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Arguing with Myself: Thoughts on Taking an Integrative Approach

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The invitation to contribute to this issue on integrative and eclectic psychotherapies gives me an opportunity to reflect on a topic that has hovered unexamined over my clinical practice for a long time. I realize now that I have not attempted to formulate these answers before because they create some anxiety, the reasons for which will become apparent as I continue. At the same time, as I think about the questions this topic raises, I am coming to understand more about my relationship to theory and its use in my clinical work. Surely the ability to tolerate anxiety and explore its sources is the premise of good clinical work? In this last sentence, I am clearly identifying myself as a psychodynamic clinician. The anxiety creeps in when I ask myself to what extent I also practice in an integrative or eclectic fashion.

I am uncomfortable with the label eclectic; the word suggests *post facto* explanations for clinical work that has not been fully thought through. Indeed, I am embarrassed by the memory of a much younger me being asked by a senior clinician, I had met socially, what kind of psychotherapist I was. Even as the words came out of my mouth, I realized that saying "eclectic" was a cop out because I could not articulate my approach at that time in my career. Integrative, on the other hand, suggests knowledge of several different modalities and different theories of mind, recognition of the overlap between them, and an attempt to include those aspects of one that might move clinical work forward; an integrative approach amounts to informed flexibility. Rational as this explanation sounds, the notion of flexibility challenges the different orthodoxies to which I have been exposed at different times in my training, the orthodoxies to which most of us are inevitably exposed during our training. Graduate schools and training institutes rarely teach integrated approaches, faculty members are selected because they represent a particular theory, supervisors because they can oversee clinical work that defines a particular way of practicing, marking them and, consequently their supervisees, as insiders. Orthodoxy is a function of the need to establish an identity.

It is not only the need for a unifying theory that can render integrative approaches suspect. Clinicians who combine different psychotherapeutic approaches frequently come under attack. In November 2009, the *Washington Post* accused therapists of being "behind the times" because, unlike well trained physicians, they do not use the latest scientific findings to guide their technique. Psychologists are singled out for behaving like kids in a candy store: "They look around, maybe sample a bit, and choose what they like, whatever feels good to them." (Mischel 2009) Although Mischel is targeting psychologists because their graduate training is supposed to follow the Boulder scientist-practitioner model, his comments apply to all mental health professionals who do not adhere strictly to evidence based treatment. Questions about integrative and eclectic choices are anathema to this kind of thinking: Mischel would argue that they encourage the candy store approach.

As an undergraduate I would have endorsed Mischel's criticism enthusiastically. A philosophy major, I felt as if the scales had fallen from my eyes when I was introduced to the British Empiricists. Here were straightforward ways to make sense of human experience that seamlessly transferred to the behavioral psychology to which I was also exposed. In the early nineteen seventies, Social Learning Theory was in its heyday and I was hooked by its simplicity and universality. But when it came to accepting

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invitations to join clinical psychology Ph.D. programs, I instinctively knew that Social Learning Theory's elegance was also its greatest fault. Its language did not do justice to unwelcome and indelible emotions. The theory did nothing to explain the surreal quality and unsettling familiarity found in many dreams. In short, it did not deal satisfactorily with what lies just beneath the surface of average, messy everyday lives. Under the circumstances, I believed I should broaden my horizons and accepted a place in a program that identified as psychodynamic. There, (as Paul Wachtel has been pointing out for over 25 years) in a course on object relations theory, I rapidly discovered convergencies between behavioral and psychoanalytic theories. I recognized that patterns of reinforcement between a mother and child could be viewed as an internalized object relationship that would shape the child's behavior and generalize to other situations. I could see how an inconsistent parent, who established what a behaviorist would call a variable pattern of reinforcement, and what Fairbairn would describe as a frustrating object relationship, could lead to what Fairbairn calls adhesive libidinal ties; while in behavioral terms, variable patterns of reinforcement result in behavior that is difficult to extinguish. Imagining an internal world constituted by the sum of these early relationships offered a much richer and less mechanistic way of thinking with patients about particular problems.

Today I sometimes explain patterns of reinforcement to patients as a way, say, of helping them extinguish unwelcome advances, or tell parents that behavioral theory shows that positive reinforcement is a much more effective means of changing behavior than punishment. This is where I start to question myself and begin to feel a little uncomfortable. Aron (1999) describes a 'psychoanalytic third,' like a professional superego, representing all our psychoanalytic forebears, carefully monitoring the clinical work of those of us who have been trained psychoanalytically. What does it mean if I deviate from accepted technique? Do I still belong to the analytic club when I teach behavioral principles to my patients?

I took away from graduate school the knowledge that as a clinician I am most comfortable working with patients at their own speed, working with the problems they bring to treatment, not overriding those concerns or imposing my theories. In the course of time, those theories will help me think through what is going on and guide the way I approach my work and the questions I ask. Given the fact that when I left graduate school I was working in an inner city clinic with a sadly neglected population, I did not have much choice. I got nowhere unless I met my patients where they were. In that clinic and in my research with Vietnam veterans, I learned one other enduring lesson: always give external circumstances their due.

Working in the inner city impressed upon me how much more I needed to learn about being a therapist. I opted for a family therapy training over a psychoanalytic institute which, at that time, did not give external events their due. Furthermore, still an empiricist at heart, I questioned the *a priori* assumptions that psychoanalytic theory, as it was then constituted, made about the underlying motives of human behavior.

I learned two enduring lessons from my family therapy training. One, of great value, offered me a way to think about family relationships. The other was much more problematic; it starkly demonstrated that when orthodoxy prevails blindly patients' needs can be dangerously denied.

On the plus side, in demonstrating his understanding of General Systems Theory as it applied to families, Carl Whitaker held up a mobile with perfectly balanced, colorful silhouettes of differing shapes and sizes dancing around one another. As he cut off one figure, the mobile went limp. Whitaker showed how easily interactions within families can be thrown off kilter by changes in one family member, and how hard others work to compensate for or to coerce the changed member to return to the old behaviors and so restore equilibrium, no matter how dysfunctional that equilibrium may be. This knowledge informs just about every one of my psychotherapy sessions with individuals, couples, and families. In fact, in every interaction where I want to understand a particular relationship within a given system, I remember Carl Whitaker's mobile.

The negative lesson I took from that institute concerns not theory *per se* but practice. As in many family institutes, a supervisor observed my sessions from behind a one way mirror. On one occasion, when I was working with a couple with an angry and withdrawn 22-year-old daughter, my supervisor phoned into the treatment room and insisted that I ask the daughter a very touchy question; the patient had just volunteered she would not answer this question if it were asked. What the supervisor actually said was, "OK, I take the bait. Get her to answer that question." Against my better judgment, but not daring to refuse, I pushed the patient. She answered the question and left the room. That night she attempted suicide, and the family never returned to treatment.

I had been told that this institute taught effective ways of rapidly making changes in dysfunctional systems. The lesson I took away reinforced what I already knew: behavior does not change rapidly; it is important to allow time for therapeutic relationships to unfold and for trust to build. Today, I hope I would have had the courage to say "My supervisor, who, as you know, is observing us through this one way mirror, has told me to ask you that very question, but I believe first and foremost in respecting your right to privacy. If you feel like answering the question when you are more comfortable, that will be fine." (And, if

I had been able to think about the entire system in psychodynamic terms, as I can today, I would have noted that the supervisor was in an enactment, joining with the intrusive parents in their frustration at their daughter, while the daughter was clearly looking for an ally to help her start to separate. At the same time, I was behaving very much like that daughter: outwardly compliant but trapped by the system.) If I had stood up to my supervisor, I would have demonstrated to this young woman, in this rigidly hierarchical family, that she had a right to stand up for herself. I hope I would have conveyed to the parents that if they showed more respect for their daughter's privacy, in the course of time she might be more open. Even now, I am in danger of falling into the seductive trap, often implied at family institutes at that time, suggesting that behavior can be changed by one trial learning.

I referred above to psychoanalytic theory "as it was then constituted." In the last 25 years enormous changes have led relational psychoanalysis away from an adherence to particular set of nonobservable and unprovable phenomena derived from 19th century physics. The psychoanalytic gaze is no longer directed exclusively at internal battles but equally at the individual's experience in the world. We understand that human experience occurs within a social system, a relational matrix that influences and is influenced by another's presence in a constantly shifting fashion. In relational theory, one size does not fit all. It was among relational psychoanalysts that I finally found a professional home. Given my personal preference to respect what the patient brings into treatment and to give external events their due, I could not have begun psychoanalytic training until these changes were underway.

In the course of this essay, several times I have emphasized the importance of slowly unfolding therapeutic relationships. The emphasis on long term treatment is at odds with most insurance plans and is frequently the target of attacks by researchers, like Baker et al. (2009) and Mischel (2009), whose work is cited above, who would impose strict scientific standards on psychotherapy. However, there is a considerable literature offering empirical support for the efficacy of psychodynamic psychotherapy. In reviewing this literature, Shedler (2010) establishes that positive effects for those who have been in long term psychodynamic therapies are as large as those reported for treatments that are traditionally referred to as evidence based. Furthermore, Shedler finds that the benefits of psychodynamic therapy extend well beyond symptom remission. These findings are similar to those described by Seligman (1995). But, for the purposes of this essay, I want to emphasize one more point that Shedler makes; many non psychodynamic therapies utilize techniques that have long been central to psychodynamic practice. In other words, Shedler is suggesting that many effective clinicians who do not identify as psychodynamic nonetheless integrate psychodynamic ideas into their practices. To paraphrase Harry Stack Sullivan, maybe we are all more simply psychodynamic than otherwise.[1] Maybe we are all more simply integrative too.

References

Aron, L. (1999). Toward a triadic relational theory: An introduction. *Psychoanalytic Dialogues, 9*, 441–443.

Baker, T, McFall, R., & Shoham, V. (2009). Is your therapist a little behind the times? *Washington Post*, November 15.

Mischel, W. (2009). Connecting clinical practice to scientific progress. *Psychological Science in the Public Interest, 9*(2). www3.interscience.wiley.com.

Seligman, M. (1995). The effectiveness of psychotherapy, the consumer reports study. *The American Psychologist, 50*(12), 965–974.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *The American Psychologist.*

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[1] Sullivan is reported to have said on more than one occasion, "We are all more simply human than otherwise."