WHAT IS INTEGRATIVE CBT?

by ***Eoin Stephens***

Abstract:
Cognitive Behavioural Therapy can claim to be the counselling/psychotherapy approach which is most evidence-based and consistent with the findings of scientific psychology, but it is by no means yet a complete therapy on its own. I believe it is therefore best used in an integrative way, incorporating the best of what other approaches have to offer, and I present here a tentative model in which Integrative CBT can be seen as relating to other therapeutic approaches on 5 Levels:

Level 1: Therapeutic Relating
Level 2: Practical Problem-Solving
Level 3: Cognitive-Emotional Re-learning
Level 4: Schema Change
Level 5: Embracing the Human Condition

The core theory of therapeutic change in this model is Beck's Cognitive Therapy. The choice of what level to focus on at any particular point in therapy can be influenced by the client's goals, the stage of therapy, the type of issues, the overall case formulation, and the therapist's individual style.

As a counsellor/psychotherapist who had a fairly eclectic initial training, I have increasingly specialised in the Cognitive Behavioural approach over more than 20 years as a practitioner. However, I believe that it is best used in an integrative way, incorporating the best of what other approaches have to offer. The components of any emerging integration should ideally gather around the approach which is most evidence-based and consistent with the findings of scientific psychology. CBT is currently the leading contender in this regard, at least for certain specific diagnoses (depression, anxiety disorders etc), but it is by no means yet a complete theory on its own. The approach currently forming around the work of integratively-oriented CBT therapists such as myself can be called Integrative CBT, and aims to have both a humanistic and a scientific basis. I present here a tentative model in which Integrative CBT practice can be seen as relating to other therapeutic approaches in a pragmatic way, based on client needs, by thinking in terms of 5 Levels of work:

LEVEL 1:
Therapeutic Relating
LEVEL 2:
Practical Problem-Solving
LEVEL 3:
Cognitive-Emotional Re-learning
LEVEL 4:
Schema Change
LEVEL 5:
Embracing the Human Condition

LEVEL 1:
Therapeutic Relating

Integrative CBT needs to be first of all grounded in a therapeutic relationship, where skills such as Active Listening, Advanced Empathy etc are used to enable the client to experience the therapeutic benefits of a helping human encounter. Sometimes this is all a client needs: containing, holding, support, validation, a safe space to explore their world and their concerns. For other clients, this working alliance serves as the basis for work at the other levels below. At this level, much can be learned from Humanistic approaches such as Person-Centred Therapy (e.g. Rogers C.R. 1961) and Gestalt Therapy (e.g. Perls, F. 1951).

Integrative CBT is, amongst other things, an attempt to follow in the tradition of Aaron Beck (e.g. Beck, A.T. 1976). When it came to the therapeutic relationship, Beck was very definitely of the 'necessary but not always sufficient' camp. He emphasised that "The general characteristics of the therapist that facilitate the application of cognitive therapy... include warmth, accurate empathy and genuineness..." (Beck et al. 1979). However, he also believed that "...these characteristics in themselves are necessary but not sufficient to produce optimum therapeutic effect..." (ibid.)

So Integrative CBT believes in introducing Cognitive-Behavioural models and interventions, as necessary, into a well-grounded therapeutic relationship. But what do I mean by a well-grounded therapeutic relationship in the context of Integrative CBT?

Firstly, I agree that all therapy is conveyed through the medium of relationship, and indeed a very particular type of relationship, based on the importance of making real psychological contact with the client. Some clients may need no more than this experience of contact with another human (for instance, clients with uncomplicated bereavement), but in many cases I would also see the need for the additional factors of Explicit Collaboration, Psycho-Education, Guided Discovery etc. In situations where we are dealing with problems like Social Anxiety or an Eating Disorder, there is a lot of detailed problem-solving, cognitive restructuring, etc to be done at other levels, and the groundwork needs to be laid at the beginning.

LEVEL 2:
Practical Problem-Solving

The next level many clients need, in order to create change in their lives, is the level of problem-clarification and practical action. However, in moving ahead with problem-solving, case-formulating and intervening at other levels, we mustn't lose the felt connection with the client. If we do, we need to go back and re-establish it.

At this level, clients can be helped to engage more effectively with their environment by decreasing negative behaviours (e.g. social avoidance, passive/aggressive behaviours) and increasing positive behaviours (e.g. using social supports, asserting oneself). This can be achieved both by introducing them to general principles of change such as goal-setting, planning and reviewing, as well as by introducing specific life-skills training in areas such as stress management, assertiveness, decision-making etc.

When we move into the problem-solving attitude of Level 2, while still remaining grounded in the therapeutic relationship, we are travelling in the company of influential figures such as Gerard Egan (Skilled Helper model – see Egan, G. 2006) and William Glasser (Choice Theory – see e.g. Glasser, W. 1999). Both emphasise the importance of establishing a warm working relationship, but also understand that clients often need us to add a directional, change-oriented focus, with a commitment to planning and behavioural trial-and-review. At this level, we don't need to reinvent the wheel, but can happily incorporate the work of the above approaches, as well as others such as Motivational Interviewing (Miller, W. R. & Rollnick, S. 2002).

Skill-training in specific areas can also be a focus at Level 2. Again, there is already an enormous amount of work available to be integrated, from Assertiveness Training, Stress Management, and many other areas.

So, although this level of work is easy enough to understand conceptually, it is very broad, and there is a lot for the practising therapist to learn about.

One final point: this level is about action, behaviour change, helping the client to have a more positive influence on their environment. It can therefore be seen as more "directive", often a controversial term. The therapist should not tell the client what to do with their lives, but sometimes they do need to be quite direct in supporting the client to find the direction they want to move in, and to test out ways of moving in that direction.

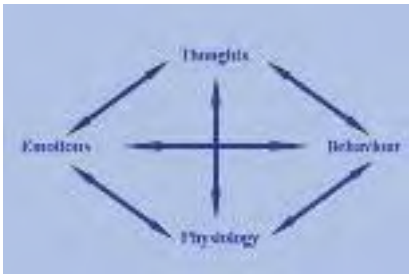
LEVEL 3: Cognitive-Emotional Re-learning

The next level of intervention which may be needed (especially for those with specific mental health issues such as Depression, OCD, etc) is collaborative, educative Cognitive/Emotional re-learning. This is the heart of CBT, and is based on the work of Beck and Ellis (e.g. Beck , A.T. et al. 1979; Ellis, A. & Dryden, W. 1999). Here we help the client to untangle self-perpetuating vicious cycles between their Environment, Cognition, Emotion, Behaviour and Physiology, so that they can unlearn what is dysfunctional and learn new, more functional, approaches. Guided Discovery processes such as Socratic Questioning and Behavioural Experimentation are used at this level, and many techniques from other approaches can also be usefully integrated; Mindfulness training is a well-known example (e.g. Segal, Z.V. et al 2001).

The central aim of Integrative CBT is cognitive change: change in the way we see things, interpret events, talk to ourselves, pay attention to certain aspects of our environment, put meaning on our lives, etc. This level therefore takes us a step beyond the work of Egan etc, into the specifically cognitive focus at the heart of the model.

There seem to be frequent misunderstandings about this type of work; common misapprehensions range from "Working with cognitions is cold, and is not concerned with emotions" to "Working to change thinking is about persuasion, and is only concerned with getting people to think rationally". Certainly none of this is true of Beck's Cognitive Therapy, which is the basis for Integrative CBT.

Focus on cognition can be relatively generic, looking at the way in which we all distort our interpretations of our experience; Ellis's Rational Emotive Behaviour Therapy and the classic Cognitive Distortions outlined by David Burns (Burns, D.D. 1989) are good examples of this. A more individualised Case Formulation can be put together with a client by identifying vicious cycles of thoughts/feelings/behaviours/physiology that are keeping a problem going.



For instance, in a depressed client, their negative thoughts feed their depressed feelings, lack of activity, and exhaustion, and are in turn reinforced by each of these symptoms. Integrative CBT gives attention to all four pieces of this symptom cycle, but is Cognitive-Behavioural in being especially focused on helping the client to make relevant changes in their thinking and in their behaviour, in order to reverse the damaging vicious cycles. Integrative CBT therapists therefore need to be comfortable in working with emotion, behaviour, cognition and physiology.

The key change process at Level 3 is what I call **Structured and Facilitated Experiential Relearning**, or **"SAFER"** – hopefully a memorable name, especially because working with anxiety is a particularly good example. When we are overanxious about something (e.g. essay-writing, attending social occasions), we no longer learn from experience in that area, because the cycle of experiential learning has become blocked (we avoid the situation, discount any successes, interpret our discomfort as a sign of failure, etc). When we do manage to make changes in a vicious cycle like this, we do so through **Experiential Relearning –** discovering through experience that our fears are not well grounded. Sometimes we are lucky, and this process happens without it being deliberately planned or structured (e.g. we find a subject that really interests us, get involved with a new social activity, etc). But when we are really stuck, this process of change requires more **Structured** Experiential Relearning; a relevant self-help book may provide sufficient structure for some people, but many people need the process to be professionally **Facilitated** by a therapist.

At this level of Integrative CBT, as in Cognitive Therapy, the learned habits of thinking and behaviour which keep the problem going can be unlearned and replaced through a process of Guided Discovery, using two very powerful therapeutic tools: Socratic Questioning and Behavioural Experiments. Socratic Questioning starts out as a cognitive/empathic process which tries to tease out what beliefs the client has learnt from their life experiences. This then leads into a probing, testing process, where the basis of beliefs are examined and questioned, not just in relation to their truth, but also their current relevance, value, importance, meaning, usefulness etc.

Behavioural Experiments are different from the Behavioural Change work we discussed at Level 2. At Level 2 we focus on

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identifying, learning and practising "good", helpful, useful behaviours in areas of the client's life where this is necessary (e.g. asserting oneself, relaxing, eating more healthily, cutting down on drinking, etc). Behavioural Experimentation, on the other hand, might equally focus on "bad" behaviours (e.g. leaving a task unfinished, not being "nice" to everyone, staying up all night, etc), since just as much, or more, can be learned experientially from the results of such experiments. So Level 2 is about engaging with the environment in order to make changes; Level 3 is about engaging with the environment in order to reality-test and re-learn; the main goal is change in the client's cognitive interpretations, assumptions etc.

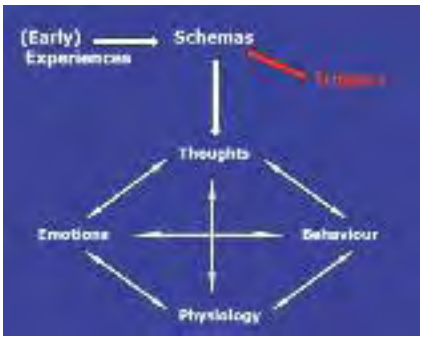
LEVEL 4: Schema Change

Therapists who are dismayed at the lack of any detailed exploration of the client's past, and especially their early development, in cognitive-behavioural approaches such as REBT and Choice Theory, will hopefully be relieved to know that Integrative CBT sees such an exploration as essential, though it may or may not need to be a central focus of therapy, depending on the client's issues and goals. Longer-term developmental work, involving more detailed life-history exploration and deeper Cognitive/Emotional restructuring at the level of Core Beliefs, can help clients to gain a broader understanding of the sources of their difficulties, as well as increasing resistance to relapse through lessening the influence of maladaptive Core Beliefs/Schemas.

One approach to this is Jeffrey Young's Schema Therapy (Young, J.E. 2003), which is CBT-based but also explicitly integrative in its theory and practice, incorporating aspects of Attachment Theory and Object Relations Theory, amongst others.
The equivalent of transference/counter-transference issues can also be explored at this level, within the framework of a Cognitive Behavioural case formulation approach, and this level allows a lot of room for integration with theoretical constructs from other schools, such as Models of Attachment, Transactional Analysis Scripts, Object Relations, Conditions of Worth, etc.

Even when the focus is mainly at other levels, therapeutic choices are best guided by a broad Case Formulation. Working at Level 4 involves adding a developmental perspective to the vicious cycles discussed earlier, expanding the formulation to include hypotheses about the client's underlying dysfunctional cognitions (see e.g. Persons 1989; Padesky & Greenberger 1995). Our earlier learning experiences leave us with deeply held ways of viewing the world, ourselves, and others, 'templates' through which we process current experience, and which therefore tend to be self-perpetuating and rigid in nature (blocking experiential re-learning at an even deeper level than that discussed earlier). These templates can be called Schemas; their contents (e.g. "I'm unlovable", "Men can't be trusted" etc) can be called Core Beliefs.

Persons (1989) suggests that this kind of formulation can explain how current problems are precipitated, and how they actually make sense in the light of underlying schemas and current triggers. It can also suggest origins of the underlying beliefs in the client's early life. A typical diagram for a Schema-based case formulation is shown below.



Negative Automatic Thoughts are seen as arising, in relevant trigger situations, from underlying Schemas/Core Beliefs. For instance, a depressed client's negative automatic thoughts could arise out of underlying beliefs such as 'I'm no good' and 'If I try anything, I make a mess of it', triggered by some current situation which is seen as a failure (e.g. applying for a job and not being called for an interview). These beliefs could be rooted in the client's early experiences of being treated as no good, or being told that he was no good.

LEVEL 5: Embracing the Human Condition

Since not all difficulties can be resolved through therapy, clients may need help to understand and process the realities of the human condition which necessarily remain. Some of these may be specific to their circumstances and history, or to their particular mental health problems (e.g. long-term health issues, marital separation, wasted career potential, partially-healed trauma). Others arise from the evolved vulnerabilities of our species (e.g. unhealthy appetite for sugar, tendency to fall in love, anxieties regarding status and meaning), or are just part of the essential nature of life (e.g. competition, rejection, risk, loss, old age, death).

Here the therapist tries to help the client towards a greater understanding of themselves as a human being, incorporating whatever perspectives they find helpful, whether philosophical, cultural, scientific, existential, or spiritual. Since this level is about humanising the client's experience, it brings us back full circle to Level 1, where the therapist tries to meet the client non-judgmentally human-to-human.

Focusing on what it means to be human can help the client to more deeply understand their vulnerability to the problems they have grappled with; not just why they are individually vulnerable to depression, or addiction, or relationship difficulties, but why human beings in general are vulnerable. This can be a great help with the process of normalising and de-stigmatising problems, and developing self-compassion.

Focusing on the human level can also help the therapist and client to plan for the client's future in a realistic way, as a human being in their own particular circumstances. Not everything is possible for everyone, and limits are set by factors such as age, resources, previous choices, personality and values. The fact that therapeutic planning happens within limits isn't necessarily bad news. Working within limits is where the creative action is; ask any artist or composer – or any recovering alcoholic.

Some view of what it is to be human is implicit in every approach to psychotherapy, and should be made as explicit as possible. A view of the human condition is not just something that we come to at the end of therapy, but a theme that runs right through the process, and influences what both client and therapist believe to be possible. The personal philosophies of being human which can be found amongst clients and therapists obviously vary enormously; along with this, there are the formal psychological theories of human nature on which any therapeutic approach is based, for example the optimistic, growth-oriented perspective of the Humanistic approaches, the relatively pessimistic Freudian view, or the pragmatic, scientific model of most Cognitive-Behavioural schools. Since the role of the therapist is to help the client towards a greater understanding of themselves as a human being, incorporating whatever philosophical, cultural, scientific, existential, or spiritual perspectives the client finds helpful, the best that can be done is to discuss these issues explicitly at appropriate points in therapy (by raising the question of long-term goals, values, etc). Client and therapist do not have to fully agree, though too great a difference in views may simply not work for the client (especially in relation to value-laden issues such as abortion, pornography, etc).

Closing remarks

Finally, I want to say a bit more about the process of choosing what level to focus on at any particular moment in therapy; I am not just describing a theoretical model here, but how I actually work. This choice can be influenced by many factors: the client's goals, the stage of therapy, the type of issues, the overall case formulation, and maybe also the therapist's individual style.

It is possible to look the five levels of Integrative CBT as a progression, and over the whole period of therapy with a client this may in fact be accurate. For example, addiction counselling often moves from developing trust and acceptance, to encouraging practical behaviour-change steps, to challenging underlying addictive thinking, to addressing "Inner Child" issues, to fostering some self-acceptance as a flawed human being. But of course the different levels are not really separate; from moment to moment in each session the therapist may be moving between problem-focus, the state of the relationship, the childhood story, reviewing goals and motivations, noticing the client's cognitive distortions, trying to validate and humanise what is happening, etc.

Yes, it does get more complicated once you try starting to problem-solve with a client, while also keeping an eye on the integrity of the therapeutic relationship; and it gets even more complicated when you add in some cognitive restructuring and developmental exploration. Of course it is easier if you take an approach which concentrates on just one of these

– but is that good enough for the client? Well, it depends on the issues. Some clients may just need some problem-solving, skill-learning assistance; they may not even need much attention paid to the therapeutic relationship, just the minimum necessary for a working alliance. On the other hand, clients with specific mental health issues such as OCD or anger problems may need to postpone much of this kind of practical work until they have learnt to think and feel differently about their problems through cognitive-behavioural re-learning at levels 3 and 4; otherwise they may be trying to solve the wrong problems (e.g. their co-workers' unhygienic habits, their spouse's high expectations!).

To be genuinely integrative, rather than just eclectic, an approach needs to be based on a core theory of therapeutic change. Following Beck, the core change in successful Integrative CBT is understood to be cognitive change (Alford, B.A. & Beck, A.T. 1997). While this change may need to be facilitated by the direct cognitive restructuring techniques of traditional CBT (Level 3), it equally may require a containing relationship (Level 1), problem-solving tools and direction (Level 2), developmental exploration, including at a transferential level (Level 4), and some attempt to set problems and recovery within the context of the human condition (Level 5). A case is therefore formulated in primarily cognitive terms (i.e. beliefs and other cognitions are seen as the main determiners of emotions, behaviours etc), but the primary work may be at any or all of the five levels described. This clearly involves a wide skill-set, if the therapist is to be flexible enough to meet a client at any of these levels.

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