

# 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.

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