What is Relational Integrative Psychotherapy?

Learn your theories as well as you can, but put them aside when you touch the miracle of the living soul. Not theories but your creative individuality alone must decide. (Jung, 1953, p. 73)

There are currently many different ways of doing relational integrative psychotherapy, a plurality fostered by a Zeitgeist which celebrates both the ‘relational’ and the ‘integrative’ dimensions of psychotherapy. Rather than rely on a single-school approach, with its specific theory and methods, psychotherapists are increasingly looking beyond traditional boundaries towards more holistic practice.

The variety of practice now available to us is not surprising, given our ability to draw upon more than 400 theories and models of psychotherapy (Norcross, 2005). This array testifies to the richness and dynamism of our field. While competing and contested approaches challenge our identity and often appear idiosyncratic and unconvincing, they also signal creativity, openness and respect for divergence. No blanket view or single technique can hope to embrace the complexity of human behaviour. We need to trawl widely to find therapy approaches which encompass both the individual and their social world and that engage intrapsychic, embodied, interpersonal, cultural and transpersonal levels (Norcross & Goldfried, 2005).

It’s probably true to say that much psychotherapy is relational and integrative at heart. If so, the convergence of these two movements may well rebalance an “over-fragmented field” (O’Brien & Houston, 2007, p. 4). In common with others, Markin (2014, p. 327) argues for a more “coherent and less polarizing professional identity”, noting that defining ourselves as coming from a particular modality sets up false dichotomies when, in practice, we routinely straddle multiple approaches.
This introductory chapter addresses the question, ‘What is relational integrative psychotherapy?’ The first two sections explore the concepts of relational and integrative, with the aim of providing an inclusive synthesising sketch while recognising some divergent voices. A third section discusses the challenges of integration we confront when practising in this relational integrative field. At the end of the chapter, a section titled ‘Concluding reflections’ begins a pattern for the rest of the book: I offer a conclusion of each chapter along with some personal thoughts and an implicit invitation to dialogue with me . . .

Being ‘Relational’

All therapists would probably concur that we humans are shaped by our social contexts and that our sense of who we are is intimately entwined with our relationships. Research consistently shows that, for people in general, close relationships are what matter most. When those relationships fail to give us what we need, we lose confidence. If relationships constitute the core of psychological problems, they can also be harnessed in the pursuit of growth and healing. Psychotherapy can be understood as fundamentally concerned with this relational context, in terms of past, present and future (see box 1.1).

**Box 1.1 Case illustration: Working relationally**

**Connie** came into therapy to work on issues of intimacy in relationships after a string of problematic relationships with men. It emerged that Connie had been born addicted to heroin and had spent the first five years of her life living in random squats or on the streets with her neglectful mother, a substance abuser. Her mother remained toxic – both literally and figuratively – until Connie was taken into care and lost contact with her. She was eventually adopted by a solid nurturing family and had a reasonably good childhood. But damage had been done.

During therapy, every time the therapist became physically or emotionally close, Connie backed away. Together they recognised how Connie had learned to shut out others and close down her needs to avoid being abused and/or abandoned. The therapist attuned to Connie by progressing slowly, carefully, gently and in a respectful way. Over many months the therapist was consistently there for Connie, gradually decreasing the (emotional and physical) space between them. A significant moment of healing eventually occurred when Connie was able to cry while being held in the therapist’s arms.
Within this general acceptance of the relational context of therapy, some practitioners promote the **therapeutic relationship**, rather than the individual client, as the *primary* focus of therapy. This is the stance of this book. The basic argument is that as our only real access to another’s experiencing is through our relationship with the Other, that relationship must be our therapeutic *vehicle*. As Yalom declares in his much-quoted professional ‘rosary’: “*It’s the relationship that heals, the relationship that heals, the relationship that heals*” (1989, p. 91, emphasis mine).

Four key tenets are central to this committed relational approach:

- **Therapy offers a microcosm.** The therapeutic relationship lies at the centre of things, acting as a here-and-now microcosm of what clients experience in their social world. In this microcosm, the client’s relational being is disclosed (Spinelli, 2015).
- **The significance of between.** The mysterious intersubjective space *between*, where we touch and are touched by the Other in multiple, often unseen ways, is of particular interest.
- **The therapist is present.** The therapist endeavours to be a safe, steady human presence that is willing to ‘be-with’ the client moment to moment, whatever emerges. The therapist is genuine and *congruent*, aware of their inner experience and communicating it honestly to the client. “Presence involves bringing the fullness of oneself to the interaction. Therapists must be willing to allow themselves to be touched and moved by the patient” (Jacobs, 1991, p. 4).
- **The relationship works as a collaborative partnership.** Relational therapy does not involve a client talking to a powerful, distanced therapist who gives information or makes interpretations; it is a constantly evolving, negotiated, co-created dialogical process to which both therapist and client contribute (Evans & Gilbert, 2005). Here relational therapists need to ask themselves regularly, ‘How am I contributing to our relationship? Is the way I am being facilitating or inhibiting the client’s awareness and contact?’

Working relationally means privileging the emergent, here-and-now intersubjective relationship *between* therapist and client (see figure 1.1), for this is where we flexibly attune to each client’s relational needs (DeYoung, 2003; Spinelli, 2015). It’s about opening to the other while being willing to give of self. The therapist needs to have the courage to stay in ‘the process’: to be emotionally present to intrapsychic and interpersonal dynamics and be aware of the particular sociocultural context, while being prepared to take some risks towards the co-creation of experience, understanding and knowledge. The challenge is to embody ways of ‘being’ and ‘being-with’ (as opposed to just ‘doing’) naturally and effortlessly, rather than be led by some intellectual principle. It’s about *being present as a human being first; as a therapist second* (Finlay & Evans, 2009).
Where the dialogue is fulfilled in its being, between partners who have turned to one another in truth...the world arises in a substantial way between men [sic] who have been seized in their depths and opened out by the dynamic of an elemental togetherness. The interhuman opens out what otherwise remains unopened. (Buber, 1965, p. 86)

How we operationalise this relational dimension and bring it into therapy varies according to perspective and context (Paul & Charura, 2015). A key debate revolves around the extent to which we privilege the here-and-now intersubjective relationship between therapist and client rather than the intrasubjective one, where therapy might focus on relationships within, between parts of self (internal voices) or where past developmental relationships are accessed transferentially. This is a matter for theoretical debate and impacts on our choice of which theories to integrate.

**Embracing ‘Integration’**

The term ‘integration’ derives from the Latin *integrationem* (renewal, restoration), itself from *integrare* (to make whole). It denotes a process of bringing parts together into a whole and moving forward in a (re-)new(ed) way.

Applied to therapy, our integrative project relates to at least two integrating movements: *client integration* and *theoretical integration*.

First, there is integration related to clients’ growth. Here therapists focus on clients in holistic, integrating ways, working with them to enable them to *bold polarities* and make new connections with previously disowned parts. The New York-based Institute for Integrative Psychotherapy explains the process as taking disowned, unaware, or unresolved aspects of the self and making them part of a cohesive personality, reducing the use of defense mechanisms that inhibit spontaneity and limit flexibility in problem solving, health maintenance, and relating to people, and re-engage the world with full contact. It is the process of making whole. Through integration, it becomes possible for people to face each moment openly and freshly without the protection of a pre-formed opinion, position, attitude, or expectation. (Institute for Integrative Psychotherapy, n.d.)
Chapter 9 focuses on this process of ‘client integration’. In this first chapter, attention is focused on the second meaning of integration: ‘theoretical integration’.

**Theoretical integration** involves adapting to both client needs and context by blending different theoretical frameworks and their methods. There is recognition that, given the diversity and complexity of human beings, no single specific approach can be clinically adequate for all clients and all situations. Research has repeatedly shown that no one therapy approach has superior efficacy, and therapists have embraced the idea that there are common processes that cut across traditional alliances (Norcross, 2005).

That said, theoretical integration does not mix approaches in an *eclectic*, piecemeal way. Rather there exists a continuum of practice, from a blending of approaches and techniques in pragmatic and instrumental ways at one end to wholesale integration at the other.\(^5\)

An example of pragmatic, instrumental integration is the employment of gestalt ‘empty chair technique’ in a cognitive-behavioural skills training programme. Another example is the use of person-centred techniques of ‘reflecting back’ within a psychodynamic encounter. The use of mindfulness interventions (based in both Buddhist and cognitive traditions) constitutes another instance.

A deeper-going version of integration (the one favoured by this book) embraces a synthesised approach that is internally coherent and offers a new emergent meta-framework. Currently there are numerous published integrative models on offer. Palmer and Wolfe (2000) discuss various British models, while Norcross and Goldfried (2005) examine those originating in the USA (see box 1.2).

---

**Box 1.2 Theory: Integrative models**


Moursund and Erskine’s (2004) ‘relationship-focused integrative psychotherapy’ approach encompasses an even bigger field, including transactional analysis, client-centred work and gestalt and borrowing from behaviourism, object-relations psychoanalytic self-psychology, systems theory and neo-Reichian body therapy. Wachtel (2014) promotes his ‘cyclical psychodynamics’ model, which blends relational psychoanalysis with systemic, cognitive-behavioural and experiential views.

(Continued)
Other published and empirically investigated integrative psychotherapy approaches draw from across the cognitive-behavioural and psychoanalytic spectrum. Well-known approaches include: Ryle’s (1990) Cognitve Analytic Therapy (CAT) (combining psychoanalytic and cognitive approaches); Linehan’s (1993) Dialectical Behaviour Therapy (DBT) (combining psychodynamic and cognitive-behavioural approaches); and Stricker and Gold’s (2003/2005) Assimilative Psychodynamic Approach (which combines cognitive-behavioural experiential and family-systems techniques in psychodynamic therapy).

In the counselling–psychotherapy field, Faris and van Ooijen (2012) offer a postmodern, systemic relational integrative model (RIM) which blends cognitive-behavioural therapy (CBT), psychodynamic and humanistic approaches. There are also a number of practice-orientated trans-theoretical models in use, including Egan’s (2010) skilled helper model and Cooper and McLeod’s (2011) pluralistic approach. Prochaska and DiClemente’s (2005) cycle of change has been widely applied and researched.

Beyond these formally prescribed models, every integrative practitioner finds their own path or preferred way of working (see the British Journal of Psychotherapy Integration, every issue of which offers students an opportunity to articulate their own evolving personal model). Their journey will be guided by: personal values and assumptions about the nature of human beings; the specific needs of each client; their professional experience and training; their work/institutional setting; and the cultural-political-ideological context.

In the US context, for instance, the evidence-based practice movement and managed care system demands empirically based treatments. Brief therapy programmes validated by outcome studies are favoured.

In the UK, fluid, intuitive approaches are acceptable in private practice. However, the NHS programme ‘Improving Access to Psychological Therapies’ has prompted a move towards recognising only empirically substantiated interventions approved by the National Institute of Health and Clinical Excellence (NICE). This has created a split in our field, with practitioners lining up on one side or the other. Integrative approaches may one day offer a much-needed bridge across this chasm.

**Challenges of Theoretical Integration**

Theoretical integration confronts us with critical challenges. Different approaches cannot be blended willy-nilly. Philosophical commitments, values and assumptions can be incompatible and resulting theories and practices are not always complementary.
Speaking personally, I become uneasy when I see inexperienced therapists pulling ideas and techniques ‘off the shelf’ without appreciating their subtle theoretical complexities and context. An example of this is the fast-growing area of mindfulness, where certain Eastern philosophical principles (holism, non-being, compassion) appear to be getting lost in translation when attempts are made to apply them as Western cognitive-behavioural interventions. Another example is the way some practitioners refer to the practice of ‘bracketing’ as a means of being more objective: the opposite of the original phenomenological intention, which attends to subjectivity.

Fundamental differences in approach cannot be wished away. For example, humanistic therapists repudiate the concept of the ‘unconscious’, so central to psychoanalytic work; they prefer to regard some things as ‘out of awareness’. In terms of technique, Freudian dream analysis, which assumes the existence of the unconscious, cannot simply be transplanted into gestalt dream work, which is understood differently. Similarly, the psychoanalytic focus on past experience is contrary to the humanistic stance of staying in the ‘here-and-now’. Applied to the concept of transference, the psychoanalytic understanding posits a regression back to earlier relationships which are displaced onto the therapist. From a phenomenological and gestalt perspective, the past is always in the present. The client is seen to bring into therapy certain relational expectations based on their experiences of life, for instance, expecting to be swiped.

*Integrative therapists* might straddle these positions by not fully accepting a view of the unconscious as something that is inevitably inaccessible and by attending to past–present–future as the time frames emerge in sessions.

There are also different perspectives concerning the nature of the Self. Person-centred notions of an authentic ‘core’ Self and behavioural views about fixed personality traits have been strongly critiqued by others. Psychoanalysis, transactional analysis and postmodern perspectives, for instance, emphasise how multiple, fragmented selves (or ego states) emerge in different social contexts, while existential therapy emphasises the process of being/becoming – the ‘self’ is a product of relational processes rather than a separate entity.

An *integrative therapist* might compromise by acknowledging the idea of ‘parts of self’ or ‘sub-personalities’, for example. Instead of seeing the person in terms of fixed enduring characteristics, they might see the self as emerging in a process of ‘self-ing’.
Views about the role of the therapist constitute another minefield. Traditional psychoanalysis insists the therapist should remain a neutral figure who interprets transferenceal processes. Gestalt therapists argue instead for the therapist to be less knowing and to be a fully present, non-interpreting human being. For their part, client-centred precepts concerning being non-directive contrast with the more directive interventional styles of systemic and cognitive-behavioural practitioners.

An integrative therapist is likely to take a responsive and collaborative stance rather than being either non-directive or authoritative. The precise style adopted will depend on which theoretical perspectives are favoured.

These examples indicate some of the dance steps required to blend competing perspectives. The key is to remember the relational. It is our relational stance which bridges theoretical differences. It’s our concern for the quality of therapeutic relationship which binds our diverse orientations (Markin, 2014). This is in tune with Spinnelli’s (2005) plea to therapists yearning for integration to “attend to the source of that yearning and permit it to lead us back to its interrelational grounding” (p. 9).

In many ways, relational integrative therapists have more in common with each other than they do with their traditional school of origin. A relational psychoanalyst, for instance, would probably feel more at home with a relational existential-phenomenologist than with a traditional Freudian therapist. A relational therapist working cognitively would probably find more commonality with a transactional analyst than with a therapist operating in a reductionist, cognitive-behavioural way. The holistic, field-theory perspective of gestalt therapists shares common ground with the perspectives of phenomenological and systemic therapists.

To illustrate this implicit relational convergence, box 1.3 shows, firstly, a therapist using a developmental-relational gestalt frame to explore the client’s reactions; and, secondly, a cognitive-behaviourally orientated integrative therapist working relationally.

**Box 1.3 Case illustrations: Working relationally**

**A developmental-relational-gestalt approach**

**THERAPIST:** Tell me some more about what that was like for you phillip, to witness your brother get beaten. … [i]t must have been really tough for you …

At this point there is a dramatic physical change in Phillip’s presence, from a sad slumped body posture to an erect and rigid position and with a face contorted with rage and distain …. ‘You haven’t a fucking clue what it was like for me’. …
I imagine I experience something of what it must have been like for him as a child – sarcasm, dismissal, humiliation and a deep sense of being ‘wiped out’…

**THERAPIST:** Phillip, I was listening intently to you talk about your father beating up on your brother, and feeling a lot of compassion I reached out to you in your obvious distress. I then experienced you responding to me with sarcasm and angry disdain, which impacted me deeply. I experienced being dismissed by you and feel unseen, fearful and angry. I want to ask you ‘Who did this to you?’

Phillip’s posture instantly deflated, as did his seething anger, and with eyes filled with tears he replied sorrowfully, ‘That’s just how it was for me’.

(Evans & Gilbert, 2005, pp. 118–119)

**The cognitive behavioural analysis system of psychotherapy (CBASP)**

**THERAPIST:** How would your first husband have reacted had you told him about your experience with the repairman?

**SUSAN:** He would have poured himself a drink and told me I had driven him to drink. He was just like daddy. He would have called me stupid, dumb, an imbecile, and the biggest loser he had ever known. (Susan is crying softly now.)

**THERAPIST:** Now, I want you to describe for me what my reaction was to the way you dealt with the repairman?

**SUSAN:** It was okay, I guess.

**THERAPIST:** Think back, what did I do, how did I look throughout, what did I say? I want you to think carefully about how I behaved with you a few moments ago.

**SUSAN:** You certainly didn’t make me feel stupid. You helped me see what I could have done better, you encouraged me, and then you were pleased when I said that the second way would have probably gotten me what I wanted.

(McCullough, 2005, p. 294)

In both the examples in box 1.3, the theoretical lens is implicit as the therapist makes space for a relational dynamic to emerge. Precisely how this dynamic is put into words and explained varies according to the dominant theoretical framework. For example, in psychoanalytic discourse we might say that the therapists have focused on the ‘transference’ and have challenged projections. In gestalt terms, the ‘critical introject’ is de-toxified and worked through. In transactional analysis, the therapists are seen as questioning and re-working
‘Critical Parent’ injunctions/messages, while in cognitive terms they are challenging proactively the impact on the client of the negative reactions of significant others. Whatever ‘it’ is called, the therapeutic relationship remains both the focus and the tool.

**Concluding Reflections**

There is a sense in which the field of integrative psychotherapy, with its multiple languages and cultures, resembles the United Nations rather than a single, unified territory. This field goes beyond single-school approaches to harness the potential of different theories and techniques in a holistic way. Relational integrative variants emphasise the emergent, co-created, dialogical therapeutic relationship along with both the intrapsychic and the sociocultural contexts. The aim is to integrate clients’ needs and disowned parts of self towards their embracing a more comfortable, relational way of being.

A key challenge we face as relational integrative therapists is to work out what, how and when to integrate. A critical appreciation of theory, and some artful finesses, are needed to navigate the contradictory messages of different theories. I see our mission as blending competing voices that can at times express themselves stridently. Interestingly, there are parallels here with the integrating work we do with clients in terms of holding polarities (see chapter 9).

We achieve our deepest theoretical integration when we are able to internalise competing voices into a transformed, coherent way of being. This is the position I strive to embody in this book – if not always successfully. I also seek to celebrate plurality and promote dialogue between perspectives. I acknowledge the value of approaches that lie outside my personal humanistic-integrative model: for instance, developmentally orientated psychoanalytic and systemically based cognitive-behavioural integrative approaches.

That said, my own preferences inevitably set the tone of this book. My primary allegiance is to existential-phenomenological and gestalt theory and practices, with some interweaving of transactional analysis and relational psychoanalysis. Cognitive and systemic thinking also informs my work, which seeks to allow therapy to flow in response to the here-and-now relationship. For me, change comes about primarily through the process of working together dialogically and creatively. It is this process, rather than instrumental techniques, prefabricated protocols or theoretical dogma, that is the primary agent of change.

Relational work inspires me. It remains a privilege and an honour to witness another’s experience and help them make sense of it. Relational practice touches heart and soul; the possibility of healing transformation is present for both client and therapist, in all sorts of yet to be imagined ways. In the space ‘between’ anything can, and does, appear (Finlay & Evans, 2009).

Trusting the process takes courage, but its harvest of rewards is immeasurable.
Notes

1 However, Wachtel (2014) makes the interesting point that too much attention can be paid to the therapeutic relationship at the expense of outside ones, and this needs to be kept in mind.

2 Congruence is one of Carl Rogers’ (1951) core conditions of person-centred work and refers to therapists’ qualities of being genuine and real (without facade). *Existential phenomenological* and *gestalt* therapists extend this notion to encompass openness and presence.

3 The Institute for Integrative Psychotherapy sees integrative therapy as offering three domains of integration: integrating the client’s personality; integrating theory; and synthesising affective, cognitive, behavioural and physiological systems within a person and in relation to the social and transpersonal systemic context.

4 Daniel Siegel (2010) identifies eight domains of integration in his version of *integral neuroscience*: integration of consciousness; bilateral integration (brain); vertical integration (body); memory integration; narrative integration; state integration (parts of self); temporal integration; and interpersonal integration. A final transpirational domain has been added and constitutes the sum of connections.

5 Norcross (2005) suggests there are four routes to integration: technical eclecticism, theoretical integration, a common factors approach and assimilative integration. He notes that most practice probably falls under eclecticism rather than being truly and systematically integrative.

6 In counter-measure, the New Horizons programme from the Department of Health (2009) recommends addressing mental health in empowering, personalised, user-focused ways, and current Government policy aims to make mental health services more widely accessible (Department of Health, 2013).

7 CBASP (McCullough, 2005) is an empirically validated, integrative, *cognitive-behavioural* approach from the US which draws on Piagetian cognitive development theory, social learning theory and *psychoanalysis*.