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IS CLINICAL THEORY NEEDED IN PSYCHOTHERAPY AND WHAT PURPOSE DOES IT SERVE? REFLECTIONS ON PSYCHOTHERAPY INTEGRATION*

> Theoretical formulations, after all, are not simply descriptions of reality. Today it is generally acknowledged that theoretical formulations are constructions, imaginative choices, that never directly represent reality. When new observations are added to the mix, the entire Gestalt is likely to look different
> *– Paul Wachtel (1997, p. 309)*

The aim of this article is to reflect on the content, form, and meaning of so-called integrative psychotherapy. I analyze the contemporary shift towards integrative therapy in terms of several aspects: (1) its history: from an "unthinkable" approach to being recognized as almost the standard; (2) its current incarnations and meanings. Is the integrative approach possible without a paradigm to start out from, which is "home" for the therapist? (3) its future – the possible directions in which it is heading.

Keywords: psychotherapy integration; *Gestalt*; clinical theory.

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* The paper presented at the 1st Clinical Psychology Conference in Poznań (Nov 17, 2014) was titled "What does a therapist need a home for? On the tempting simplicity and painstaking complexity of integration in psychotherapy: A 'duck' or a 'rabbit'?" (the title was inspired by a drawing of a *Gestalt* in which the shapes of both animals could be discerned).

Is the integrative approach a fact? What kind of fact is it?

As we find out today, the ideological cold war between paradigms in the 1970s was only a stage in the development of science: it was a necessary and even natural predecessor of seeking rapprochement. The Society for the Exploration of Psychotherapy Integration (SEPI), established in 1983, spent a long time debating on whether the word "exploration" should simply be removed, replaced with "evolution," or retained as a sign of doubts, testing the ground for the integration that was to come in the future (cf. Norcross & Goldfried, 2005). The final debate of the two great precursors and advocates of integration – Paul Wachtel and Marvin Goldfried – concluded in the notable dream of the latter that, in 100 years, there will be... only one therapy. The common desire to look beyond the limits of the paradigm coincided with the requirements of insurance companies, ready to refund short-term therapies with proven effectiveness. Since the 1990s, tolerance for different paradigms has been clearly visible, and assimilations of other (once "contrary") conceptions and, especially, techniques are performed increasingly often. Of course, there are many advocates of highlighting unbridgeable differences between paradigms, but their voice is weaker today, and the "climate" is definitely integrative.

After 2000, the number of publications presenting syntheses of methods and concepts has been growing rapidly. At least one fourth of therapists worldwide, and in some studies even a half of them, declare themselves as integrative (Norcross, 2005). In Poland, 64% of therapists make such a declaration (a study on a sample of 1,837 therapists; cf. Suszek, Styła, Grzesiuk, Krawczyk, & Rutkowska, 2014). However, when researchers ask them to choose the applied therapy out of specific paradigms and the eclectic-integrative approach, only 11% choose the latter. The difference is fundamental: in the latter case, integrative psychotherapy is treated as a "paradigm" – the final outcome of integration, while in the former case the choice is about a preference for integration as an open process: an uncompleted action. This difference is reflected in the name of the SEPI society (Society for the Exploration of Psychotherapy Integration), in the title of the book by Norcross and Prochaska (*Handbook of psychotherapy integration*), and in the title of its Polish counterpart: *Psychotherapy Integration* (*Integracja psychoterapii*; Grzesiuk & Suszek, 2010) – not integrative psychotherapy. The word "exploration" is supposed to highlight this process – according to Wachtel, this word interferes with the rhythm (there being three consecutive nouns in the name of SEPI) but shows how integration is thought of (Wachtel, 1997, p. 323).

Although Lazarus laments that the field of psychotherapy "is still replete with cult members" (cited in Norcross, 2005, p. 4), it is almost certain that the cult of one approach has gone. It is becoming a habit to strive for integration rather than to avoid it. The spirit of the day is pluralism – or, as postmodernists put it, "multiversionality" (Chrząstowski & de Barbaro, 2011).

In conclusion of this brief introduction, this pluralism should be stressed, as it may not only refer to the form of the phenomenon – it seems to influence its contents too. One of the eminent integrationists, Stanley Messer (1992), observed that it would be more satisfactory as well as more elegant if the world of psychotherapy was one universe instead of many. But pluralists insist this is not going to happen – not soon, at any rate (Norcross, 2005, p. 4).

What was *Gestalt* and what is it today?

What is a paradigm? Let us first recall the four great clinical and therapeutic schools: psychoanalysis, the behavioral–cognitive approach, the humanistic approach, and the systemic approach (let us also agree for behaviorism and the cognitive approach to be considered jointly, since both perspectives were the first to integrate when no one was even thinking of the integration of "everything"). A paradigm as understood by Kuhn (1962) is a special perspective – a characteristic view of the world. This view, or viewpoint, is determined by central concepts (cf. Price, 1978), and its relation to other paradigms – or, more accurately, our way of perceiving it – can be illustrated by means of the concept of *Gestalt*. Just like in the famous face-vase figure (Rubin, 1915) it is possible to discern either a centrally located white vase or – on its left and right – the profiles of two black faces, also in a patient's behavior it is also possible to see a disorder (problem) described by the concepts of one paradigm *or* one described by the concepts of another. We cannot perceive the vase and the faces simultaneously, and we cannot conduct insight-oriented therapy together with conditioning-based therapy. At a given moment, only one image/viewpoint is the figure (the form: *Gestalt*) determined by our view of the world (our paradigm). As Wachtel (1997) observes, facts are not really "empirical" but derived from theory – "theory--laden." Theories influence both what people see and what they do.

Thus, it was obvious, at least in the science of the 1970s and 1980s, that:

(1) the problem in a person with a disorder can be considered or treated from more than one perspective at the same time, since in every paradigm different kinds of events are regarded as worth investigating and important;

(2) it is impossible to resolve empirically which perspective is "right," since they disagree on which events are critical ("relevant"). The results of studies conducted in one paradigm do not invalidate or confirm another – they are of no significant to it;

(3) the way a behavioral disorder is defined, what is recognized to be its cause, and what method of therapy is adopted depends on the perspective – on the paradigm we work in (cf. Price, 1978).

This position, formulated quite categorically in the Polish literature by Brzeziński (1987) as the principle of consistency (or at least noncontradiction) between theory and empiricism, is unpopular today and seems to be... outdated. The fact that paradigms adopt different ontological assumptions – different conceptions of human nature – and that their epistemologies differ no longer seems to be an obstacle to combining them. Interparadigmatic differences appear to belong to the past rather than the present way of thinking about paradigms and about . . . reality. The paper by E. Paszkiewicz (1983), a key text on the principle of paradigmatic consistency, is recalled in an integration handbook published 30 years later (Grzesiuk & Suszek, 2010) as part of the problem's history rather than as a stance to be respected today.

Theoretical integration: How paradigmatic contradiction ceases to be a contradiction

The answer to the question of why it is already **allowed** now to combine paradigms is complex, and I will try to formulate it in Conclusion. What is important here is *how* paradigms are combined. Namely, how do specific "integrations" overcome the paradigmatic contradiction?

Let us first consider why an approach combining two (or more) paradigms should be better than a "pure" one-paradigm approach. Paul Wachtel, one of the first "integrators" of paradigms (and not just any paradigms but psychoanalysis and behaviorism), believes the very same reason that divides schools to a significant reason for seeking their rapprochement (cf. Wachtel, 1997). This is because what constitutes a limitation of an individual school is the fact that, even though it facilitates discerning the disorder and indicates a method of intervention from its own perspective, it limits the discernment of facts and methods seen by a different school. Orthodox psychoanalysts ignored what behaviorists saw, and orthodox behaviorists prohibited perceiving phenomena in the psychoanalytic way. An advocate of one school, as we know, remained blind to the observations

of another. The "integrator's" task, Wachtel (1997) stresses, is not only to discern the "facts" seen by various schools but also to investigate **how** the observations of a different school **change the meaning** of what his or her own school proposes, because *Gestalt* (the view of things) will be entirely different then. Thus, **theoretical integration**, which consists in carefully studying and reworking the assumptions of a different paradigm, means that if new/unfamiliar observations/interventions are introduced, the "integrator" will feel "the need for reformulating **even one's understanding of familiar observations**" (Wachtel, 1997, p. 309, my emphasis). A theory, just like a net, does not catch all facts (all fish), though it often professes to "catch all" or maintains that it has caught at least "all that are fit to eat" (Wachtel, 1997). **Expanding the field of vision (to include the fish not caught by one's own net) is the most interesting aspect of integration**. It is hard to imagine, for example, projective identification being noticed by anyone except psychoanalysts, and among them – by anyone except object relations theorists. To an adherent of a different paradigm, recognizing this mechanism would have to mean reformulating what he or she knows and what he or she can see in the client's problem, and also what he or she strives for in therapy. Discerning it is also much more possible if it is formulated in terms of relational analysis rather than Klein's object relations theory.[1] Similarly, noticing mentalization processes (Fonagy, Gergely, Jurist, & Jarget, 2004; Fonagy & Bateman, 2006) would not have been possible if it had not been for the influence of cognitive constructivism on psychoanalysis (papers by Mitchell, 1983), which enabled focusing on relatedness and on its cognitive representations. In other words, the fact that theories differ does not imply that they cannot be integrated. Differences constitute a challenge for integration, and it is differences that make it interesting.

Although sets of procedures as well as theories and the related philosophical assumptions of paradigms differ from one another and are even contradictory, it is interesting and, of course, possible to selectively distinguish significant elements in each of them and combine them into a new synthesis. That synthesis has its own structure and its own consistency – it is a separate unit, which comprises not only elements derived from the original paradigms but also new characteristics and new assumptions.

[1] Emotions, which, in projective identification, the patient induces in the therapist, are not – as the classic theory would have it – "thrown" into the psychoanalyst as a container but represent an attempt to communicate to him or her the feelings that have been repressed (the assumptions of the relational theory – Wachtel, 2012).

The ways of integration: Old, new, or superfluous *Gestalt*?

Theoretical integration, presented above, is only one method of integration, though it seems to be the most ambitious. At the same time, in the presented perspective proposed by Wachtel, it shows very well how elements of theory and therapeutic practice cease to be contradictory. Therefore, what argues for integration is not the similarities but the **differences** between paradigms – differences that are eliminated only when the ad*O*pted element has been ad*A*pted, reworked in a new way, involving the accommodation of the old theory. It was in this way that Wachtel adapted the behaviorist perspective to psychoanalysis, with its practice of considering the current (not the past) situation, actual (not imaginary or fantasized) accounts, as well as therapist's active and supportive (rather than passive and necessarily neutral) attitude.[2] As a result, he was even able to notice that behavioral techniques were experiential, which further enabled him to see the continuum between behavioral and analytic interpretation ("The analyst's actual behavior, attitudes, and demeanor, even the inevitable variations in when she comments or asks questions and when she sits and listens, will always have an impact on the patient's experience"; Wachtel, 1997, p. 313). The author called his approach cyclical contextual psychodynamics and located it within relational psychoanalysis, which he formulated on the basis of earlier observations made by analysts such as Horney and Sullivan, Winnicott and Fairbairn, and more recently – Kohut and Modell or Mitchel and Stolorow (Wachtel, 2012, 2014; cf. Drat-Ruszczak, 2000, 2004). The *Gestalt* (point of view) offered by Wachtel's theory is new indeed, formed in the course of many attempts at fitting the psychoanalytic *Gestalt* to the behavioristic one and as a result of a transformation (accommodation) of the former carried out in such a way as to enable the adaptation of some behavioristic theses and techniques.

Usually, however, a new theory does not emerge (or it does emerge relatively seldom, though many announce it already at the stage of the *adoption* of a new technique). "Integrators" remain in their paradigm, which is their "home," though they selectively include practices and views of a different school. This manner of integration is referred to as **assimilative integration** (Messer, 1992, 2001; Norcross & Goldfried, 2005; Jędrasik-Styła & Styła, 2009). The originator

[2] Let us remember that analytic psychotherapy does not use the term "psychotherapy" but opts for the term "analysis" precisely to stress that the therapist *does not* influence the patient but remains as neutral as possible, analyzing... the patients interactions (transferred to himself or herself). (Gil & Wachtel, as cited in Wachtel, 1997).

of this concept, Stanley Messer (2001) assumes, unlike Wachtel, that theoretical integration – the accommodation of one's own paradigm – is not necessary in this case.[3] He stresses, though, that the incorporation of a given clinical procedure requires making sure whether it fits into the different therapeutic network of concepts and, additionally, whether it retains its clinical significance as well as its empirically proven effectiveness in the "new setting."

Regardless of Messer's "permission" to retain one's own paradigm in an unchanged form, assimilation is nevertheless the first attempt and the first step – well used or not – on the way towards theoretical integration. It should be assumed that the "integrator" discerns not the similarity of the assimilated techniques to his or her own but precisely the difference that will then induce him or her to reformulate familiar observations in order for the assimilation to succeed. It seems that what remains a problem is whether the integrator is able to see the old as new or whether he or she sees the new as old. The latter solution would be only vestigial integration, not capable of changing much in *Gestalt* and not certain to change much in the client's problem.

Are other paths of integration possible?

Apart from integration at the theoretical level and assimilative integration, "technical" but opening the way to a revision of theory, the integrative perspective also allows for integration at the practical level, which has no theoretical aspirations and even renounces them. **Technical eclecticism** strongly prefers combining techniques of therapy, not theories. The aim is for the therapist to acquire the ability to choose the best therapy for a given person and problem. Arnold Lazarus, a great advocate of psychotherapy integration at the level of its techniques, believes trying to build theories combining techniques to be "as futile as trying to picture the edge of the universe" (Norcross & Goldfried, 2005, p. 8).

It remains an open question whether eclecticism, interested in all techniques that "work" but not seeking convergences and syntheses, can be regarded as actual integration, since *Gestalt* in this case is something completely different. The clinical reality is seen "technically" and just like in many hand-books of psychology, it is "divided" into specific psychological processes (sensations, notions, cognitive processes, emotional processes, interpersonal relations) referred to as "modalities" in Lazarus's theory. According to Lazarus, the therapist determines the level of the client's difficulty in areas of particular modalities and thus becomes aware of their profile. What is available to him or her is all techniques

[3] Many years later, Messer believes that assimilative integration is – apart from theoretical one – the only acceptable integration (oral information – 2nd International Conference *"Integration in Psychotherapy: Effectiveness and Limitations."* PSIP, Warsaw, June 6-8, 2014).

from the major schools of psychotherapy and... his or her own flexibility. The therapist should adjust the intervention to the patient's needs, putting on the colors of a particular "school" as a "true chameleon" (Prochaska & Norcross, 2002). It can be supposed that the profile of modalities effectively directs the therapist's attention to data, and so the method starts out "from (the difficulties of) the patient," ignoring their causes, just like behaviorism did. The chameleon is not very likely to change the color of the skin often by putting on, for instance, analytic colors. He or she will feel the most comfortable wearing the robe of an advocate of the social-cognitive learning theory, and this is the paradigm recommended by the originator of the approach (and at the same time an opponent of "cult members"!). It will easily be noticed that this particular more suited that others to be expressed in terms of modalities.

Finally, the fourth route to integration is looking for so-called **"common factors."** This approach assumes that, despite observable differences, the therapeutic process itself remains the same, and focusing on the positive outcome of therapies is more important than concentrating on the unique factors that differentiate them (cf. Czabała, 2007). The initiator of this approach, Jerome Frank (1973), perceived common features in healing practices as distant as shamanism, faith healing, or communist ideology. The status of this approach appears to be rather peculiar, since it resembles transpractical assessment of the efficacy of different therapies rather than analyses of their substantive contents. The common factors that are pointed out include the patient's repair (corrective) experience or therapist feedback. Seeking a theory of the common factor in therapy, the approach constitutes a metatheory of the therapeutic process rather than a clinical metatheory capable of generating specific interventions (cf. the transtheoretical approach proposed by Prochaska & DiClemente, 1992, which investigates changes common to different therapeutic systems as well as common stages and levels of change (Grzesiuk & Suszek, 2010).

To sum up, only in the first, theoretical approach does psychotherapy integration aspire to a new synthesis – one that would respect differences between paradigms and have the ambition to work on them: to try to understand what change to one's own paradigm these new facts bring. Assimilative integration also opens up a way to such a synthesis. It should be stressed that hastily looking for similarities and blurring the differences between paradigms puts an end to realizing the creative possibilities offered by their analysis.

What is *Gestalt* in therapeutic practice and why is it impossible to do without it?

Let us now move on to practice. Below, using three examples, I discuss the relationship between clinical theory and therapeutic practice, pointing out the significance of theory for the application of a particular technique or method of therapy rather than others. Unlike technique eclectics, I assume that the decision to choose a particular technique stems from the theory behind it. **It is the theory that identifies the c a u s e of a behavioral disorder, and it is precisely on this basis that the therapist predicts that a given procedure will bring the desired effect: solving or relieving the patient's problem**.

As integration is an increasingly widespread process and only one of the four ways of pursuing it is truly theoretical, voices recalling the importance of theory are less and less numerous, and their significance is slowly becoming marginalized. This makes it all the more justifiable to present the criticism recently offered by Hoffart and Hoffart (2014), especially as their critique refers directly to the object of my reflections on the meaning of *Gestalt*, being the theory-driven view of the nature of things or the client's problem. Although Hoffarts' critique concerns Goldfried's idea (1980) – influential in the common factors perspective – which seems to the Hoffarts to be insufficient to justify integration, I believe that, in fact, it concerns any integration ignoring theory. At the same time, this critique makes it possible to present the thesis, important here, that what leads to assimilative integration and the theoretical integration that may follow is not a focus on what is common to theories or therapies but a focus on the evident differences between them.

Goldfried (1980) maintains that common factors should be sought neither at the abstract level of theory nor at the concrete level of techniques, but at the intermediate one, which he calls the level of clinical strategies. However, precisely because it does not link technique/intervention with theory, this level turns out to be useless in closer analyses, though it intuitively seems promising.

Hoffart and Hoffart (2014) define psychotherapy as "an interpersonal activity between a therapist and a client to bring about desired changes in clients' mental problems" (p. 264). The therapist has the knowledge on how to intervene to effect that change. The relationship between the therapist's knowledge (the theory he or she refers to) and the expected effect has a causal character: **theories of therapy must** specify causal relationships; that is, **they must indicate causal mo-**

dels or schemas containing a slots[4] that define the cause of the client's problem as well as specifi the procedure, the process generated by this procedure (intervention), and the outcomes of this process: the change/improvement in the client's problem (cf. Hoffart and Hoffart, 2014).

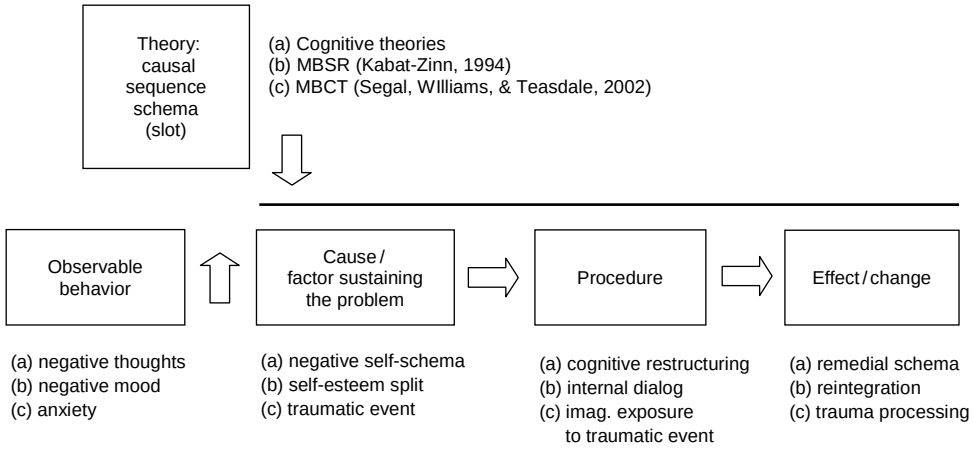
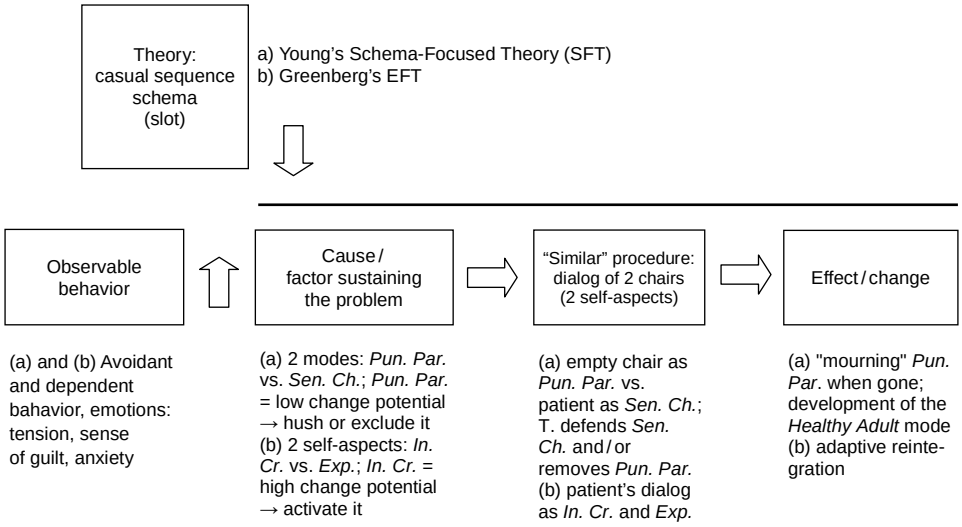


Figure 1. Therapeutic intervention: causal sequence schema (slot) applied depending on the theory of therapy that the therapist refers to: (a) A. Beck's theory of depression; (b) L. Greenberg's emotion-focused therapy (EFT); (c) E. Foa's trauma theory (author's Figure based on: Hoffart & Hoffart, 2014).

Thus, as the authors stress, to identify the cause of the client's problem, the therapist categorizes this problem in terms of causal schemata. This means that: (1) a specific observable client behavior (e.g., depression) (2) becomes an indication for the therapist to refer to conceptual knowledge in the form of a causal schema (e.g., a cognitive model of depression). The schema thus answers the question of what caused the observed problem. If therapy theories posit *different* causal schemata, the same phenomenon will be clinically categorized in different ways. If, for instance (cf. Fig. 1; example taken from Hoffart & Hoffart, 2014), the therapist refers to Beck's theory of depression, he or she will decide that the client's depressive mood is caused by negative thoughts (about themselves, the world, and the future) – element (a) in Fig. 1. If the theory referred to is

[4] The processor socket, the place in the motherboard of a computer where a device in the form of an expansion card is inserted.

Greenberg's (2002) emotion-focused therapy (EFT), both negative mood and negative thoughts will be considered as an outcome of the process of self--evaluative split, in which one part ("the Inner Critic") harshly criticizes the other part ("the Experiencer Subject"– Fig. 1 – b) and forces it to do something. Finally, if the therapist refers to the trauma theory (e.g., Edna Foa's; cf.. Foa, Hembree, & Rothbaum, 2007), he or she will place emphasis on the traumatic event "frozen" in the memory (Fig. 1 – c) . Thanks to such categorization, the cognitive therapist (1 – a) will direct intervention to the client's negative beliefs, the EFT therapist (1 – b) will direct it to the internal split of self, and the trauma therapist – to the process of retrieving the traumatic event. Because the aim of intervention (a technique or procedure) is to effect changes „in the schema--organized target," this target is part of the procedure. Consequently, as the authors stress (Hoffart & Hoffart, 2014), **"techniques and procedures are internally related to the causal schema within which the therapist is operating"** (p. 265).



Abbreviations: *Pun. Par*. – Punitive / Demanding Parent; *Sen. Ch*. – Sensitive Child; *In. Cr*. – Inner Critic; *Exp*. – Experiencer

Figure 2. Therapeutic intervention with a seemingly similar procedure based on different theories: (a) Young's SFT (schema-focused therapy) and (b) Greenberg's EFT (emotion-focused therapy). Different interventions and different types of expected change (author's Figure based on: Hoffart & Hoffart, 2014).

It is important to realize that the ***Gestalt*** (perspective, point of view) that a given theory/paradigm offers **is** not only abstract assumptions concerning the nature of reality, easily forgotten at the level of practice, but – as Hoffarts' argument shows – **a causal scheme of the entire sequence: the hypothetical cause posited by the theory – the procedure generated by the theory – the predicted effect**. If two different causal schemata are applied to the same problem, they cannot be considered as complementary or consistent.

As the authors stress, "psychotherapy is a complex and demanding activity" (p. 267), and the slot does not develop automatically, independently of the client's motivation and the therapist's behavior. It is **the theory that points to operationalizations, serving as a guide that tells the therapist how to understand a particular clinical situation and what intervention to apply.**

A rule to follow in therapy – an intervention or a procedure – cannot be the only source of support for the application of a given causal scheme. Clinical pictures of the patient's disorder/problem may be similar, but it is the theory that shows what mechanism and what disorder the client's behavior indicates. Figure 2 presents this relationship using the example of Young's (2003/2014) schema theory (ST) and, again, Greenberg's (2002) emotion-focused theory EFT; (example is again taken from Hoffart and Hoffart, 2014). The patient's emotions: tension, anxiety, and sense of guilt, as well as avoidant, dependent behavior classified as Type C personality, will be interpreted differently by the therapist depending on which of the two theories he or she refers to. This is the case even though both theories use the construct of intrapersonal "split" of the self and even though both propose a therapy of dialog between these two structures. Yet, because their ontological assumptions are different, the entire "slot" – the causes and the procedure specified by the theories – is different as well. Greenberg's EFT assumes that every person has some potential for change/self-development, and behind the Inner Critic figure (self-aspect) this theory perceives the person's fears and hopes. The schema theory, related to a greater extent to work with patients suffering from strong personality disorders and/or patients burdened with the experience of trauma, discerns that what lies behind functioning in the Punitive/Demanding Parent mode[5] is hostility, and abuse with no for potential change. If during a dialog between the Punitive Parent and the Sensitive Child (the procedure of "two chairs," in which, however, the chair symbolizing the former mode remains empty) the Punitive Parent's hostility does not diminish

[5] Mode is understood as a lasting but changeable state of mind, strongly associated with emotions – this understanding is embedded in the cognitive-behavioral paradigm, but with an attempt at incorporating the psychodynamic theory (Young et al., 2003/2014).

(the patient still maintains that the contents addressed to him or her are hostile), that particular interlocutor is excluded: the therapist puts the chair symbolizing this mode outside the room. As a result, predicted by Young's theory and belonging to the entire sequence (slot), if the patient processes the grief after losing an "internal object" and rids themselves of the Punitive Parent mode, they can, in further stages of therapy, develop the Healthy Adult mode they have not developed. In the case of EFT therapy, the two "parts" of the self are integrated, and the self acquires a new quality.

In my opinion, apart from showing the inseparable unity of the theory and practice of therapy as the previous one does, this example additionally shows how important it is to discern the differences between theories. The similarities of techniques may be superficial – without knowing the theory behind them, it is difficult to apply them in a responsible way. By means of a theory, the therapist recognizes what the patient's behavior indicates (the clinical picture it presents). In the above example, the therapist should notice the difference between the traumatizing Punitive Parent, with the experience of harm behind this figure, and the Critical Parent, whose criticism hides anxiety as well as concern.

What implicitly follows from this example is also the futility of using only techniques of therapy. The profile of modalities does not seem to be sufficient basis for the therapist to rely on: a technique (intervention) is based on a theory, generated by it, and should be applied together with it, not separately from it. As regards referring to common factors, such as "corrective experience" or "change," it is the right thing to do: after all, in both cases the patient does experience a repair and a change (of some kind) does occur, but these are nonspecific factors. If the therapist is not to get lost and to understand what and why he or she is using, he or she needs **the entire sequence** of reasoning, presented in the examples.

Theoretical integration in practice: Old or new *Gestalt*? (On the nature of integrative assimilation once again)

Let us now check, using the same schema, what assimilative integration – i.e., selective inclusion of techniques from a different paradigm – would be and what would have to be done for it to be recognized as theoretical integration. A good example is the theories and therapies of the so-called "third wave" of cognitive-behavioral therapy. (cf. Hayes, Follette, & Linehan, 2004; Castonguay, Newman, Borkovec, Holforth, & Maramba, 2005; Grzesiuk & Suszek, 2010). Most therapies representing this approach are interested in the ways of modify-

ing cognitive processes by controlling attention – that is, by focusing it on direct experience. *Mindfulness-Based Cognitive Therapy* (MBCT) by Segal, Williams, and Teasdale (2002), aimed at preventing relapses into depression, makes use of the practice of mindfulness developed by Kabat-Zinn (1994) as *Mindfulness--Based Stress Reduction* (MBSR) – meditation practice free of Buddhist ideology and terminology and adapted for the Western "user."

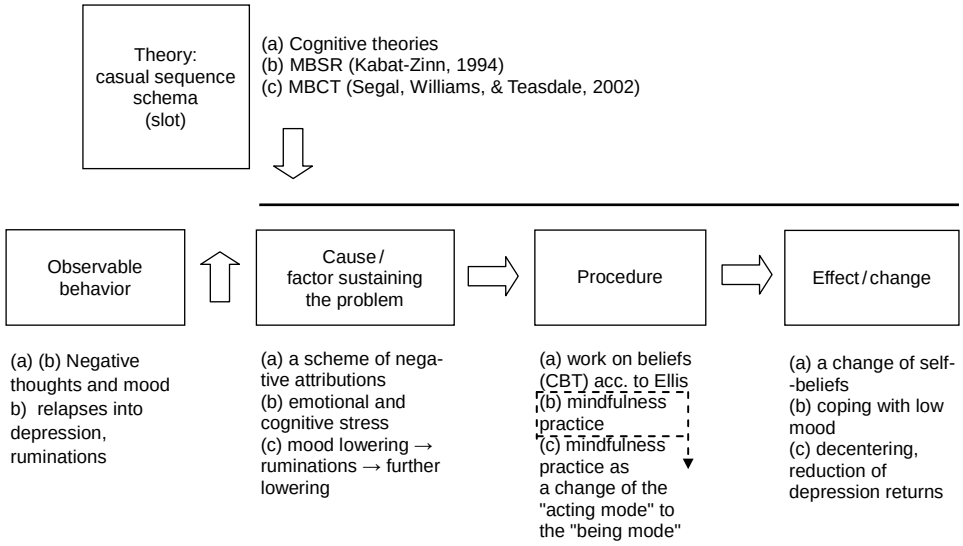


Figure 3. Therapeutic intervention: causal sequence schema (slot) applied in the case of the following theories: (a) cognitive; (b) Kabat-Zinn's stress reduction therapy (MBSR – mindfulness-based stress reduction therapy); (c) mindfulness-based cognitive therapy (MBCT; Segal, Teasdale, & Williams, 2002).

Figure 3 presents a sequence: clinical problem – theory – cause – procedure – outcome, obtained using this particular therapy. According to the MBCT theory, susceptibility to relapse into in depression stems from the links between cognitive elements (negative beliefs about oneself, the world, and the future) and affective ones (negative mood, tension), which become increasingly strong with successive recurrences. This theory makes use of the research by Nolen-Hoeksema (1991), which show that ruminations are a nonadaptive way of information processing, since they intensify negative mood instead of reducing it. Therefore, even momentary mood lowering in the remission phase poses a threat of activating further ruminations and further mood lowering, i.e., a relapse into

depression. The use of meditation (mindfulness training) causes a switching from the **action mode** (ruminating) to the so-called **being mode**. The decentering that is obtained is "the ability to adopt the observer's perspective and the ability to perceive the temporary nature of psychological phenomena without attempting to control them cognitively" (cf. Grzesiuk & Suszek, 2010, p. 142).

Thus, while traditional cognitive therapy (e.g., cognitive restructuring according to Ellis, 1999) refers to the mode in which the client operates when generating his or her symptoms (information processing), mindfulness-based therapy switches the client to a different mode, in which he or she uses only nonjudgmental attention, focused on personal experiences and letting them "be" (i.e., accepting them).

From the historical point of view, this approach is a modern incorporation of the ideas of the humanistic-experiential paradigm into the behavioral–cognitive perspective, while the technique itself is an old, 12th-century Zen practice, enjoying a renaissance in the United States – and not for the first time (cf. Ozeki, 2014, the Japanese protagonist's stay in California). What I am interested in is the question of whether the assimilation of the practice of mindfulness, first by Kabat-Zinn and subsequently by the entire third wave movement, is still assimilative integration or perhaps already theoretical integration.

Kabat-Zinn's operation has a typically assimilative character: a new element (meditation as a mindfulness practice) was incorporated into the "old" behavioral–cognitive approach. Initially, this was a case of adoption rather than adaptation of the method. However, the assimilated element – meditation – was fittingly modified. In Kabat-Zinn, meditation is accompanied by reliable behavioral techniques such as home tasks or formalized instructions concerning their performance. In Segal, Williams, and Teasdale (2002), these forms still remain Eastern (sitting meditation, walking meditation, elements of hatha yoga, body scanning, mindful eating). In Hayes (2004), by contrast, in the quickly developing Acceptance and Commitment Therapy (ACT[6]; cf. Hayes, 2004, 2007; Hayes & Smith, 2005), techniques of contact with experience acquire the form of interesting therapeutic metaphors or scripts (cf. Stoddard & Afari, 2014), presented as "behavioral therapy focused on valuable engagement in life" and written by . . . the ACT community (therapists/trainers and their clients).

[6] As if to distinguish his own ACT therapy from the flood of abbreviated names of other therapies (CBT, MBSR, MBCT, or Linehan's DBT), Hayes insists that ACT should be read as Act C-T, not as letters: A-C-T (Hayes, 2004, p. 6).

What changes is not only the form of intervention; also the aim of assimilation is modified or specified. Stress reduction – the aim of meditation in Kabat-Zinn's approach – was not a new idea. Zen philosophy recommended meditation for the same purpose, seeing it as an antidote to the "feverish" mind (cf. Oleś & Drat-Ruszczak, 2010). However, if we adopt Wachtel's criteria discussed above, the proposal offered by Segal, Williams, and Teasdale (2002) does already have a certain theoretical status, since the authors "saw" the essence of rumination in a new way – or, more broadly, they saw the futility of cognitive processing associated with negative emotions. Thus, the old "familiar observations" began to "look quite different" (Wachtel, 1997, p. 309).

A change in the "appearance" of "old/familiar observations" (i.e., the accommodation of an old theory) can be clearly observed in the proposals offered by Hayes, who formulates a theory of cognition and language (the relational frame theory, RFT; cf. Hayes, Barnes-Holmes, & Roche, 2001), stressing the role of symbols and specific linguistic expressions in the formation of a network of interrelations in the mind. On the one hand, this network makes it possible to get to know something without having to experience it directly; on the other, it results in the linguistic and mental picture of reality ("I am worse than others," "I cannot compare with others") being mistaken for reality itself. Mental representation of reality, the authors write, may in some cases become a "cognitive instrument" of our torment (Hayes et al., 2001).

A return to experience, postulated earlier by the humanistic approach and formulated in the co-called *Gestalt* therapy tenets (Oleś & Drat-Ruszczak, 2010, p. 687), now comprises a "return to the present," understood in ACT therapy as three fundamental skills: (1) cognitive defusion (the process of thinking from the world structured by thought), (2) acceptance – coming into the present with "a voluntary and undefended leap into the multifaceted, multisensory moment" (Hayes, 2007, p. 50-51), (3) the acquisition of a transcendent sense of self--developing a consciousness that patients are both their experiences feeling, thoughts, and judgements, and, in some sense, independent of them (Hayes, 2007, p. 51).[7]

Similarly to Maslow and Rogers, who once emphasized self-realization or taking actions most deeply associated with personal preferences, Hayes proposes actions based on values ("opened up to what we most deeply want in our life"). Hayes, however, does not rely on intuition. "*Research suggests* [emphasis mine –

[7] What helps acquire this awareness is, for instance, an exercise in perceiving successive objects in the surroundings and repeating the words: "I am not that"; cf. Stoddard & Afari (2014).

K. D.-R.] that the only values that can transform lives are those that are purposely chosen, reflect what you really want…"; Hayes, 2007, p. 52). Thus, Hayes's ACT therapy comprises a conception of general psychology, a conception of psychopathology (distinguishing psychological pain from its linguistic emanation), and – in accordance with the behavioral-cognitive tradition – an extensive background of empirical research on the application of ACT techniques to a wide range of mental problems (psychological suffering). As such, it not only adapts a "new" element but also actively transforms its own paradigm – or, as Hayes, Folette, and Linehan (2004, p. XIV) put it – "expands the cognitive-behavioral tradition." The evolution of the paradigm also includes its ontological and epistemological assumptions, which are now derived from S. C. Pepper's (1942) functional contextualism, stressing the context and function of phenomena. If something does not reflect the ongoing interaction between whole organism and their context, defined both situationally and historically, it is not an event at all. What matters is not the form of an event but its function (Hayes, 2004, p. 8).

Marsha Linehan (Heard & Linehan, 2005) also perceives elements of Eastern techniques in her dialectical-behavioral therapy. She noticed the limitations of the traditional behavioral approach with regard to patients with borderline disorders quite early, in 1993 (the complex and never-ending problems of those patients turned out to be totally impervious to traditional behavioral–cognitive interventions). Now, however, she is aware that the proposed dialectic balancing of acceptance and change (using techniques of cooperation on the one hand and confrontation on the other) has many common points with Hayes's contextualist proposal (Heard & Linehan, 2005), namely, the above-mentioned ability to position the self as a context for what one is currently experiencing.

Although Linehan's general theses, such as the idea that "behaviorism and Zen both recognize the importance of interrelatedness" (Heard & Linehan, 2005, p. 301) may sound surprising, her indications of such interrelatedness at the level of therapeutic technique are less so (as when, for instance, the author derives the technique of extending the patient's stance beyond the limits the patient has established[8] from the rules of the martial art of Aikido, or when she recognizes her own technique of irreverence to be similar to the strategy that Zen masters used

[8] For example, when a patient insists on lodging a complaint against the therapist, the therapists lets the patient "follow up" this behavior by offering to devote a session to writing the complaint. Treating the patient's behavior more seriously than the patient himself or herself does, the therapist does not manifest the resistance the patient expected and does not strive to "repair" the "threatened" therapeutic relationship.

in conversations with their disciples in order to interrupt their habitual patterns of thinking and to make "enlightenment" possible for them).

The philosophy of theory as presented both by Hayes and by Linehan shows very well the breach that "assimilative integration" makes in a paradigm. The assimilation of elements that are new to the paradigm makes it necessary to re-examine the entire paradigm, whose assumptions, including ontological ones, undergo a fundamental change, even if we call them merely (paradigm) "extension." This is the case even though the authors, both Hayes and Linehan, adhere to the behavioral–cognitive "home" paradigm, just like Wachtel adheres to the psychodynamic paradigm.

Paradigm then and now. What, if anything, will be "home" in the future: Where is integration heading and what does it lead to?

Before reflecting on what integration leads to or at least in what direction it is heading, let us stress that integration itself has been brought about by evolutions within paradigms. As a result of assimilative, and especially theoretical integrations, paradigms have undergone considerable transformations.

When the humanistic paradigm was emerging, it was hard to imagine that it would ever achieve even the smallest convergence with behaviorists' ideas. The subsequent cognitive paradigm seemed to enhance these differences even more: the patient brought his or her own way of "constructing" experience (his or her own cognitive schema) into the therapist's office, and the therapist was supposed to help "reconstruct" that experience and make the schema more "rational." Was it possible to predict that cognitive therapists would propose... a return to direct, "nonconstructed" experience, recognizing both the "construct" and "constructing" itself a burden? Was it possible to predict that they would see a value in what Rogers (1959) called "unconditional self-regard" – in rejecting or at least liberating the processes of evaluating this experience? Or that, finally, they would make precisely direct experience a method of therapy? And, after all, a return to experience is just one aspect of the extension of the cognitive-behavioral paradigm. Equally complex and equally fraught with consequences is the opening of the paradigm to patients' emotions and their interpersonal relations. Therapists, who have devoted a considerable number of sessions to the reduction of emotional experiences, have begun to work on their expression and extension, already knowing that what is beneficial to the client is not only controlling of emotions but also disclosing them. With Jeremy Safran's (Safran &

Zindel, 1996; Safran & Segal, 2004) interpersonal approach, the paradigm's characteristic "cognitive schema" went through a significant expansion: the schema remained a mental representation of the self, but – in Safran's version – it became a totally interpersonal representation: a cognitive-affective structure (*"hot" cognitions*) reflecting… people's early relationships with significant others.

Thus, cognitive-behavioral therapists expanded their therapy to include techniques whose purpose is to examine interpersonal relations as well as techniques revealing and deepening the emotions experienced. To some extent, analysts behaved symmetrically. As a result of Wachtel's (2012) work, and previously the work of a broad array of interpersonal approach pioneers (cf. Stern, Mann, Kantor, & Schlesinger, 1995) we well as, later, the work of Stricker and Gold, (2005), they began to take into account the patient's actual current relations, not only the early childhood relations transferred to the therapist and not only fantasized ones.

As can be seen, it is precisely due to assimilative theoretical interventions that the so-called "Great" and originally totally distinct clinical-therapeutic schools have come considerably closer to one another – if not in terms of the way they examine problems, then at least in terms of the spheres of the psyche in which they see problems. Although it is still unlikely that "in one hundred years' time" there will be one clinical school and the model of therapy will be "common" (the number of theories and therapies is increasing rather than decreasing), a more detailed analysis of those that have emerged reveals their gradual interpenetration replacing the original separatedness.

This interpenetration, however, does not mean and, it seems, is not going to mean the blurring of borders. "Home" – the original individual therapeutic system – still has an advantage over the pragmatic mixing of methods and techniques because, as assimilative integrationists stress, it provides the therapist with a structure, support, and orientation (cf. Norcross & Halgin, 2005, p. 444). In the already cited study by Grzesiuk and colleagues (cf. Suszek et al., 2014) it turned out that "one paradigm" therapists declared a relatively higher level of satisfaction with their work than eclectic therapists. "Home" thus seems to play the role of a "safe base," from which – according to Bowlby (1969) – the child (therapist) makes excursions into the world. The base means not only shelter and the place to return to; it also means the starting point, inspiring and encouraging exploration. The paradigm that is the "home" appears to be important to the *Gestalt* it offers – the "perspective" on the client's problem (the phase of "turning on" the slot), and does not have to mean "tarrying" – adhering to one approach only. Today, when paradigms have considerably expanded the scope of their inte-

rest and the ways of approaching the client, it is much easier to find a "different" perspective on the client's problem. Let us note that Paul Wachtel spent many years bringing behaviorism closer to psychoanalysis. Initially he was doing it alone, encountering astonishment more often than understanding. Steven Hayes not only needed less time for integration – from the very beginning he attracted followers and collaborators, and he developed and continues to develop the entire "third generation" of paradigm boldly, with impetus and without to much modesty.

In conclusion, it should be stressed that a paradigm, together with its assumptions about the nature of reality and the nature of cognition, is largely an emanation of the time when it emerges – the cultural and even the civilizational problems that are recognized as pivotal in a particular time. Consequently, the "old" paradigm begins to be a limitation to the "new" times generating new problems, including new clinical problems. Each of the great old paradigms emerged in a specific cultural context. Psychoanalysis in the 19th-century Vienna could not possibly observe actual traumatic events, and the belief in the importance of libido-stimulated fantasies was a good reflection of the deeply patriarchal system of social relationships. Behaviorism was an inherent part of American pragmatism, which, somewhat later, induced Aaron Beck (the cognitive perspective) to doubt the power of psychoanalysis – his initial subject of study – to explain "everything." Distortions, as he saw them, belonged to the domain of reality rather than to that of dreams. The humanistic emphasis on self--actualization expressed the reaction of American society in that period to the sense of the individual being threatened by industrialization and to the fear of nuclear danger, very intense at that time. Individuals were supposed to develop their potential far from social institutions and to be guided, as fully as possible, by their own experience (cf. Drat-Ruszczak, 2000). The trap of never-ending "cognitive constructs" would be noticed only later by neopragmatists, observing clients' "irrational" efforts to repeat "irrational" experiences. The systemic approach was inspired by cybernetics in the 2nd half of the 20th century, and the ones who found their place in it the most keenly were . . . former psychoanalysts. Imprisoned by "one person's history," they gladly expanded the object of their research to include the whole "family system," using and perfecting their now systemic approach to the problem of resistance (a trace of their techniques can be found in the already mentioned "irreverent" aspect of Linehan's therapeutic approach).

The present-day postmodern move away from "scientific facts" and "objective truth" towards emphasis on chaos, fragmentariness, and "contingency" (Ror-

ty, 1989; Giddens, 2006; Gergen, 2009; Bauman, 1995, 2006) – unexpected for many – has taken the form of a narrative paradigm, stressing multiversionality: the equality of many points of view (cf. Chrząstowski & de Barbaro, 2011). Its advocates refuse, on principle, to follow theory (cf. de Barbaro, 2010) and are not entirely ready to call their approach a "paradigm." After all, they started out by questioning the modernist philosophy of science, which they believe to have "produced" the paradigms competing with one another (cf. Loytard, as cited in Gergen, 2009). The narrative approach easily took over the earlier systemic approach (cf. Górniak & Józefik, 2003), accustomed to listening to family members' narratives, which differed from one another. "Multiversionality," being the basic experience of a family therapists, could remain the pivot of therapy in the narrative approach, while at the same time providing an impetus for the development of new techniques (Chrząstowski & de Barbaro, 2011). And even though the narrative approach cuts itself off from theory,[9] it does, as we can see, have its own ontology (the philosophy of constructionism); it also has its own rules and techniques of therapy, derived from these assumptions. Therapists, however, seem to care very much that there is no "causal" slot here. What the patient is suffering from as well as what helps him or her is supposed, on principle, to be established by the patient rather than by the therapist.

However, to do justice to the idea of integration, one should note that it is essentially "postmodern": integrationists are interested in various approaches to therapy and curious about "many different" versions of reality.

Will future integration center around new syntheses (new theories) or is it going to develop methods adjusted to many "mini-theories" – theories explaining a specific disorder (such as borderline personality disorder, depression, or obsessive ruminations)?

Are therapists going to seek a "home" (one approach providing the basis), or will they yield to the temptation of eclecticism, resembling the currently popular exchangeable "modular" approach? Or perhaps they will adopt narrative therapists' rejection of theory as "obscuring" the picture of reality? If they use modules (which, in the "home" metaphor, comes closest to "renting a flat"), will that prove to be a "good enough" practice in the profession of psychotherapist?

Introducing the reader to third-generation therapy, Hayes and colleagues (2004), stated that this movement "is challenging exciting, and hopeful" but „it is

[9] Cf. e.g.: "learning a theory can be harmful, since theories mainly obscure the picture of reality" (Tom Andersen, as cited in: Chrząstowski & de Barbaro, 2011, p. 214). "A therapist submits his or her own reflection . . . [and] does not give his ideas the status of knowledge or truth."It is just a reflection: it may be useful, or it may not" (p. 206).

not possible to know where this will lead" (p. XIV). The same can be said today that the entire integrative movement: we do not know what forms it will take and how it will conclude. What remains is to hope that not only our acceptance of integration but also our need to understand the problems it involves will continue to grow.

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