shared this conclusion with them, they looked at one another and laughed. He asked them if they minded explaining the shared moment with him. Hank gestured for Trish to speak. "Hank's dad is a wonderful person," she said, "but he has very strong opinions. It's kind of amazing that you picked up on that so fast. We hadn't put it together that it's our fear of telling him about me going back to work that's making this so hard, but it makes total sense."

Over the course of three more sessions, George explored previous times Hank and Trish had struggled to find ways to manage disagreements with Hank's dad. In the course of these sessions, they problem-solved and role-played ideas for letting him know that Trish was going back to work. "It's only part-time, for Pete's sake," Hank said. Trish added, "Big Hank (Hank's father) lets me get away with stuff he doesn't accept in some of the other kids and their spouses. But we're both worried that this will push him over the edge." In the process of working on these issues, even in the course of four sessions, George felt that Hank and Trish strengthened their own relationship. He thought that doing so also might help with some of the ongoing developmental issues around separation, individuation and autonomy that he heard in their descriptions of their relationships with their families of origin and with their own children. However, since his assessment was that the family was functioning well overall, he maintained her focus on their success in taking the small steps that they were interested in taking.

There are times when it can be useful to set an impossible goal with clients—e.g. asking an alcoholic or chronic drug user to be completely abstinent from the beginning of treatment. McMain, Sayrs, Dimeff, and Linehan (2007) discuss the importance of a clinician's working with a client to recognize and manage the tension between the desire to accomplish large goals and the frustration of taking small steps to get there. They sometimes begin with what they call a "door in the face" demand that a client immediately commit to an often unrealistic goal of immediate total abstinence. When a client recognizes the impossibility of achieving this goal, a clinician will introduce a "foot in the door" strategy of finding a smaller, more manageable agreement. For example, they suggest determining with a client what he thinks is the longest period that they can commit to being abstinent at that moment. DBT techniques are used to help him achieve that initial goal and gradually expand the period of abstinence over time until he reaches the goal of total abstinence.

Ongoing Assessment

Small steps work best in conjunction with an ongoing assessment of a client's level of discomfort and also that client's ability to tolerate some degree of unpleasantness in order to achieve a future shift. We can utilize information from a client in almost any session to determine whether an immediate symptom-focused intervention is necessary or whether a client can tolerate some exploration and opening up of dynamics that might be causing the difficulties (see Connors, 2006). However, since it is often necessary to intervene before an assessment is complete, it is useful to remember that a client's reactions to an intervention can often provide additional information about a client's symptoms, strengths and needs (see Mitchell, 1993). A clinician can also engage a client in the decision-making process, discussing whether to focus on direct symptom-relief or gradual uncovering of underlying causes in order to make longer-term change. Not only do these discussions help clarify the therapeutic contract, but they can also empower and enhance a sense of agency in a client.

This is how it went with James and Laurie. In consultation with Ms. Herman (we will discuss this further in Chap. 9), James came to understand that Laurie's impulsive and self-harming behavior was at least in part related to her fear of being hurt and abandoned by important people in her life. He realized that building trust with her would be a slow process and needed to be a long term goal. As a step towards that goal, he began to work with her on building some skills that would give her more control over some of her behaviors and feelings. He also began to put into words his understanding not only of how hard it was for her to tolerate those feelings, but of how her behaviors had been a way of coping with them. "Listen," he said to her at one point when she was putting herself down for not being able to carry through on an assignment, "you did the best you could. These behaviors have been your way of coping for a long time. We're not going to change everything overnight. But you're starting to pay attention to what you're feeling, aren't you?" She nodded. "And you're starting to notice when you're getting ready to act in an impulsive and counterproductive way, right?"

She nodded but added, "Yeah, but I'm still doing the same things that have always gotten me into trouble."

James acknowledged that this was true. "But the first step is to recognize the moments before you start to act," he said. "You can't change anything if you don't know that it's happening. You've taken that step. Let's keep practicing that step for a little while. When you've got it down pat, you'll be ready to take the next one."

While the idea of breaking larger goals into smaller steps is a distinct element of DBT and ACT as well as other contemporary cognitive behavioral techniques (see, for just some examples, McMain et al., 2007; and Raja, 2012), it can also be an important component of psychodynamic and body-based work. For example, Sullivan's (1953) emphasis on small details encourages clinicians to focus not on the greater goal of personality change, but on the small steps that lead to any problematic behavior. Mindfulness techniques that help bring awareness to the specifics of a

given moment can also help clients break experience into smaller, more manageable factors rather than overwhelming generalizations.

Clinicians who work in the medical field have found the idea of small steps crucial in work with clients who have to change life habits for medical reasons. There is often tremendous pressure on clients to make these alterations quickly; but often small modifications that can actually be accomplished are better than large changes that never happen. For precisely this reason, the American Diabetes Association (1995–2013) encourages patients who need to reforms their diets to make minimal and manageable dietary shifts with which they gradually become comfortable; then they can attempt other modifications. The Harvard Medical School (2000–2013) advocates a similar approach to lifestyle changes needed to manage heart disease. I am always reminded in this discussion of my own father, whose doctors recommended a heart healthy diet after major coronary surgery. When he arrived home to cabinets stocked with his new foods, he informed his loving and over-zealous family that he would rather starve to death. Unhappily, we restored all of his high fat and salt-loaded favorites, leaving him to slowly make minute alterations to his life style on his own time. He continued with these small shifts until he died at 91. Another protocol of manageable (although far from simple) steps, revisited and reworked over time, is of course offered by Alcoholics Anonymous and the many 12-step programs based on this philosophy (see Kaskutas, 2009; Prochaska et al., 1992). Again, despite internal and external pressure on individuals who struggle with addictions, it seems that making small, sustainable shifts in behavior can lead to larger, more lasting change.

Setting Limits

As we noted in the last chapter, boundaries are extremely important in any therapeutic endeavor, in order to protect not only a client (Gabbard & Lester, 1995) but also the therapeutic process. Boundaries in therapeutic work include the frame—that is, when a session begins and ends, how long a session will last, who will come into the office, and clients' payments for therapy. When a clinician sets and reinforces boundaries firmly and tactfully, she models an important set of behaviors for clients, especially those who have difficulties setting limits themselves. Questions of extra-therapeutic contact, with a client, family members and other professionals involved in a client's life, need to be discussed and boundaries established. However, there are also times when such agreements need to be revisited. For instance, Laurie was often late to her sessions. Although James was working to soften her overly self-critical attitude towards her own imperfections, he also maintained the therapeutic frame by ending her sessions on time and by encouraging her to arrive on time. When she became self-critical, he re-focused her by suggesting that they try to examine some of the reasons she might be having difficulty getting to her sessions. With gentle exploration, it became clear that Laurie often underestimated the

amount of time that it would take her to get anywhere. Further discussion led to links between her lateness and her tremendous dislike of being kept waiting. "I'd rather arrive late than have to wait around," she said. She often felt hurt and rejected when someone else was late. Although James thought it was significant that she was not particularly worried about doing the same thing to others, given Laurie's insecurities he decided to leave exploration of that issue for later in their work. He focused instead on what she lost by being late.

When they had established that she did not like missing part of her appointment every week, he opened up the idea that she took it personally when someone was late. "Yes, of course," she said. "It means someone doesn't care enough about me to get there on time." He asked if that was her sense of him. "No. But if I sit outside your office and wait, I'll start to think about it. You never let my sessions go over," she added, "so if you let someone else run over their time, I'll feel hurt—and angry." James encouraged Laurie to talk about these issues with Ms. Herman, who was still working with her on the underlying psychodynamic issues that were feeding into her symptoms. He said, however, that she seemed to want to hold onto these beliefs. She said that she did not want to hold onto them, but that if she arrived and he was late, she would not be able to avoid them. He asked if it would help to have something else to distract her when she arrived, just as a parent might distract a small child while waiting for something. She looked a little taken aback. "You mean, if I bring a book, I won't mind waiting so much. And my mind will be occupied, so I won't be thinking about whether or not you care about me." It was somewhat amazing to James that this had never occurred to her before, but some weeks later she eagerly shared that it was something she had begun to apply in a variety of situations—waiting for a friend, or for a dance teacher to arrive. By setting firm boundaries in a tactful and nonjudgmental manner, James opened up an area for psychodynamic exploration. He also heard and addressed rigidified thoughts (e.g. that if someone kept her waiting, it meant that they did not care about her) and then, when Laurie had more of a sense of what might be creating some of these difficulties, he offered her a specific tool for managing some of the problematic thoughts and associated feelings.

Small Successes, Powerful Motivators

Psychologically, the idea of breaking any goal into smaller steps that can be achieved more quickly makes good sense. In part, this is because success motivates us to move forward, which means that over time, with the help of ongoing small successes, we are more likely to get to the larger goals we have set (Hayes, 2004; Linehan, 1993; Prochaska et al., 1992; Raja, 2012). Similarly, when goals are smaller, failure to achieve them may be easier to deal with. These small disappointments have other benefits as well, including providing an opportunity to work on coping with the feelings attached to them—pain, frustration, disappointment, sadness, sense of inadequacy, self-blame and blame of others—which frequently cannot be addressed as

easily when the letdown is too great. I have written about the ways that this process helps clients to strengthen their "feeling muscles" (Barth, 1998, 2003). As with any form of exercise, beginning with small, manageable activities and, as the "muscles" get stronger, gradually progressing to more difficult ones, is often more productive than trying to do tasks that are beyond our capacities. Disappointment is also an opportunity for reviewing goals. Is it a signal that they need to be broken down further? Are they unrealistic? Is it time to move in a different direction or to choose different objectives? One of our most important tasks as clinicians is to help clients feel good about the small steps they are taking. We can do this by keeping in mind the parallel between clinical work and normal development.

Developmental Progression

Working in small steps is also an occasion to engage with a client from a developmental perspective. Children may appear to grow in leaps and bounds, but they actually develop one step at a time. Because it seems inevitable that there will be gaps in any developmental process, most of our clients will have missed out on some component of their psychological and emotional development. As they learn about taking small steps in therapy, clients will hopefully internalize a way of thinking about any learning process, whether it is within their own experience regarding a new job or new relationship, or about their children's developmental paths.

When I think about these ideas, I often find myself thinking of an example I was privileged to observe many years ago. I was visiting friends on a holiday weekend, and we were outside, talking and visiting and watching their young children. Their toddler approached the front stoop and sat looking thoughtfully at it. She was a competent walker who had not yet mastered stair-climbing; but she was at the age where the world was her oyster (Mahler, Pine, & Bergman, 1973) and saw every new obstacle as simply one more opportunity for expansion. As we watched, she stood and started to walk up the stairs. One of her parents dashed over to keep her from tumbling down, but before they arrived, the little girl seemed to realize it was beyond her capacity and quickly solved the problem by crawling up on her hands and knees. With her mother standing nearby, she reached the top, sat for a moment, and then started to crawl back down. Apparently deciding going down the steps face first was not a good idea, she carefully turned around to sit and bump her way down on her bottom. She repeated these steps several times over the course of the first day. The next day, engaging again in her new activity, she stood and slowly made her way up, steadying herself with the aid of the railing. She turned and grinned at her admiring audience, then sat and again bumped down as she had the day before. After 3 days of up and down practice, she decided to try to take the steps in both directions standing on her feet. Angrily rebuffing parental attempts to hold her hand, she regally marched up the steps and slowly, again with the aid of the railing, walked down them. Our applause was totally unnecessary. She was incredibly pleased with her accomplishment; and then, in the next moment, she was ready to move on to other challenges.

This image captures some of the work that James and Laurie were engaged in as well. Explaining to Laurie how important it was to practice each step before she could move on to the next one, James said that he thought she had missed some important developmental steps in her childhood. "You can't go back and undo what has—or hasn't—happened," he said, "but we can strengthen some of the places that are kind of weak. That's what these exercises are about." He added that her intelligence and sense of humor had probably helped her manage despite those areas of vulnerability. "As you get stronger, they'll be even more useful!"

Although clients and clinicians understandably wish that achievements could be made more quickly and in larger chunks, it is often these small steps that are the most significant in the long term (not unlike Sullivan's idea that small details are the most revealing). Focusing on existing strengths can be a great help in building the skills and "muscles" in areas of weakness. While clients often feel pressure, both internal and external, for example, to begin an extensive exercise regimen in order to improve their bodies, I have found that it is often far more useful to help a client start with much smaller goals—even with a single workout a week, or sometimes simply with a 5 min stretch routine 1 day each week. A clinician's personal experience can be useful in supporting our belief that such change can occur. Looking back at my own early experience of taking dance classes at the same time that I was starting therapy, I am impressed with the amount of change that occurred in my life after 6 months of doing each only one time a week!

Raja (2012) similarly encourages clients to see small stages as important in developing an ongoing exercise routine. Although developing such a routine can make a client feel better, sometimes exercise itself can create distress. Raja (2012) further notes that some clients can be overwhelmed or traumatized by the initial bodily experiences that come with exercise, which is another reason that she takes a step by step approach to developing an exercise routine with clients. The struggle is to help clients find an activity that is tolerable, not overly distressing, and that also provides them with a sense of accomplishment. Sometimes this balance is only found by trial and error. A clinician's belief in a small step approach, while empathizing with a client's frustration that change is not occurring more quickly, can provide a holding environment during these initial stages. It can also be an important source of motivation as a client moves slowly forward.

Development of Trust

While we might wish that a client could come in for several sessions a week, it can sometimes be more productive to start slowly, to allow a relationship and sense of trust to grow. This is, of course, not always the case, in particular when a client is extremely anxious or depressed and needs more frequent contact with a clinician. When a client enters our office with overwhelming symptoms, it is part of our work to offer them tools to help them begin to feel better as quickly as possible (for further discussion of this idea from an integrative perspective, see Connors, 2006;

Frank, 2005; Wachtel, 1997). An integrative clinician may decide to recommend a consultation for medication as well as suggesting some specific tools for managing the symptoms immediately (such as breathing, mindfulness, body work, cognitive behavioral interventions, and so on), and offering more frequent contact. I have found that sometimes just the offer of extra contact can be enough for some clients. They do not always need to come in for extra sessions, especially when they are able to begin engaging in some of the other work that a clinician might suggest.

A client's history, personality, social and professional environment and current issues can all influence his capacity to trust his therapist, as can a clinician's personality, style and the setting in which he practices (e.g. see Meissner, 2007a, 2007b). For instance, James had come to understand that Laurie longed to trust him but was afraid of being hurt by him. The idea that the process of change involves small steps is hard for many clients to grasp (it is, in my experience, difficult for most people). A client's struggles to manage the conflict between high expectations and limited capacity can be manifested in their transference to their therapist. Worries that a clinician is either critical and/or dismissive of their abilities may emerge along with unarticulated (at least not directly) criticism and denigration of the therapist. What is often difficult for clients and therapists is that both idealization and denigration of a therapist can exist practically simultaneously. Kohut (1971, 1977) suggests that idealization is a natural part of development and that non-traumatic disappointment in and anger at an idealized object is necessary to healthy human development. While Kohut advocates an empathic, understanding approach to both idealization and disappointment, Kernberg (2000) believes that underlying aggression must be recognized and formulated in order for opposing emotions (like love and hate) to be integrated. I would suggest that at different times both are right, but that the real trick is to find ways for a client to manage whatever emotions are beginning to emerge throughout the therapeutic process. My experience has been reinforced by recent research (see Bateman & Fonagy, 2004; Weinberg, Ronningstam, Goldblatt, Schechter, & Maltsberger, 2010) showing that different treatment techniques directed at managing these emotions all focus on understanding of clients' needs for help regulating affects, behavior and interpersonal interactions (see also Connors, 2006; Frank, 2001; Wachtel, 1997).

Agendas, Hidden and Overt

For any clinician, one of the hardest tasks may be to limit our own goals for our clients. Our goals may be far grander than those of our clients; or we may share their unrealistically high expectations. This is not to say that people cannot change, and change a great deal. It is only to say that sometimes the smallest changes are the most important; and a clinician's task is to recognize and underscore these changes in order to promote further growth—or, as Basch (1980) has pointed out, to allow a client to leave therapy with a feeling of accomplishment.

For example, in his work with Hank and Trish, George recognized that he was going to have to limit his expectations. Although he thought it would be useful for Hank to work on some of the issues he heard in his relationship with his father, Big Hank, he recognized that Hank was not interested in delving into his own psyche in that way. His culture, both personal and professional, was not one in which feelings were discussed or examined, and the accomplishments made in the five marital sessions seemed to be making a difference not only in his relationship with Trish, but also in his sense of anxiety and the physical symptoms which had been distressing him. George knew that to push Hank to do further work would be outside of the therapeutic agreement with him. It would also negate the very real positive accomplishments they had made by suggesting they had not done the "real" work (see Basch, 1980, for a further discussion of this idea). And as a result it would also diminish Hank's and Trish's sense that they could trust George, who might represent a different kind of father figure to Hank, to do what he said he would. He thought it was far better to end the contract as they wanted, supporting the clear gains they had made, and leaving the door open for further contact if they should feel the need for it, either individually or as a couple. Because he knew that therapy was not something they were familiar with, he also made a few suggestions of the types of things that might be signals that they should come back to see her. "Sometimes sleep problems, nightmares, arguments that you feel like you didn't really want to get into, feelings of frustration, changes in appetite, or a return of some of the pain you were feeling; or if the two of you aren't able to keep doing the work we've started. All of those things could come back. It doesn't mean you've failed in anyway. Sometimes it takes a few brush-up times in therapy to completely change habits that we tend to fall into without realizing it."

Not Pushing a Client Out of the Door

Therapists have a reputation for holding onto clients far too long. Perhaps out of a fear of being seen in this way, therapists sometimes end the work prematurely, before a client has accomplished his own goals. It is important to remember that sometimes a client would like to continue to work with us on longer term goals. I have often had supervisees share that they are concerned that they are forcing clients, either directly or indirectly, to stay in therapy for their own (the clinician's) needs. When I have explored this concern, I occasionally hear that a client is communicating, albeit sometimes indirectly or very subtly, a desire to end the work. Often, however, I have heard material that suggests that a client is happy to be coming to therapy. For example, he arrives on time or even early for all of his appointments, brings in material that shows that he has been thinking about or responding to previous sessions, and talks about changes that he or his family and/or friends have noticed since he started coming to therapy. This material may be blended with less overt expressions of anxiety about potential loss of the support of therapy or with behavior that is still problematic or indicates an underlying resistance to the

work. Overt compliance can, of course, also disguise resistance. An assessment of a client's actual needs can be colored by a clinician's needs; but it can also be colored by a clinician's worries about imposing those needs on a client.

Many of the clinicians who have discussed fears about "keeping" a client in therapy past the time they should be there have expressed something like, "I am enjoying the work, and I don't want to keep him (a client) in therapy just because I enjoy it." In my experience, it is often (though certainly not always) the case that if a clinician is enjoying the process, a client is getting something out of it as well. Rather than stopping therapy arbitrarily because of an "experience-distant" application of theory, it can be an important part of the process to engage a client in a discussion of his accomplishments thus far, and a reassessment of his goals and expectations. Such a discussion must be engaged in with some care. Clients often attempt to read between the lines of any intervention; and they may experience such an exploration as a clinician's attempts to get them end therapy.

This kind of miscommunication can be alleviated—or turned into further grist for the therapeutic mill—if a clinician shares something of her thought processes with her client, not only in this discussion but also throughout the exploratory process. As noted in Chap. 7, showing how we think is not the same thing as disclosing all of our feelings and wishes. As Renik (2006) explains, it is instead a way of modeling what we hope our clients will learn to do in the course of any integrative therapeutic work: pay attention to the gradual unfolding of their own thoughts and feelings.

Modeling one's thought processes in this way can also help when a client has a hidden agenda (see Barth, 2003).

Conclusion

Frank (1999) reminds us that any psychotherapy is an interactive process between two individuals. Not only does a clinician's theoretical approach impact the work, but a client's personality, style, needs, capacity to understand and ability to act (what Frank, 1999, calls "talent for action") also color how much and what kind of work gets done in therapy. Setting small, realistic goals and recognizing and reinforcing small achievements is extremely useful in managing individual differences in the capacity to accomplish therapeutic change.

Chapter 9
Building and Working with an Integrative Team

Keywords Fragile clients • Interdisciplinary teams • Teamwork • Managing conflict • Splitting • Support • Clinical interventions • Research • Clinical illustrations • Integrative social work practice • Evidence • Cognitive therapy • Behavioral therapy • Body-mind dynamics • Psychodynamic work • Attachment • Secure base

When I was in analytic training, it was generally accepted that working with more than one clinician would be harmful to a client. The belief was that having two therapists would disrupt the development of transference, which was where much of the therapeutic work was supposed to take place. But in the psychiatric hospital where I worked and in the agency where I saw people with eating disorders, many clients were in therapy with several different professionals at the same time, since they might be in any combination of medical, group, family, individual, nutritional and occupational therapy. I discovered that there were actually a number of advantages to a client's being seen by several different therapists. Team members provided different perspectives on dynamics and behaviors, supported one another through difficult situations, and provided backup so that a client was never without the support of a known and trusted therapist. Meissner (1983) and Adler (1985) discuss the importance of such backup for the needs of both client and clinician, especially when working with fragile or difficult clients who need extra support or tend to fragment or de-stabilize when their primary therapist is unavailable. What I learned during those years was that when a team worked together to help a client manage difficulties and explore conflicts, the therapeutic process seemed enhanced rather than diluted by the involvement of more than one professional, and even, when appropriate, more than one therapist.

Teamwork, or "work done by several associates with each doing a part but all subordinating personal prominence to the efficiency of the whole" (Merriam Webster Online Dictionary, 2013), has become increasingly popular in fields ranging from business to medicine to education. Research shows that teamwork can improve productivity in business to a significant degree (Ezzamel & Willmott, 1998)

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and, in medical settings, can significantly reduce accidental patient death (Lerner, Magrane, & Friedman, 2009). Although the data to date on the impact of teamwork on mental health is somewhat limited, what has been done suggests that teamwork in this field can improve client care as well (Brown, Crawford, & Darongkamas, 2000; Dorahy & Hamilton, 2009).

Teamwork also seems to be a natural component of an integrative approach. Given that a single practitioner cannot know every possible way of working with every possible combination of difficulties presented by clients, and given the idea that an integrative approach can often enhance our clinical work, it seems natural that at some point a team might be a useful way of working with certain clients. However, how does this work? When do we decide to utilize a team approach? What are some of the potential pitfalls, and how can an integrative clinician avoid them?

Throughout this book we have seen examples of teamwork, some formally and others more loosely organized. In the mental health field, teams may be formally organized, in an agency or hospital or college counseling office, or informal, for instance when a psychotherapist in private practice refers a client for adjunct work such as medical intervention, family or group therapy, nutritional or job coaching, and so on. They may be well-planned or ad hoc; they may be instigated at the suggestion of a clinician, physician or client. They may involve different forms of psychotherapy, different professions and/or different modalities. Sometimes a team may even be composed of two therapists doing basically the same work, but in different settings. September 25, 2013.

When I began working with college students struggling with eating disorders, I discovered that they were often struggling with what we then called separation-individuation issues, and also with what, as I explained in Chap. 3, I would now call attachment-individuation issues (Barth, 2003; Lyons-Ruth, 1991). Often these difficulties were linked not only to their current developmental stage of development, but also to earlier difficulties negotiating the difficult process of individuating from and remaining attached to their parents. And equally often, the separation difficulties were also linked to problems they had with self-soothing and self-regulation, for which they still needed parental assistance, but for any number of reasons were either unable to obtain or accept from their parents. Sometimes lack of ability to self-soothe was related to parental management of the complex process of separating from, yet still maintaining a connection to, their maturing child. At other times, it was related to the child's physiological and personality characteristics. Many times incapacity to soothe and regulate the self was simply a result of an adolescent and family having a particularly hard time with some of the developmental demands of this stage of life.

What I learned was that it was often useful to take a team approach to this work. For example, it could be important to coordinate with a physician and/or nurse who would supervise medical issues related to a client's weight loss and physical condition. Since we were discovering that anti-depressant medication helped many of these young women, it was also important to stay in touch with the prescribing psychopharmacologist in order to monitor the effectiveness of the drugs and their

potentially serious side effect. n. My regular contact with the psychiatrist helped us address resistance and minimize acting out with medication. For many of our clients with eating disorders, a mixture of family, group and individual work was often more beneficial than a single therapeutic approach (see also Brown et al., 2000; Stewart & Williamson, 2004). Expediency, experience and training meant that sometimes the same clinician worked in several modalities and sometimes the involvement of several different professionals was needed.

I also found that while it might complicate the transference to one therapist or the other, it could also be extremely helpful for some of these young women to have two different therapists—one at school and the other when they were home for holidays and summer vacation. One advantage to this system was an "in-person" relationship with two supportive professionals. Although splitting was sometimes a problem, as we will discuss shortly, this arrangement actually seemed to help clients build a strong alliance with both clinicians, which was particularly useful in terms of dealing with separation issues and developing a greater capacity for self-soothing and managing affects. I have written about the idea that eating disorders in college students are often related to developmental struggles in the arena of separation and attachment (Barth, 1989, 2003). Issues of object constancy and affect regulation can be overwhelming during this period. Having a face-to-face relationship with a therapist both at school and at home provided a secure base in each place when a client had a tendency to over-exercise, restrict food intake, withdraw, and/or lose a dangerous amount of weight in a short period of time. Although phone sessions were sometimes useful, we discovered that it was important to have a professional who could see any physical changes that a client might not report herself.

Similarly, despite traditional ideas about separating parents from their adolescent children's therapy and therapist in order to protect their nascent identities, I have found that it is often extremely important for the parents' and individual therapists to work closely together in many of these cases. Issues of confidentiality and privacy are relatively simple to manage when both clinicians focus on the common goal of helping a youngster and her family move away from problematic patterns of behavior. Team work also can help both therapists recognize that there are two sides (at least) to most difficulties. Splitting, victimization and parent-blaming, which are all common complications in this work, can be ameliorated by ongoing team contact.

Group work, family therapy and medical supervision also often provide a sense of safety, a secure base from which these clients can begin to integrate a healthy and functional sense of self as they move into the adult world. Knowing that the professionals involved are pulling together to help her get better can be a powerful factor in a client's investment in her own therapeutic development. Recognizing that symptoms are often the result of an interaction of a number of complex dynamics can also help eliminate blame and criticism not only within the family, but also between professionals. This is particularly useful in dealing with families in conflict, where interpersonal antagonism can derail the therapeutic work. Open communication and a respectful stance can also help clinicians manage the splitting that often occurs when there is more than one therapist involved.

Clearly, one of the potential pitfalls of such an approach is that for some clients such information-sharing feels like an invasion of privacy or a crossing of personal boundaries. In order to make decisions about how a team will proceed with each client, therefore, a thorough assessment of a client's needs, dynamics and goals must be made.

Tools for Working in a Team

Working with a team can sometimes be complicated and requires specific tools, but an integrative practitioner already has many of these tools in her repertoire. Three important tools that we have actually already discussed in other contexts make teamwork viable. They are (1) establishment of mutually agreed-upon goals; (2) mutual respect; and (3) open communication. As these three aspects of a team are operationalized, they enhance and strengthen all therapeutic alliances and a client's sense of agency.

Establishing Goals

As we talked about in the chapter on the therapeutic relationship, it is extremely important for a clinician to engage with a client around establishing goals for the work. Often this means both helping a client articulate previously unformulated desires as well as both short-term and long-term goals. A clinician must also be clear with a client about what he is able to provide, and how he will provide it. This brings the question of information-sharing into the work early in therapy. This is one of the times when the myriad of unpleasant paper-work that is part of our professional lives today actually serves an important therapeutic function. When we ask clients to sign releases for us to share and/or gather information, we have an opportunity to explore their feelings about our talking to others concerning them, and to establish boundaries for those discussion.

For example, when Laurie, the young dancer, began working with both her individual therapist, Ms. Herman, and the team at the drug treatment center, there was a great deal of discussion about what Ms. Herman would and would not share with James, who headed up Laurie's team. From the perspective of the treatment center, Ms. Herman was being brought onto the team and therefore expected to share everything Laurie told her. From Ms. Herman's perspective, such an expectation could be potentially damaging to her work with Laurie. As she and Laurie explored this issue, they opened up a number of extremely important aspects of Laurie's dynamics centering on boundaries. For example, it turned out that Laurie was extremely close with her mother, with whom she shared everything about herself and her life. Her mother then told everything to her father. "I know she's going to tell him," Laurie said, "which means I don't ever have a real conversation with him." Ms. Herman

asked her to talk about how that worked. “Well, sometimes it’s fine. But other times it feels like I don’t have a real relationship with him, either.”

One way of thinking about therapy is that it gives clients an opportunity to tell someone else their personal stories, and in the process, to hear some of the contradictions and/or unformulated meanings contained in ideas they have always simply taken for granted. As Laurie and Ms. Herman focused on the ways in which Laurie and her parents had traditionally interacted, Laurie began to wonder if she could have a different kind of relationship with each of her parents. The work with Ms. Herman and James became a kind of testing ground for some of the changes she gradually began to put in place with her family, and eventually with friends, colleagues and her boyfriend.

Communication

Communication between team members is probably the single most important means of keeping a team running smoothly. A formal, structured team generally has built-in regular meetings which often provide an opportunity for working through issues related to clients’ needs and team conflicts. Thus it is important for a team leader to set the stage for open, nonjudgmental exchanges of information and ideas. When I worked on a locked inpatient unit of a psychiatric hospital many years ago, I learned the importance of such leadership very quickly. The psychiatrist and head nurse had worked together for many years and encouraged team members to talk openly about a variety of issues related to patient care. When the team began to uncharacteristically argue about applying standard rules to a recent admission, the nurse grinned at the psychiatrist and said, “Guess we’ve got a borderline on the unit.” They explained that in their experience, clients with Borderline Personality Disorder frequently seemed to unintentionally but dynamically stir up conflict in an otherwise cohesive unit. Besides offering helpful lessons in assessment and splitting, these two pros helped the team begin to sort out the conflict and understand the ways that certain interactions from the client had divided and stirred up conflict among the team members. Working with this client in both family and group therapy, I found that understanding the dynamics within the context of the team helped me begin to recognize and address splitting that appeared in both therapeutic settings.

Communication among members of an informal team often requires more effort on the part of the members, since there is not a built-in structure of regular meetings available. However, it is worth the energy, since maintaining some sort of ongoing interactive contact is often crucial to the smooth flow of the different aspects of the therapy. Assessing a client’s needs and negotiating with client and all collaterals over confidentiality, loyalty and goals are important. Recognizing that team members have different but not mutually exclusive techniques is part of the process. Similarly, goals of an identified client may need clarification when the client base also expands to family and group members.

Mutual Respect

Clearly, there are ways in which each of these factors interacts with the others. According to researchers, one important key to successful teamwork lies in mutual respect and trust between team members (Ezzamel & Willmott, 1998; West et al., 2012). Mutual respect involves both acknowledgement of one another's strengths and open but courteous communication about conflicts or disagreements. By definition an integrative perspective recognizes the importance of different types of interventions, different skill sets and different views of the same client's dynamics. However, even these firmly held beliefs cannot always provide an adequate buffer against feelings of frustration and devaluation when a client chooses one form of therapy over another, or prefers one clinician to another. One important antidote to such conflicts is open and mutually respectful discussion between team members when such conflicts arise.

Part of the work for an integrative clinician, whether or not she is in the role of team leader, is to help a client make the best use of the team experience. This may mean running interference for a client when there is conflict among team members, or helping a client negotiate different aspects of the team experience. It also may mean accepting and working with some negative transference from a client and/or from other members of a team.

For example, in the drug treatment facility where James worked with Laurie, there were daily team conferences to discuss each client's progress and difficulties. Ms. Herman became an informal adjunct to the team, although there was some concern about this "bump" in their system among the staff at the agency, and Ms. Herman felt that there was also some resentment from staff both because she did not join the daily meetings, and also about her "special" relationship with Laurie. Laurie seemed to be sensing this conflict but was unable to put it into words until she complained that she was starting to binge again. "How can this be?" she demanded. "I've been doing so well!"

Ms. Herman asked her to talk about what had been happening in the days before she started bingeing, and Laurie said that some of the staff was making comments about her being given special treatment. "And that made you uncomfortable?"

Laurie nodded. Based on the material that she and Laurie were opening up, she hypothesized that some of these feelings mirrored some of Laurie's dynamics within her family. She said to Laurie, "It's sort of like you and your mom isn't it? You tell me everything, and then I'm supposed to share it with James and the folks at the center. But I think they may feel like you and I are both getting special treatment. Maybe they're a little envious?"

Laurie said that she hated that idea. "I don't want anyone ever to envy me." Ms. Herman asked her to talk about that concern, and Laurie spoke about how much she hated people she envied, and how she did not want anyone to feel that way about her. I have written about how envy is often viewed as all-bad, and the importance of helping clients begin to see some other aspects of this so-called negative emotion

(Barth, under consideration for publication). Ms. Herman was working to help Laurie begin to manage some of the contradictory aspects of her feelings, and also to put the feelings into the context of some of her personal stories. She therefore offered Laurie an explanation of why these feelings distressed her so much. "I think maybe they feel like they disrupt all of the good feelings you have about someone or that someone might have about you," she said. Laurie agreed. "I don't think they have to do that," Ms. Herman said. "Maybe we can find some ways for you to feel special and maybe even be envied, but also to help the staff and the other members of your group feel that they're special too?"

Laurie was intrigued by the idea but wondered if it was being manipulative. Ms. Herman asked her to talk about that concern, which opened up more of Laurie's feelings and more of her personal story. It turned out that she felt that to talk directly to her father would in some way be manipulative. "It's like I want him to pay attention to me, and that's how I get him to do it." Ms. Herman said she had a slightly different perspective, and asked Laurie if she would like to hear it. When Laurie nodded, she said, "I think people don't always know when they are loved or cared about. I wonder if both James and your dad feel like you don't talk to them because you don't like them." Laurie did not think this could possibly be true, because she adored her father and had a huge crush on James, but she was willing to try an experiment suggested by Ms. Herman. "Let's take me out of the equation with James and the other team members about one thing," she said. "You choose what, but why don't you try talking to James about something you haven't shared with him before now? And if that seems to work out, maybe you can try the same thing with your dad."

Basch (1980) writes about the stories that we tell ourselves about our parents and how these stories are often based on childhood explanations of parental behavior. Since children have limited explanations for complex behavior, it can be powerful to re-examine the stories from an adult perspective and sometimes, as Basch beautifully illustrates, can lead to significant changes not only in parent-child relationships, but in how that individual experiences other aspects of her life as a result. In Laurie's case, beginning to speak directly to James was not easy, but it was both freeing and empowering. She then spoke to her father and found that he responded with such gentleness and pleasure that she could not imagine why she had never done so before. "It just wasn't part of the story," Ms. Herman said. "You're writing the next chapter now."

In this discussion Ms. Herman directly addressed both the team issues and goals and the dynamics that she and Laurie were working on. She also encouraged Laurie to be an active part of her own team. In doing so she was also helping promote her client's sense of agency, and offering an opportunity to talk about, explore and hopefully work through long-term sibling rivalry and problematic interactional issues with parental figures within the context of an in vivo experience. And she was engaging with Laurie in negotiating and setting a contract and boundaries for their therapeutic relationship both individually and as part of a team.

A More Complex Therapeutic Alliance

An umbrella over all of these concepts is the therapeutic alliance. Adler (1985) notes that mutuality and collaboration are important components of any therapeutic alliance. As we have also discussed throughout this book, significant amounts of research (e.g. Meissner, 2007a, 2007b) show that a strong working alliance with a professional improves a client's chances of recovery from a wide variety of ailments, both physical and psychological. Mutually agreed upon goals, mutual respect, and communication are components of a strong therapeutic alliance. When the therapeutic alliances are with more than one clinician, there is a possibility of splintering and disintegration that can disrupt the positive outcome. Mutual support and respect among team members, even in the face of disagreement with one another, can help clients manage splitting and other forms of internal conflict that may be manifested in their relationships with team members. Division of labor can also help both clients and clinicians manage the multiple transferences. One of the ways that this approach can be helpful is when a resistant client is able to transfer positive feelings about one clinician or form of therapy onto another, which he may be more reluctant to try.

For instance, at the agency where Hank, the emergency worker went first for acupuncture and then for couple's therapy, team members met weekly to discuss any problems that might arise with clients, but they did not formally discuss shared clients on a regular basis. However, the sense that all of the members worked together as a team was very strong, and was communicated both directly and indirectly to clients. When his acupuncturist referred Hank to a couples' therapist, it was done seamlessly because they were both part of the same team. Hank said that he trusted his acupuncturist to send him to a good guy. After they had developed a positive relationship with George, their couple's therapist, Trish, Hank's wife, told George that she was worried about Hank.

"She always worries," Hank said. But when George gently probed, it turned out that Hank was having nightmares again and that he was often irritable. George recommended that he see one of the individual therapists on staff. "He's part of our team," he said, "so if you'd like, I can tell him some of what we've been working on." This information-sharing, which for some clients feels like an invasion of privacy, was perfect for Hank who had difficulty talking about himself and his feelings. George went on to say, "I think this is something you can get under control pretty easily. He has some tools that will help you deal with whatever's triggering the nightmares. You should feel better after that." Because Hank had already come to trust two members of the team—the acupuncturist and George—and also because he knew that some of his older and respected colleagues had also utilized the agency, Hank accepted the referral to the individual therapist this time. Thus in some situations a team approach can not only make a client feel safer, but it can sometimes also help some clients overcome resistance to the therapeutic process itself.

Trust is also an important factor, but it does not come automatically. As we have discussed, trust is something that must be earned by a clinician. Clients bring different degrees of trust to their therapy. A capacity for trust is built by life experiences

and personality; but a client's reasons for seeking help and the setting in which they are being seen will also color their feelings about any new clinician. Clients also put their therapists through conscious and unconscious tests to help them decide whether or not they can trust both the clinician and the clinic (see Weiss & Sampson, 1986). The same is true about developing a positive relationship with a team.

Transference to a Team or to a Setting

When I was in college, I worked as an aide in a residential treatment facility with young children who for various reasons could not live at home or even in a foster home. While these youngsters became attached to individual members of the treatment team, they were often more significantly attached to the residence itself. When sent home for an overnight, they would show evidence of separation anxiety; and when they returned in an agitated state to the building after a visit with a parent, they could be calmed by sitting in a familiar and comfortable chair and watching television, or sitting at their regular spot at the table and having a snack. Interestingly, many of the children had a parent and often a sibling who had grown up either at that residence or within the umbrella of the larger agency that managed it. One of the long-term staff members, who had worked with several of these multigenerational clients, told me that the parents brought their children to the facility "the way you and I would take our little ones to stay with our parents when we needed help managing them." Transference, then, was to the institution and not necessarily to an individual. In attachment language, the institution was the secure base for the parents and became a secure base for their children.

Although Winnicott is known for his contributions to individual psychoanalysis, he has also left us a lovely description of his own discovery of the importance of the setting, not just as a transference object, but also as a soothing and containing other. His comments are, like so much of his writing, poetic and inspirational. Part of his war-time work was at a residence for boys separated from their families in England during World War II. The youngsters at what he calls a "wartime hostel for evacuation failures" were acting out, having difficulties with the separation that was supposed to protect them from the trauma and danger of the bombings in the cities. As we know today, this well-intentioned separation was actually far more traumatic than anyone had imagined, so from a contemporary perspective it is not surprising that Winnicott's exploratory approach and focus on intrapsychic conflict did not have the impact that he had hoped. He describes something else that was far more useful in helping the boys deal with their emotional pain. As he puts it, "the therapy was being done in the institution, by the walls and the room, by the glass conservatory which provided a target for bricks, by the absurdly large baths…by the cook, by the regularity of the arrival of food on the table, by the warm enough… bedspreads, by the efforts of David [the director] to maintain order in spite of shortage of staff and a constant sense of futility of it all…" (Winnicott, 2011, material in brackets added by this author).

Some Difficulties for a Team Therapist

Winnicott touches on an important aspect of teamwork in this brief but beautiful paper. Gently laughing at himself and his own grandiosity, he describes "growing downward," the phrase with which he characterizes learning that his psychoanalytic skills were only a tiny part of the therapeutic community that was healing these boys. Although we recognize the importance of a therapeutic relationship to the successful outcome of the work we do, in some cases a successful transference is to a setting or an institution instead of an individual. As Kohut (1971) points out, a clinician needs to have a good handle on his own narcissistic needs in order to work well with clients who cannot view him as a separate entity. Humility and team spirit can be important tools when working with clients whose transference is to a group rather than to an individual therapist. The three tools described above are useful in helping team members negotiate the narcissistic injuries that may occur when we find ourselves less significant as individuals and important only in the context of the team.

Agreeing on Goals

Different professionals may have widely differing goals for a client, not only in terms of what is to be accomplished, but also in terms of how the goals will be achieved. A psychopharmacologist, for example, may focus on immediate symptom-relief while a psychoanalyst or psychodynamically-oriented psychotherapist may see symptoms as signals of underlying issues that need to be addressed. Family members, friends and clients themselves also often have varying expectations. For example, a man who complains incessantly about his girlfriend will perhaps be encouraged by friends and family to seek a solution—either to go for couple's therapy or to consider ending the relationship. Yet there may be psychodynamic reasons that he stays with this woman, for instance that he is uncomfortable acknowledging how much he depends on her, or that he doubts his ability to meet another woman. However, he may not be consciously aware of these issues and may not be able to articulate them even if he is aware. This can make an assessment of the dynamics and the goals toward which he wants and needs to be working difficult. One of the benefits of a team is that a clinician can consult with other professionals who know a client to help make such an assessment.

Splitting, which is generally viewed as problematic, and which can certainly create difficulties in teamwork, can also paradoxically sometimes be worked with more easily in a team than in individual therapy. When a client views one member of a team as helpful and kind and another as potentially critical and unkind, if the team members can remain united during the process, they can provide an opportunity to work through some of the difficulties this client has in interpersonal relationships. The process often involves both clinicians accepting and being curious about

that client's feelings about both of them without judgment or defensiveness. Eventually, some of the "other side" of these feelings may begin to emerge in a client's conscious awareness. It is important for both clinicians to listen carefully to these tiny shifts, but without insisting that a client acknowledge the feelings or accept their presence until he has tools for coping with these emotions. Sometimes exploring how a client would like to handle team-related issues can provide an opportunity for developing some of these tools and building skills for using them.

For example, with Laurie's permission, Ms. Herman reached out to James to find out more about his team's concerns and goals for Laurie and to explain any dynamics that she saw and thought might be useful for the team to work with. She was careful, however, to protect Laurie's confidentiality at the same time. As she explained to Laurie, "Unless there is something that I think is putting you in danger, or something specific that they need to know—which I will try to discuss with you before I share it with them—I will talk to James more about dynamics than about specific things you tell me." Laurie wanted to know what that meant, so Ms. Herman gave her an example that actually reflected on some of the transference issues that were beginning to emerge in their work.

"You've told me you have a crush on James, right?" Laurie nodded. "So I wouldn't tell him that, of course." Laurie sighed with relief. "But you told me the other day that you feel angry that he gives some of the other group members more attention than he does to you. I might ask if he has noticed that you are more withdrawn in the group and ask him what he thinks that's about. And I might ask how they approach group dynamics. Once I hear what he says, I might say that I think that you're feeling something that's like what you feel in your family—a little sibling rivalry—and ask if he has any thoughts about how you might deal with that." Laurie was both fascinated and uncomfortable with the idea that Ms. Herman would share this information about her with James.

"Does it feel like I would be exposing you in some way?" Ms. Herman asked.

Laurie nodded and said, "I know that doesn't make sense, because I've talked to him about those things, but somehow it still feels like you're going behind my back and opening up something I'm not ready to open up."

Ms. Herman said, "We've been working on boundaries—how you can pay more attention to them, and set and maintain them even with people you're close to. This sounds like it's somehow connected to that theme. Let's keep talking about it for a while and see where it takes us. So for the moment I won't say anything to James about this issue, then, unless he brings it up himself. And if he does, I'll tell him you and I have discussed it and ask him to talk with you about it. Does that feel okay to you?"

Laurie nodded. "I can't believe that you actually will do what feels right to me," she said. "What if I'm wrong? You're the professional. How can I tell you what to do?"

This discussion opened up many different aspects not only of Laurie's therapy, but also of her dynamics in the world at large. Ongoing conversation about her own ideas about what she needed led to a further elaboration of the idea that feelings and thoughts are not static. They are part of a process, and they develop and become clarified in interaction with another person.

Conclusion

Teams provide a number of supports for clients, including back-up in time of crisis and different perspectives on a client's dynamics. They can also create difficulties, of course, including splitting and conflict within a team, which can then interfere with a client's therapeutic progress. Mutual respect and mutually established goals among team members and client(s) can help ameliorate such conflict. Recognizing that therapy is a process and maintaining open and honest communication about that process can be key not only to teamwork, but to the therapeutic work itself.

Chapter 10
Working On and Working Through

Keywords Research • Clinical examples • Evidence • Integrative social work practice • Research • Phases of therapy • Beginning • Middle • End • Small steps • Process • Detailed inquiry • Cognitive therapy • Behavioral therapy • Mindfulness • Psychodynamic therapy • Body-mind • Development • Long-term therapy • Short-term therapy • Termination • Ending

In this final chapter, we will look more closely at how an integrative clinician works. By now it should be clear that an integrative practice begins with the first contact with a client, whether it is a phone call to arrange a consultation or an initial meeting in an agency waiting room, and continues throughout the therapeutic work, until and even beyond the termination process. The two organizing principles of (1) a detailed inquiry, or nonjudgmental curiosity about the small particulars of a person's life, and (2) an awareness of the significance of process, both in life and in therapy, can help a clinician make an empathic and professional assessment of a client's needs at any point in their work together. Such an assessment is crucial in determining what interventions will be probably most helpful to that client at that time. As we have seen, a client's response to any intervention is part of any process and provides invaluable data that can help determine the next therapeutic steps. Before turning to this more detailed clinical material, I would simply like to remind readers that these examples are amalgams created from clinical material I have gathered from many sources over the course of a long professional career. Therefore, while they represent situations I have encountered as a clinician, supervisor and consultant, they are not descriptive of any actual clients or clinicians.

As I was working on this chapter, I asked myself why I was returning to this point at the end of this book. Confidentiality needs to always be recognized and respected, whether a therapist is writing process notes for supervision, progress notes and information for records and for insurance purposes, or, as in this case, for clinical discussion. Yet I believe I felt the need to reiterate the way that I write illustrative material at this juncture in the book because of the topic I am about to

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discuss: the issue of trust in a therapeutic relationship. Many individuals who seek professional assistance have multiple difficulties feeling safe with others. Some are unwilling or unable to open up to another person for fear of being hurt, rejected, abandoned or worse. Others cannot let go of give up control to another, even for a therapeutic purpose. And still others trust too easily, sometimes indiscriminately, thereby leaving themselves open to boundary violation and loss of self.

While some of these fears may be the result of problematic and/or traumatic experiences with some of the people they should have been able to feel safe with, some are also linked to an inability to trust themselves. As one young man who was speaking to me about his fear that his wife might be unfaithful put it, "I don't know if I would be able to stop myself from doing something I shouldn't with another woman, if the opportunity arose. So how can I believe she won't do the same thing?" This is one of the places in which process is central, since genuine confidence in both self and other can be built only through an ongoing process over time. Unfortunately, in the current climate of health care makes it difficult to engage in the time-consuming progression of rupture and repair that Kohut (1971, 1984) says is the path to such assurance. Still, even in the short term, a therapist's understanding of and nonjudgmental curiosity about inevitable empathic failures can be a therapeutic building block for developing confidence in self and other.

Working On and Working Through

When I turned fifty, I decided to learn Spanish. It was something that I had wanted to do for a long time, and I had even taken a short course in it one summer, but I never seemed to have the time that I needed to truly begin to learn the language. Now I decided that whatever it took, I was going to become conversant in the language. It was a far more difficult task than I had imagined, but I was very lucky to find an incredibly talented, patient and often funny teacher Painstakingly going over material numerous times, repeating vocabulary I "should" have known, he helped me gradually, bit by bit, learn to speak Spanish. And he reminded me of another lesson, one that I had learned in social work graduate school and again in psychoanalytic training: that learning does not happen all at once and is never complete. It is an ongoing process. Loewald (1989) writes about this phenomenon, suggesting that understanding the learning process is a key to doing psychotherapy.

I like to keep this experience in mind when, as sometimes happens, clinicians consult with me because they feel that their work with a particular client is stale or stuck. Although a client is sometimes genuinely not moving forward, often there is deep but quiet work happening. Both members of a therapeutic dyad may feel that they are simply repeating themselves; but sometimes important learning is happening in these repetitions. This is what makes the so-called middle phase of therapy perhaps one of the hardest parts of the clinical process. Whether it lasts a month or a year, whether the interventions are cognitive, psychodynamic, developmental, or bodily, it is often a time when work is progressing, and yet it may seem that it is not going anywhere.

Patience, thoughtfulness and a sense of humor can help us get through this period, as can an understanding that sometimes while in the center of the process, we cannot see or feel how much is actually happening. In the early phase of therapy, client and clinician are getting to know one another. As time goes on, however, and the pair gets more comfortable with one another, the work can seem to slow down. Patterns have become clear, but they continue to be repeated despite both client's and therapist's best efforts. Resistances emerge. Now is when an integrative approach can be particularly useful.

For example, if a clinician is using a cognitive framework to help a client change patterns of behavior, and some patterns simply are not responding, it can be useful to take a few sessions to work on understanding what might be interfering with the work. What anxieties, fears or discomforts is a client avoiding? What would it actually mean to change? What might be the dangers of living without the old symptoms?

Recognizing Patterns and Themes

While most approaches look for repetitive patterns of problematic behavior, there is a wide range of positions on how these patterns should be dealt with. Novick (1982) calls this middle period an "incubation period" during which an idea can develop and take form. In my experience, there are a number of such phases in any therapeutic work. One part of a clinician's task is to provide a setting that feels safe and comfortable for the incubating work to go on. Recognizing patterns, helping clients see continuity from session to session and within their own experience can be part of the incubating work. "Here it is again," or "I'm doing it again," is often said with shame and embarrassment. Yet patterns are part of what makes us human. Beginning to see them when they happen is the first step in being able to change. Reinforcing a client's successful recognition of a pattern, or what Bollas (1989) describes as celebrating the arrival of an emotion, can be a powerful therapeutic intervention.

This is how it happened with Tricia and Hank. Hank was feeling better, and he and Tricia were getting along much better. They were discussing the possibility of ending their work with George in one session, and then they came into the next session quite distraught. George looked at each of them and waited for one of them to start to talk, as they usually did. But neither one said a word. "You look pretty upset," he said. "Are you having troubles talking about it?" They both nodded. "Okay, so why don't we go back to the way we used to start. Would that be okay?" Again they nodded. George reminded them that one of them would tell the story in their own words, without being interrupted by the other, and then they would switch, with the other talking without interruption, even if they did not agree with each other's interpretation of events. They nodded again, but neither was willing, or perhaps able, to start, so George suggested that Tricia, who he knew was the most talkative in general, start the ball rolling.

Not looking at Hank, Tricia said that he was having nightmares again.

"It's just been a couple of times, for pity's sake," Hank said. George knew that Hank saw any psychological distress as a sign of weakness; George responded that he realized it probably was not a huge deal, but that at the same time, he knew that Hank needed his sleep in order to be up to the demands of his job. "Yeah, well, if it gets worse I'll get some sleeping pills," Hank replied.

"What about going back to the acupuncturist?" George asked.

Hank was surprisingly unenthusiastic about the idea. "I thought you found her really helpful," George said. "Can you talk about what has changed your mind?"

Hank was not happy talking about it, but Tricia said that he had told her that he did not like lying on the table with the little needles in his back. George turned to Hank and asked if Tricia had gotten it right.

"Yeah," he said. "I didn't mind it so much at first. And it did help. But I just can't get myself to go back and do it again."

George could have tried to explore Hank's resistance further, but he was concerned about undermining Hank's sense of self-confidence, which was crucial to his work and had already been compromised by the very fact of his asking for help and by his continuing to come to couples therapy. Instead of digging into the material, George opted to share something of his own experience, knowing that Hank identified with and admired him. He said that he understood Hank's feelings about the needles, that he occasionally went for acupuncture and although he found it helpful, he was not particularly fond of the procedure either; and then he added, "But let's see if we can find some other ways to get these nightmares under control."

As we discussed in Chap. 7, much has been written about the pros and cons of self-disclosure (e.g. Gerson, 2001; Goldstein, 1994; Johnson, 1999; Mitchell, 1998). Sharing personal information can be both a powerful tool and disruptive to therapy and needs to be considered carefully. In this instance George believed a limited disclosure would help diminish Hank's feelings of shame and would move the work forward. Mitchell (1999) points out that a clinician does not always know until after the fact why a certain intervention seemed to make sense; but it is extremely important that we try to understand it after the fact, even if we could not explain it to ourselves at the moment. Only in this way can we determine whether our actions are based on a client's needs or our own countertransference enactments. Loewald (1989) writes that confusion and disorganization are necessary parts of learning. Bromberg (1994) suggests that by asking clients to put experience into words, a therapist is not only asking what that experience means, but is also establishing a relational interaction that allows us to understand that meaning. The same is true when a clinician attempts to understand his own unarticulated reasons for any action.

While it is not unusual for either a client or a clinician to feel frustrated at the reappearance of symptoms that seemed to be under control, it is important to recognize that this is a normal part of the working on and working through of therapy. Rather than a sign of failure, it is actually an opportunity to re-visit and re-work issues that are part of a client's dynamics (e.g. Barth, 2008). Recognizing that this was true of the return of Hank's nightmares, George did not feel irritated but instead patiently re-focused the couple on the symptoms. Using something similar

to Connors' (2006) two-pronged approach, George reviewed techniques that they had learned for managing the techniques that they had learned to manage the nightmares and also gently probed to see if they could put into words some of the feelings and thoughts that might have triggered them. He reiterated that his goal was to get the nightmares under control. Knowing that Hank would resist any overt sympathy about either the dreams or the lack of sleep, he took a firm, but supportive position as Hank's ally in fighting this problem. He had previously referred Hank for individual therapy, but the couple had reported back that Hank had not gone to see the other therapist. Reluctance to go into individual therapy was not unusual in the population of first responders and emergency workers who were seen at this agency, but George brought the question up again. Hank immediately bridled.

"There's nothing wrong with me. I don't need a head shrinker, thank you very much."

George nodded. He had come to believe that for many of his clients, couples therapy was actually more effective than individual, in part because it was more acceptable within their culture ("oh, you know, the wife made me go with her to talk to somebody" was how one of his clients jokingly said he put it to a buddy) and in part because, if therapy was successful, a spouse could sometimes provide functions that an individual could not provide for him or herself (e.g. see Kohut, 1971; Lapides, 2011). He therefore said that if Hank would like, they could try to deal with what might be stirring up the nightmares and get him back to sleep at night. Hank agreed, although still sounding a little reluctant. George asked if he and Tricia could remember when the first recent set of nightmares had begun.

Hank had no idea, but Tricia said, "Oh yes, it was the night we got back from the beach, honey. You remember? We'd been with the family. I remember, because you'd been out on the dock fishing with little Henry (his nephew), and I thought that was what you were dreaming about. I can't remember why I thought that, though."

Because George had decided to work with the couple as two parts of one whole, using a systems approach, he engaged with Tricia's difficulty remembering as a signal of the couple's difficulties with whatever might be causing Hank's nightmares. They might both be resistant to opening up whatever the underlying issues were; but by exploring the material together, they could be support to one another and perhaps get to some of the material that either one of them might have difficulty addressing alone. George was not trying to help Hank move into psychoanalytic exploration of his underlying conflicts. But since Hank was having troubles using some of the soothing tools he had learned previously, George thought he thought that understanding what might have set off the nightmares could help Hank make use of some of the techniques that had worked before. He therefore worked with the couple as he would have with a resistant client in individual therapy—not pushing for the content of the forgotten memory, but gently asking both of them to try to remember details about the day that Tricia had earmarked as preceding the first nightmare.

Hank looked at Tricia, who said, "Nothing happened that I can think of that might have made Hank have a nightmare."

"Oh, that's okay," said George. "Just take me through the day, step-by-step. What happened, what you did, who you saw, what you were thinking about. It doesn't

even have to be in any kind of order." He looked at Hank. "And both of you just jump in and say what you remember."

Tricia began by saying that Hank had gotten up, had a cup of coffee, and then had breakfast. George interrupted her gently. "Actually, Tricia, even though you aren't the one who had the nightmares, I'd like to hear about what you did as well. It will give me a fuller picture of the day."

Together they gradually presented a picture of an idyllic day with Hank's large extended family. George did not try to puncture what he believed might have been an idealized memory, but he believed that something might have gone on that they were not aware of. Since Tricia had said that she somehow thought that first nightmare was related to fishing with Hank's nephew, George decided to see if he could get more details about what had happened down at the dock. Hank answered, since Tricia had not been with them.

"We sat and fished. I had a smoke. Henry's a good kid. Reminds me of myself at that age. He was telling me that he wanted to grow up and be like his dad and me—do the same kind of work."

George noticed a slight shift in Hank's body movement. "Can you use that mindfulness technique we worked on before right now?" he asked. Hank looked surprised. In order not to make Hank feel singled out, he said, "Actually, both of you. Can you close your eyes and just pay attention to what you're feeling physically? What does it feel like in your body? What does your back feel like? Your neck? Your legs? You know the drill, right?"

They both nodded, sat up a little straighter, put their feet flat on the floor, and closed their eyes. They were silent for a few breaths, then Hank looked at George. "So, what did you notice?" George asked.

"I don't know why, but I was feeling tense," Hank said. "My back was tight. I couldn't tell you why. Maybe just because I didn't sleep too well last night."

George nodded. "Were you aware that it was feeling tense earlier today?" he asked. Hank said he had not noticed.

To keep the pressure off of Hank, and because he was working with the couple as a system and thought Tricia's response might help shed some light on the subject, he also asked Tricia about what she had discovered. "I was a little tense, too," she said. "I think it was about Henry. Some of the girls (referring to her mother-in-law and sisters-in-law) and I were talking about how smart he is. We were saying how much we'd like for him to break out of the family tradition and go into another profession. But he thinks Hank walks on water, and wants to be just like him."

"Yeah," Hank said. "We'd all really like him to do something else. Even my dad, whose heart would have broken if I'd followed a different path, wants Henry to make something of himself."

"Hmmm." George said. "Does that mean that your dad doesn't think you made something of yourself?"

Hank looked surprised again. "Nah, he's proud of me. It just means he's seen what the work's done to me and my brothers. It's a lot harder these days than when he started out."

Hank's diagnosis was not PTSD, but George believed that he nonetheless suffered from both direct and secondary trauma (see Tosone, Nuttman-Schwartz, & Stephens, 2012) as a result of his job. Within the context of the couples' work George had taught Tricia and Hank techniques for managing the difficult feelings. These included some simple breath work, mindfulness practice, and some ideas drawn from ACT and DBT workbooks (see Hayes, 2004; Linehan, 1993; Nhat Hanh, 1992). In conjunction with some tools the acupuncturist had also provided, Hank's nightmares and sleep difficulties had receded. Both clinicians had agreed not to label these experiences as trauma-related, because Hank and many of his colleagues viewed the very idea of trauma as a weakness. Therefore it was impressive that Hank's dad, a died-in-the-wool old-schooler, had acknowledged that his sons were being negatively affected by the work they were doing without criticizing them for it.

After obtaining some more details about the day and the evening before the first nightmare, George thought he had an idea about some of the psychological factors that had contributed to the reappearance of Hank's nightmares. He suspected that Hank was feeling some conflicting emotions about his nephew Henry, of whom he was very fond. He was probably worried that he might suffer some of the same (unacknowledged) anxiety and other emotional pain with which Hank struggled; yet at the same time he might also enjoy the boy's admiration and envy his freedom to choose, something Hank and his brothers had not been given. However, rather than point these conflicts out to Hank and Tricia, George asked the couple to both again pay attention to how they were feeling physically and emotionally. Tricia replied that she noticed that she was shredding a tissue in her hands. Hank said that he could feel his legs tensing up.

George reinforced their observations, and asked if they could say what they were feeling emotionally. Tricia said she thought they were both tense. Hank looked at her and then nodded in agreement. George asked if they had any idea why.

Tricia said, "I think Hank worries about Henry." Hank started to deny that he worried, but George said, "Let's hear what Tricia has to say. I think she might be onto something." Tricia said that Henry was like Hank's own kid, and that he wanted him to be happy. "Maybe that conversation that day made us both kind of uncomfortable." George looked at Hank then, and asked if Hank thought that was possible. Hank acknowledged that Tricia might have a point.

It was time for the session to end, so George suggested that they both try to pay attention to any signs that they might be getting worried or tense over the next week, and see if they could try putting some of their concerns into words to each other. "And maybe just for caution's sake, you could try going back to some of those exercises I showed you when you first started coming to see me," George said. He reviewed some of the self-calming exercises he had taught them both, and added a reminder that it might help to do some stretches in the early evening while they were unwinding, before they went to bed. They agreed, and left seeming calmer than when they had come into his office. George was struck by the difference between this session and some of the early meetings with this couple.

Trust in the Therapeutic Relationship

We have looked at the issue of trust previously in the chapters on assessment, the therapeutic relationship, and small steps. Over the years, as I have worked with a wide range of clients and clinicians, I have come to believe that the issue of trust is one of the threads that are woven through, although often not discussed, many different types of psychotherapy. Worked and re-worked in any therapeutic process, I believe that questions about trust of another person link to questions about trusting oneself, and that these questions can be at the heart of an integrative practice. For one thing, in an integrative practice a clinician attempts to understand what a client actually needs rather than to impose a particular type of therapy based on external or, as Kohut (1971) calls it, "experience distant" formulations. For another, as I have pointed out in other chapters, the unconscious testing of another person to ensure that they are trustworthy is both normal and adaptive, even if sometimes frustrating (see Weiss & Sampson, 1986). I have found that a clinician's nonjudgmental acceptance of and interest in a client's doubts and concerns can be an extremely important part of any therapeutic process. In this final chapter, then, let us look at some of the ways that this process can help an integrative clinician practice effectively.

Kohut (1971, 1984) tells us that an ability to tolerate a client's idealization and denigration is necessary for any true therapeutic work to be done. Bollas (1989) similarly notes that both anger and love are part of any therapeutic process, but that one or the other may be too uncomfortable for one or both members of a therapeutic pair to manage. A clinician's capacity to not only endure these difficult emotions, but to be both empathic and interested in what they mean, helps clients work through issues of self-doubt and fear of trusting others—even when these concepts are never verbalized in the therapeutic work, as we saw above. Like many clients, Hank and Tricia did not immediately feel confident that George could help them. In the early days of therapy, in fact, Hank had been quite resistant to most of George's suggestions. But gradually they came to feel that rather than imposing some sort of cold professional techniques on them, George made suggestions that grew directly out of a genuine comprehension of what was troubling them. Over time even Hank's suspicions diminished, so that when George suggested that he go back to some of the old techniques that they had worked on previously, he was willing to comply. The next week he reported that he had forgotten, but Tricia brought up the assignment each night and together they did some stretching, breathing exercises, and mindfulness work. And he had been free of nightmares all week.

Ending

Although a great deal of important psychodynamic work often goes on in the final phase of therapy (e.g. McWilliams,), demands of insurance companies as well as contemporary expectations and life styles do not allow for much exploration of these issues.

However, recently a number of short-term approaches have begun to include discussions of how the termination process can be utilized to enhance or amplify the central themes of any therapeutic work (e.g. Fosha, 2000; Grand, 2009; Miller, Rathus, & Linehan 2006, Selva & Malan, 2004).

Yet even planned terminations cannot change the fact that ending therapy can be difficult for clients and clinicians for a variety of reasons. Not only do old symptoms often re-emerge as clients begin the final phase of the work, but both members of the therapeutic dyad may have to struggle with a re-awakening of their own separation issues as they begin to say goodbye. An integrative approach offers a clinician an opportunity to look at any ending from a several different perspectives, with a goal of finding a way of addressing issues that are most pertinent to a specific client at that specific time.

Hard to Say Goodbye

I have never liked the word "termination" for this part of a clinical experience and was therefore happy to read Davies (2005) comment that it is a cold and clinical term that does not do justice to the deep emotional meaning of the phase. (It is also a little too reminiscent of the popular and violent movie about hired murderers to be a comfortable clinical concept.) Significantly, however, the concept of termination does not resonate with one extremely important component of this part of therapy—the ongoing aspect of the work which a client will be doing now that the clinical process is over. In other words, the last phase of a clinical encounter is both an ending and a beginning—the closing down of an active working alliance and the opening up of a client's ongoing personal practice and integration of what he has learned in the context of this relationship.

Even for individuals without separation difficulties, it can be hard to close down the intense and meaningful relationship that often evolves between client and clinician, sometimes in a surprisingly short period of time. Therapists are sometimes surprised by their sadness and sense of loss when a client they have enjoyed working with leaves therapy, but such feelings seem both normal and appropriate from a perspective that includes both attachment and relational conceptualizations of the relationship. Clients also frequently describe some concern that they have become so attached to a professional who they do not even know very well, but a sense of grief at loss of a supportive and caring person in their lives is a common and normal response to the end of the work.

An integrative perspective can be particularly useful in this phase of a clinical encounter. Different clients have different needs during the ending phase of therapy; and most clients also have needs and capabilities at the end of a clinical experience that are changed from those they had at the beginning, even when old symptoms return for a final farewell. Based on an assessment of a specific client's needs and abilities at this point in time, as well as the goals he and his clinician established, that clinician's personality and professional style, agency policies, and other specifics

that color each therapeutic relationship, a clinician can work with a client to choose a way of ending that is both appropriate for and meaningful to her.

Trying to find ways to bring "unthought" feelings into the therapeutic space can be an important part of the work at any stage, but it is not always recognized as part of the ending process. However, since this is often one of the times that both clinician and client's feelings and thoughts are not completely clear, it can frequently be helpful for a clinician to model the process of trying to think and talk about them (Davies, 2005; Renik, 2006) with a client.

Yet it is also important for a clinician to be alert to how a client will experience the feelings he wants to talk about. Who decides when to end?

Most often, a client makes a decision to leave therapy, either because the work is done or because life circumstances make it necessary for him to leave. There are also times, of course, when a client leaves because the work is too hard or the material being opened up is too painful for him to deal with. There are also times when a client is not happy with either his therapist and/or the way his therapist is working. This is one of the times when both an ongoing assessment and an open discussion of goals can aid the therapeutic process. If there has been a clear and honest ongoing discussion, it can be easier for a clinician to express any concerns she might have about a client's decision, and for a client to clarify why she feels that it is time to leave. Such discussions also open the door to discussing the therapeutic relationship, a client's future goals, work he will continue to do outside of the therapist's office, and they clear the way for potential return to therapy at some time in the future.

If a client who is not happy with the direction therapy is taking is willing and able to talk about areas of disappointment, it is also sometimes an opportunity to explore a larger picture of what happens when he is disappointed in others. In some cases, a clinician's willingness to listen and take a client's complaints seriously can actually open up the work in new ways.

This is what happened with Connie, who we met earlier in this book. Her therapist, Dr. Aikens attempted to refer to another clinician when she refused to do any of her assigned DBT tasks. Connie was distressed because she felt that she had disappointed Dr. Aikens. After a consultation with a psychodynamically-oriented clinician, Dr. Aikens was able to shift gears with Connie. Hearing that she was afraid of disappointing him in almost every session, he began to ask her to talk more about this concern and to make some links to these fears in other facets of her life. After exploring this fear in a number of different situations, he also began to hear that she became disappointed in many of the same people she worried about letting down. He asked if this might be a possibility with him. Could she be feeling that he was not giving her what she had wanted or expected from him?

At first Connie denied that she could possibly find anything wrong with his work, but over time, she began to speak of some areas in which she was not completely happy with his suggestions and assignments. Dr. Aikens listened carefully to her complaints and attempted to respond with understanding. In some cases, when appropriate, he even adjusted some of the assignments, so that they better fit Connie's specific needs and lifestyle. Because he was practicing an integrative approach with Connie, he did not have a planned end date with her, but as Connie

described feeling more in control and in charge of her own life, he wondered if it was time to move towards ending the work.

As soon as he brought up the question ending, many of Connie's symptoms re-appeared. Dr. Aikens consulted with the therapist to whom he had initially attempted to refer Connie, and she said that she wondered if fear of separation was one of the underlying issues in Connie's initial development of the symptoms. With this dynamic in mind, Dr. Aikens suggested that they not terminate immediately, but spend some time exploring Connie's fears of separation and her difficulties managing the feelings that went along with it. After they had discussed it and explored it for an extended period of time, they agreed to gradually cut back on their meetings. Slowly going from once a week to twice a month and then to once a month allowed Connie time to both get used to managing without the weekly support of Dr. Aikens and also to talk about her struggles with separation in a wide range of situations. They continued to meet more than a year on a once-monthly basis, and then cut back even further. "I just want to know that I can check in with you," said Connie, who had become aware of her need, like a rapprochement aged child, to "check back" with a parental figure. (See Pine, 1985, pp. 143–147, for a wonderful clinical example and discussion of a linked process with a client who almost never came to her sessions.) "I can keep a picture of you in my mind," she said, referring to an ongoing discussion of object constancy. "Is it okay if I call your answering machine from time to time just to hear your voice?"

Dr. Aikens told her she was welcome to do so, and to leave a message for him whenever she liked. He suggested that she let him know if she needed him to call her back or if she simply wanted him to listen to any messages she left. "Would you really do that?" she asked. The question opened up her sense that he might be bored by her, or that it would be a burden for him to listen to her messages. They spent a fair amount of time exploring what this fear was about, which Dr. Aikens found particularly interesting since he had been frustrated, irritated and moved by Connie, but never bored. Eventually she said that this discussion had helped her tremendously. Her fear, she said, had always been that she would disappear from his thoughts and even from his memory when she left therapy. "Out of sight/out of mind," she said. "I like the idea that you will be listening to my voice too."

Unprompted, she also said that she would leave short messages. "I don't want to take up too much of your tape," she said. "I don't need you so much anymore—I can leave space for some of your other clients." She grinned, knowing that he knew that she had once not been able to tolerate the idea that he had other clients.

Not everyone needs a slow weaning from therapy. In other words, as has been true throughout our discussion of an integrative approach, it is very important for a client and clinician to work together to develop an agreement or a contract about how they will proceed in the concluding phase. Once again it is useful to discuss and attempt to establish mutually agreed upon goals and then to move forward based on this agreement. Ideally, client and clinician arrive at a mutual agreement that their work is done, but this ideal is also not always achieved. Clients may leave before a therapist believes they are ready, both with and without alerting their clinician to their planned departure.

Problems of course arise when there is open disagreement, for example, when a client wants to leave therapy and a clinician does not think the time is right. In such cases, it can be extremely important for a clinician to examine his reasons for keeping a client. If the reasons are that he likes working with this client and does not want to lose him, obviously this is something he will need to work out in his own therapy. He may also have goals for the work that his client does not share, and this is something that needs to be explored in supervision. Basch (1980) suggests that when this conflict in goals occurs, if there is no danger to a client, it can be far better to support his gains in therapy and work towards a mutually agreed upon ending than to focus on remaining problems. Acknowledging his strengths and newly learned skills can allow him to leave feeling pleased with the experience, which leaves the door open for a return to the work in the future. Pushing him to see areas of weakness can leave him with both a sense of failure and a bad feeling about therapy itself, which may close the door on future work.

When a Therapist Ends the Work

As I noted earlier, some therapies include a built-in concluding date from the beginning of the work. In such cases there is also sometimes a formal recognition of a client's accomplishments in therapy. Miller et al. (2006), for example, offer a detailed DBT approach to helping vulnerable clients with the ending process when contracted goals have been achieved, including a formalized "graduation" ceremony with certificates and, at times, gifts that have specific meaning to a client and to the work she has done with her DBT therapists. However, there are times when a clinician ends the work without a mutual agreement with a client. Sometimes, however, a therapist ends therapy before a client seems ready. Changes in a clinician's life, including illness or psychological problems (his own or a family member's), marriage, pregnancy and/or birth of a child, professional move (e.g. going back for further training, graduation, and/or a new job), retirement, and so on can all create the need to end a therapeutic relationship before a client is clinically ready. In other cases, a clinician may feel that she has reached the end of her capacity to help a particular client, or may feel that she does not have the ability to deal with the issues a client is bringing into the work.

In some cases, setting a time to end may be utilized as an attempt to force a client to do work he has been avoiding; however, this approach can backfire on both client and clinician. Freud's famous decision to set an arbitrary final date with his client the Wolfman, for example, has been the subject of much discussion over the years (see Couch, 1999; Tosone, 1997) including his own review near the end of his career, in which he notes that setting the time limit was little more than a misguided attempt to coerce his client into changing (Freud, 1937). Novick (1997) points out that no matter what the reason, when a clinician initiates the end of therapy, a client

will almost inevitably feel rejected and hurt. Oddly, even when a client is being difficult and almost appears to be asking to have a clinician end their work together, his feelings can be hurt when it actually happens. In some cases, paying attention to and even putting this conundrum into words can be enough to get the work back on track with an acting out client. Something like "I think you want me to kick you out, but I'm not really interested in doing that," can reassure a client that her therapist both understands something about her internal conflicts and can tolerate her confusion. Sometimes it can also be important for a clinician to share that she thinks a client is ending therapy too soon. Directly explaining some of the reasons for a clinician's thoughts, including concerns about such issues as self-destructive behavior and depressive symptoms, can lead to a client's ability to talk about fears of addressing important or disturbing material. It can also be yet one more way to model the process of thinking about how we think to a client (see Renik, 2006). Paradoxically, clinicians also sometimes err on the side of ending therapy prematurely in order to avoid being seen as holding onto a client too long.

This is how it worked for Ms. Robinson, who began working with Mr. Andrews when her son was hospitalized for medical reasons. After an initially rocky start, Ms. Robinson clearly made good use of her meetings with the clinician and showed significant evidence that their work together was helping her. When her son was discharged from the hospital, she asked if she could continue to work with Mr. Andrews. Although it was not general policy for a clinician to continue with a family when a child was no longer an inpatient, Ms. Robinson was part of a new project which would have allowed her to continue her work with her social worker. However, Mr. Andrews was concerned that he was holding onto her inappropriately because he enjoyed working with her so much. "I don't want to keep her in longer-term work to satisfy my own needs," he told his supervisor. "And I don't want to make her dependent on me." Mr. Andrews' supervisor asked if there was evidence that Ms. Robinson was becoming dependent on him. "No, actually she talks about feeling like she has more agency—well, she doesn't use that word, but that's what she describes," was the answer.

One of the great benefits of an integrative perspective is that it allows a clinician to look at a client from a broad perspective. Mr. Andrews was caught up in a particular vision of clinical process, one in which he felt that clients could be "bamboozled" (in his words) into staying with a therapist longer than necessary. His supervisor helped him see that sometimes clients stay because they are still getting something out of the work. "When she has accomplished all of her goals, or when she is feeling like she's no longer getting anything of value from therapy, if you try to hold onto her then, we can re-visit this question. But for the moment," his supervisor said, "it seems like she's getting something very valuable from the process." His supervisor added that it might be useful to think about what it would mean to Ms. Robinson if her therapist told her she should not continue with therapy. Mr. Andrews spontaneously answered, "Oh, I think she would feel hurt. It actually would probably undo some of her new-found sense of self-confidence."

A Positive Ending

Providing a positive experience at the end of the work, celebrating a client's accomplishments, and discussing tools he now has for coping with the difficulties that brought him into therapy can all help clients make a successful and positive transition out of therapy (e.g. Basch, 1980). Mirroring and empathizing with painful feelings that are evoked at the end of the work, and exploring both what these feelings mean and the ways a client has learned to cope with them over the course of therapy can be helpful to some clients.

A clinician must attempt to recognize and be attuned to a client's needs and capacities for managing certain kinds of feelings. Although we might want to share our own sense of connection to a client, sometimes a direct expression of caring can create more discomfort than pleasure. At other times, discussing what a client might continue to work on when therapy is done, exploring the possibility (when a clinician believes it to be the case) that it would be better to continue in the work until a particular goal is reached, or establishing an agreement about how the work will continue can also be ways of expressing caring. These discussions, which may begin as early as the first session or as late as the last one can also be a way of addressing the idea of ending, like therapy itself, as a process.

When a Therapist Disagrees with a Client's Decision

While I agree with that it is important to reinforce a client's accomplishments at the end of any therapeutic experience, I also believe that there are times when it is appropriate for a clinician to take a stand against a client's leaving therapy at a given time. This can include when a client is overtly acting out and/or resisting therapy, when there is danger to a client or to members of his personal support group if he leaves, when there has been a rupture between client and clinician, and when a client feels conflicted about deepening the work at a specific time. This does not mean that a client must be forced to remain in therapy with a specific clinician. Sometimes referral to another professional, either within or outside of the therapeutic community in which the clinician works, can be the most productive approach. This is yet one more of the many benefits of having a team already in place when working with any client. Another team member may step in and take over the work in a seamless manner when there is a need.

I have worked with a fair number of clients who I helped make a transition to another therapist or to a clinic or agency that seemed to be able to meet their needs in ways that I could not. I have sometimes been pleasantly surprised to receive a phone call from some of these clients, sometimes years later, saying that there are some aspects of the work with me that they now would like to pursue. An integrative perspective takes into account that clients have different needs and therefore need different interventions at different times in their lives.

Conflict and Contradiction

Accepting that endings, like many other aspects of life, are often filled with contradictions can be part of the work that leads to some kind of closure. In a wonderful discussion of the conclusion of a therapy filled with conflict and contradiction, Davies (2006) describes how finding ways to tolerate and manage paradox can be part of the therapeutic work for both client and clinician. Even in straightforward work, there is also often a sense of sorrow and frustration that the relationship cannot go on. Sometimes a clinician is distressed by not knowing what will happen next in a client's life, or how his story will unfold in the future. Clients often express pain that no one in their daily lives can understand them the way their therapist does. These feelings can be titrated by a sense of accomplishment and pleasure at what has been done, and by recognizing the importance of the relationship and the work to both members of the therapeutic dyad.

When the outcome is less than successful, there are other dynamics for both client and clinician to deal with, including mourning the unachieved goals of the therapeutic work and managing feelings of disappointment and dissatisfaction both in each other, in the therapeutic work, and in ourselves. Awareness of what has not been done and articulating and managing disappointment in unmet expectations can also be an extremely important part of the therapeutic work (Kohut, 1971). What is perhaps most important of all, in this process, is a clinician's struggle not to take the content of a client's communications or his behavior personally.

Not Taking It Personally

When I was a young therapist, I worked with a woman who started every session with a criticism of something I was wearing or something about my office. Since I was just starting out, I was very sensitive about how I appeared. Did I look professional enough? Did my office? She always prefaced her remarks with, "I never say these things to anyone else, but I'm supposed to say everything I think in therapy, aren't I?" I did not know how to respond to these digs. I felt both hurt and irritated, but I did not think it would be therapeutic to tell her as much. In fact, since I believed that therapists were not supposed to get upset with their clients, both my sensitivity and my irritation seemed to me to indicate a major inadequacy on my part.

I discussed my concerns with my supervisor, who did not seem to share my fear that I was too self-involved to be helpful to her, but who suggested that rather than take her comments personally, I try to understand what they meant to her. He asked how I would think about her comments if I did not take them personally. I had troubles getting my mind around the idea at first. The words were directed at me, so how could they not be personal? But as I thought about it, I remembered something else this young woman frequently said. She had always been a "good girl," never arguing with her mother or older sister. Could she possibly be practicing

being a little less good with me? And at the same time, could she be checking to see how I reacted when she said these things to me? Without knowing that she was doing it, could she be hoping that I would show her a better way to handle the kind of criticism she often heard at home? Just putting these ideas into words for myself changed my feelings from hurt and irritation to empathy for her.

The next time she put me down I asked her if she was being intentionally critical. She said, "No, of course not!" After a brief silence she added quietly that she hadn't realized it, but she could see that what she said could have sounded mean. She was extremely upset by the idea that I could possibly have thought that she was trying to hurt me. It took some time to soothe her, but over the next months and years we talked a great deal about the "unthought" or unformulated ideas and feelings that she had been expressing without realizing she was doing so.

When she was ready to leave therapy, she spoke of that early incident as one of the most powerful components of our work. "I was so hurt that you could think I would try to be mean to you," she said. "But you just kept trying to understand what might be behind those words. You weren't mad at me. You didn't hate me." She said that that was the moment when she started learning that she could be honest with me. "I didn't have to hide what I was feeling. You would be there if I was nasty, even if it was unintentional, just as much as when I was nice." The idea broadened over time. "I think you'll always be here for me, in my heart, even if I leave you."

Separation was also a struggle for this young woman. She left therapy and came back to see me any number of times over the subsequent years. We talked about her fear that leaving someone would feel like a rejection to them, and her need, like a rapprochement aged child, to make sure that I would still be here and would be glad to see her if she needed to come back. From a developmental perspective, it is easy to understand why we take things personally. During infancy and early childhood, we experience the world as revolving around us. Piaget (1952) found that a young child looking at a picture believes that an adult on the other side of the table sees exactly what he sees (even though the adult actually sees the picture upside down). When the picture is turned so that it is right side up for the adult and upside down for him, the youngster continues to believe that they are both seeing the same image.

Obviously, part of our intellectual and psychological growth includes the gradual understanding that we do not always see the same thing as someone else. Yet sometimes we confuse this understanding with experiences of empathy. Very early in life, long before we learn to differentiate perspectives, we see our own emotions mirrored in the eyes of others—and we are mirroring emotions back to loved ones (Fonagy, Gyorgy, Jurist, & Target, 2003; Schore, 2003; Siegel, 1999). In adulthood, empathy and perspective sometimes get tangled up. Even professionals who are trained to be aware of our own feelings can have difficulty separating our own feelings from those of others, particularly those who we think we understand or who understand us. In other words, it can be hard to sort out what is about or inside us and what is about or inside the other person. Especially in moments of vulnerability, this distinction can get lost. This struggle can be particularly true in any highly charged period of psychotherapy, and the ending phase is often one of those times.

The Work of Therapy Goes On

It is also important to remember that endings come in many different forms. As noted above, even some structured and time-limited approaches make room for a client to "re-contract" for further work, either in a group or individual setting. Yet the time eventually comes for therapy to end. Because the work is never really completely done, even the best-planned ending must leave some things unaccomplished, which may mean that one or both participants feel like failures. Making space for a client to talk about painful feelings like disappointment and sadness about loss not only of a clinician's support and understanding, but also of hope for a "new" self can be an extremely important part of the therapeutic process. In many instances, I have found that clients learn to embrace not only an imperfect self, but also an imperfect world in the final stage of the work.

However, I do not wish to communicate that there is a way to tie clinical work up in a nice, neat package. The end of any therapeutic engagement is never the end of the therapeutic process. One hopes that in any clinical work a client has developed new tools for living a healthier and more productive life and has gained an expanded vision of himself and the world in which he lives. But perhaps more than anything, the goal of all therapy is that a client will use these tools and this widened perspective in order continue to grow and develop as much as he is able to. For many of us in clinical work, we frequently do not get to see our clients engaged in this ongoing development. One of the great pleasures of having practiced for as long as I have is that I have also had the joy of hearing from many of my previous clients over the years. Some have returned to work further on issues that we began dealing with in our first engagement. Others have returned to deal with painful life experiences that I would have preferred they had not had to face, but that I am glad that I am available to support them through. And still others have simply contacted me to let me know that they are continuing to move forward in life—sometime in ways we had hoped, and sometimes in directions we could not have even imagined when we ended our work together.

Conclusion

We have reviewed a wide range of research in the course of this book. As we have seen, there is significant evidence (Connors, 2006; Johnson, 1999; Kaplan and Garfinkel, 1999; Novick & Novick, 1998; Roth & Fonagy, 1996; Zerbe, 2008) a mixture of symptom-focused, cognitive behavioral, supportive, insight-oriented, affect-regulatory, medical and psychopharmacological interventions is often more helpful with a variety of clients than a single, linear approach. Much of this same research has shown that work with a team in which different specialties are provided by different therapists—e.g. family, group and individual, medical and

psychopharmacological, cognitive behavioral and insight-oriented—can also be beneficial (see also Novick & Novick, 2005). In this book we have considered two distinct but often intercepting concepts of integrative work: the use of multiple theories and techniques by a single clinician and also the use of a structured (whether formally or informally) group of professionals with different specialties working together as an integrative team in the therapy.

While psychodynamic exploration alone is seldom enough to produce significant change in some clients (e.g. Barth, 1998, 2008; Connors, 2006; Johnson, 1999; Kaplan and Garfinkel, 1999; Zerbe, 2008), it can still be a powerful tool for helping a clinician choose appropriate interventions, and for enhancing the effectiveness of other approaches with a range of symptoms, personality styles and family dynamics that manifest with these symptoms (Bromberg, 2001; Connors, 2006; Frank, 1999; Leichsenring & Rabung, 2008; Wachtel, 1997). On the other hand, a two pronged approach, such as that described by Connors (2006, 2011) focusing on self-regulation and self-initiated behavior change, can help a client manage emotions stirred up by psychodynamic exploration. Thus in my own work as both a social worker and a psychoanalyst, I have learned that it is not only not antithetical to provide concrete services and focus on psychodynamics at the same time, but that these two different aspects of the human experience are deeply and inextricably linked with each other. They inform one another, enhance one another and simultaneously explain one another. An integrative perspective is extremely useful in that it expands both available tools for working with different aspects of any client's struggles, and provides a larger therapeutic pool upon which a client can draw for assistance.

Years of clinical work have led me to believe that many, if not most clinicians bring integrative practices into the work on a daily basis. This book has been an attempt to help professionals find a way to talk and think about these practices. Further, I would suggest that today almost any intervention, whether a psychoanalytic interpretation, a cognitive behavioral exercise, a mindfulness technique, a self-soothing strategy or a prescription for medication—or anything else in our deep basket of contemporary psychotherapeutic possibilities—is, in and of itself, an integration. The concepts of "detailed inquiry," "process" and "small steps," which I have discussed throughout this book, can be stepping stones for both clinician and client in this process.

One of the great contributions of an integrative perspective is the recognition that endings, like therapy itself, and indeed like human beings, come in many different forms. The work of finishing therapy, like that of every other aspect of the process, from an integrative perspective is to help clients find ways to end that are appropriately growth-promoting and directed specifically at their needs at a given time. Recognizing and reflecting feelings that emerge during and handling tasks specific to this phase can enhance work that has already been done and make it possible for a client to continue to grow on his own, without the supportive presence of his therapist. Paying attention to a client's goals and finding ways to help him both articulate and work towards these goals can help a clinician find the most meaningful way to

end a therapeutic encounter, whatever the reason for the ending. Perhaps what is most important is that we have provided a client with new tools for coping with situations and emotions that have previously been problematic, and that we have helped them recognize that neither we nor they will always have the perfect solution to any problem. But that a good enough solution is, as Winnicott (1965) says, often better than perfect.

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