



Levels of meaning and the case for theoretical integration

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Cognitive therapy tends to focus on how the client's thoughts distort reality and lead to anxiety and depression. But what if reality contains stresses that might cause anyone anxiety or depression? Sharon Berlin (2002) in her book, *Clinical Social Work Practice: A Cognitive-Integrative Perspective*, emphasised the need to integrate into cognitive-behavioural assessment and treatment traditional social work person-in-environment concerns about the real challenges of the environment of the client. The point is fundamental: the very notion that an individual's cognition is 'distorted' or 'irrational' depends on a prior assessment of the real environment and whether the individual is reacting normally to it, so cognitive assessment makes no sense without bringing in the individual's relationship to the environment.

The problem of lack of attention to environmental context goes well beyond cognitive-behavioural theory. One of us (Wakefield), in a recent book with sociologist Allan Horwitz titled *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder* (2007), argued that the current fourth edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM;

2000) failed to consider the context of depressive symptoms. It thus failed to distinguish normal sadness due to environmental stressors from genuine depressive disorders in which something has gone wrong with an individual's emotional functioning and the individual is 'stuck' in a pathologically deep or prolonged state of sadness and associated symptoms.

Because sadness is biologically designed to be an emotion experienced in response to certain kinds of losses and other environmental stresses, one cannot infer that there is a biological or other internal dysfunction without evaluating the relationship between the environment and the individual's response to it. Misdiagnosis of normal responses to distress as depressive disorder may be the reason, for example, why in the Dunedin longitudinal study of health outcomes in youth, fully 17% of a New Zealand sample of 26-year-old Caucasian young adults qualified for having major depressive disorder in that very year. This is a level that seems implausible for true disorder, but may reflect normal reactions to stress and loss.

The realisation that cognitive-behavioural theory must be expanded to include assessment of environmental variables leads to the question:

are there other limitations in the cognitive-behavioural perspective that unnecessarily constrain the worker's understanding of and response to the client's problem? We believe the answer is that, perhaps with cognitive-behavioural theory as a base, today's practitioner must be an integrationist about theory and incorporate defensible insights from a variety of theoretical perspectives into the basic cognitive-behavioural repertoire.

Reasons for integration of psychotherapy theories

There are persuasive scientific and moral arguments for the integration of clinical ideas in social work education and practice. The scientific argument for an integrationist view of psychotherapy theory is simple: each of the major theories focuses on one piece of the truth about human nature and each of the major theories does get at part of the truth. There are several levels of meaning at which individuals operate, and all of these levels are potentially involved in a psychosocial problem and in its treatment, but each theory treats mostly one level.

Briefly, levels of meaning processing include at least the following:

- (1) Although not strictly in itself a level of meaning, people's meaning systems are rooted in biological structures that support the generation of meaning in the brain.
- (2) People are instrumentally conditioned by contingent reinforcers and classically conditioned as well. We know this not only from

a vast empirical literature on learning but also from recent neuro-scientific discoveries that reveal the anatomy of learning; so people really do have conditioned behaviours subject to the principles of learning.

- (3) People have cognitive/representational mental contents including conscious beliefs and desires, sometimes irrational, that motivate and guide their actions. We know this not only from our commonsense understanding of our

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own and others' minds, but also from the remarkable effectiveness of 'folk psychology' (i.e. the intuitive understanding of people in terms of beliefs and desires that cause their actions) that we use to interact with others in our everyday lives. For example, how is it that all the articles from around the world comprising this special section converged in New Zealand at the right moment for publication? The only answer is that the various writers had

certain beliefs about the deadline and what was required, and certain desires such as to have their article included, and thus their actions led to the convergence of the articles. There is nothing in behavioural or psychodynamic theory that would begin to enable one to predict such events. Cognitive explanation in terms of beliefs and desires is firmly anchored in this folk-psychological understanding, which may itself be a biologically rooted way we have of interpreting one another. But beyond folk psychology, this level of conscious representations is also supported by a vast cognitive science empirical research tradition.

(4) People are also influenced by an extensive network of mental representations that are outside their awareness. We know this not only from everyday experience but from a vast research literature in cognitive science that demonstrate the unconscious activation of meanings, as well as from some reliable elements of the psychodynamic literature. These unconscious meanings can interact with conscious meanings in ways we are not aware of.

(5) People are shaped in ways they may not be aware of by cultural and family rules and other interpersonal processes that form the context and background for their actions and provide implicit rules that may be followed without awareness. For example, when having a conversation, people from different cultures feel comfortable standing at different distances, some closer, some further away (at international conferences, this becomes apparent as people adjust themselves to others' comfort levels).

The moral case for integration is simply that it is in effect a form of malpractice to approach the client within one theoretical perspective when it is scientifically known that the truth is more complex and the therapeutic options available are broader than those encompassed by any one theory. Informed consent requires that theoretically divergent intervention options be presented to the client, and that treatment not be limited by the worker's theoretical persuasion. The moral argument is based on the scientific argument. It is, first, that research

demonstrates that no one treatment works for everyone. To serve all clients the practitioner must be prepared to be flexible and offer a change of treatment strategy when warranted by the client's lack of response or incomplete response to the initial intervention strategy. Moreover, because each individual is operating at all the meaning levels noted above, different sorts of interventions are often required in the

course of treatment to get at aspects of the very same problem. The different levels are so interconnected that, except for the biological level (which arguably requires an entirely different training to directly evaluate and treat, although all the levels are influencing and are influenced by biology), a worker must be prepared to utilise any of them with a given client, so referring out seems a cumbersome and inadequate process.

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Why researchers need integration and cooperation, not competition

For most practitioners, theory – even cognitive-behavioural theory – is a means to clinical goals, not an end in itself. Yet practitioners often become wedded to one theoretical approach in a way that can constrain clinical decision making.

One common idea in support of theoretical exclusivity is that it is more scientific and intellectually assertive if there are multiple, competing, strongly defended theories, so integration is a bad, even scientifically flaccid, idea. It is true that scientific progress is best derived and truth best revealed from the vigorous clash of opposed ideas. But when it

comes to theories of practice, this proposal is based on an anachronistic picture of theory in the mental health field. It harks back to the 'psychotherapy wars' in which universal claims were made by each theory as to its truth and therapeutic efficacy, and each theory competed with all the others. It seems fair to say that this strategy has not led to a scientific resolution in favour of one or another theory and has not yielded much progress. The reason for this failure is that the competition was based on a misconstrual of the relationship among the various theories. They were framed as mutually exclusive universal theories, but their relationship turned out to be complementary.

If one open-mindedly considers the evidence from research, clinical experience, and everyday life, it seems apparent that all the major theories of psychopathology have important elements of truth. The processes described by behaviourists, cognitivists, psychodynamicists, systems theorists, and biological researchers all shape behaviour and are all necessary to explain disorder in some contexts. Moreover, a process may be useful in treating a disorder even when the etiology lies elsewhere. In other words, on the basis of the overall evidence available at this time, if there is any theory of etiology and treatment in which it is rational to believe, it is some version of integrationism. From this perspective, all the traditional theories, if framed as universal, exclusive alternatives, are pseudoscientific; their unjustifiably inflated claims are based on ideology rather than evidence.

For example, the many theories of depression – behavioural, biological, systems-theoretic,

cognitive, and psychodynamic – appear each to capture some possible cases and thus to be about specific etiologic pathways rather than universal theories of etiology. These theories are not logically in competition – or at least to the extent they are formulated in a way that they are, the formulations are needlessly inflated and ignore reality. Rather, each theory attempts to capture one possible causal pathway that can, by itself or in conjunction with the others, lead someone to become disordered. Consequently, what is called for is not competition but cooperation to identify etiologically pure

patients and to identify the role of each explanatory hypothesis in hybrid cases. In a multiple-etiology reality, a competition between single-etiology nosologies is not progressive and cannot yield a valid diagnostic manual.

There is much to criticise in the DSM's operationalised definitions of various mental

disorders (Wakefield, 1996, 1997). However, one of the great contributions of the DSM has been to provide theory-neutral criteria that do not cite any etiology and, because they are based on manifest symptoms, can be used by adherents to all theoretical schools to identify individuals with a certain disorder. The DSM enabled the different schools to talk to one another and compare their theories in a way that had not happened before. This subtle but historically important and beneficial contribution of the DSM to providing the conceptual infrastructure for theory integration has not been adequately recognised.

Types of integration

Traditionally there are four forms of psychotherapy integration (Gold, 1996);

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technical eclecticism, the common-factors approach, theoretical integration, and assimilative integration, all of which combine theory and technique. Technical eclecticism has been considered the most clinical and technically oriented form of psychotherapy integration; however, it is the least conceptually or theoretically integrated (Stricker & Gold, 2003). In technical eclecticism, clinical strategies and techniques from two or more therapies are applied sequentially or in combination. Techniques are chosen based on clinical match to the needs of the patient without any systematic theoretical rationale, based on clinical skill and intuition as well as patient preference.

Common factor integration is based on the idea that groups of therapies share similar change processes and techniques (Rosenzweig, 1936). Additionally, all therapies share commonalities such as socially sanctioned rituals, the provision of hope, and encouragement to the client (Frank, 1961). When using the common factors approach, the therapist attempts to identify which of the common factors will be most important in interventions for specific cases; then a review of the relevant intervention and psychotherapeutic interactions is conducted to determine those that best fit the client's situation. The goal is to provide the client with the best possible unique combination of known therapeutic factors to ameliorate his or her problems.

Common factors integration often combines insight, new relational learning and experiences, as well as hope by way of the therapeutic relationship. The therapeutic relationship is now believed to be the most potent common factor. Theoretical integration consists of a synthesis

of central elements from two or more theories, potentially including the theories' models of personality, psychopathology etiology, and mechanisms of psychological change. By forming one consistent theoretical system incorporating different models, there is a logical coherence to theoretical integration lacking in the other approaches. This allows the therapist to approach a case in a more systematic fashion. Different theoretical assumptions are placed within one overarching theory, so the therapist can make principled judgments.

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Safran and Messer (1997) argue from a postmodernist position that different theories have such different ontological assumptions that in principle they can never be theoretically or technically integrated. This seems a dubious argument, if

we are right that the theories capture different levels of the meaning system that in fact does exist in human beings and that the different levels do interact in overall functioning. This is because the parts of the theories that reflect reality do interact and are part of one larger reality that a future theory ought to be able to capture. The postmodernist view seems a dead end intellectually that freezes us in a state of therapeutic ideology. The theories as currently stated are incompatible in part because they each claim to have the exclusive truth and apply to all possible situations, which is false, and in part because each of the theories is just incorrect on many points. The point of theoretical integration is to evaluate which components of each theory deserve to be retained, to moderate the claims of each so they can be placed within a larger system, and to hypothesize how the overall system of interacting levels of meaning works so

that intervention strategies can be devised accordingly.

However, there has as yet been no successful super-ordinate integration that includes personality, psychopathology, worldview, meta-theoretical and epistemological assumptions, or a theoretically coherent and adequate technical eclecticism (Safran & Messer, 1997). One answer, other than awaiting a future theoretical integration, has been to embrace theoretical pluralism. The pluralistic tradition falls within postmodernism, and holds that one theory cannot pre-empt an alternative organisation of the evidence; therefore,

the best way to approximate truth is to have multiple theories competing by way of evidence (Safran & Messer, 1997; Borden, 2008).

Pluralist points of view emphasise the current limits of human understanding and assume that no single framework captures the variety and complexity of actual experience in the real world. Thinkers and practitioners approach concerns from multiple, independent perspectives, realising that there are mutually exclusive descriptions of the world and equally valid points of view that inevitably contradict one another. In this respect, pluralist perspectives challenge notions of grand theories that presume to assert universal truths, and take the more realistic position that theoretical formulations and empirical findings at best provide partial, incomplete understanding of experience. From a pluralist point of view, then, theories serve a range of functions, providing tools for critical thinking and decision-making as practitioners carry out their work. Every theoretical system is distinguished by

its particular concerns, purposes, methods, strengths, and limits, and no single approach – however encompassing it may seem – can possibly meet all needs over the course of intervention.

Another answer to the challenges of integrating diverse theoretical approaches is assimilative integration. Stanley Messer (2001) argues that theories of therapy are grounded in observation and evidence, but contain multiple truths defined and contained by the interpersonal, historical, and physical context in which interventions occur. Theoretically integrative

approaches are assimilative when they start from one approach as fixed and primary and open themselves to incorporate new techniques into the existing conceptual model of practice. When the therapeutic context differs from the context in which the new techniques were developed, the meaning, impact, and use of the

interventions may be modified and reinterpreted to fit the primary model. The psychodynamically based integrative therapy developed by Stricker and Gold (1996) is an example of assimilative integration according to Messer. This is because the therapy proceeds along standard guidelines, but other methods are used as needed and these may advance psychodynamic goals while affecting the target problem.

Next steps in integration – what cognitive theory might assimilate from psychodynamics

Cognitivism attributes problems to irrational or distorted cognitions. It thus holds that the solution is to correct beliefs through disputation

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or learning, the latter including, for example, extinction or disruption of negative thoughts and reinforcement of positive thoughts. What might such cognitive theory still learn from the psychodynamic tradition?

One lesson – that cognitions can be unconscious – has already been learned, both with respect to the individual’s initial lack of awareness of automatic thoughts and to the deeper lack of awareness of the meaning schemas that generate the automatic thoughts. With respect to the existence of mental representations outside of awareness, there has been a convergence to some extent

of cognitive-behavioural and psychoanalytic views. To take one example: The cognitive-behavioural theorist Aaron Beck (1976) posits deep schema derived from childhood experiences that shape and generate the automatic negative thoughts

that people have about their relationships and other aspects of their lives. John Bowlby (1958), the object-relations theorist responsible for attachment theory, similarly posits mental representations outside of awareness that are derived from childhood attachment patterns and constitute an ‘internal working model’ of attachment that shapes expectations in relationships throughout life. These views are in many ways quite congruent.

In our view there are other aspects of psychodynamic theory that could be usefully assimilated to cognitive theory. The intellectual apparatus of psychoanalysis is aimed at understanding how human problems go beyond what can be accounted for by cognitivism. The two most essential problems not dealt with by cognitive theory are weakness of will and

conflict. Weakness of will is the single most basic challenge to the cognitivist position. For example, if I am having a problem eating cake, the cognitivist looks for the irrational or distorted beliefs that lead to the self defeating behaviour.

However, what psychodynamicists see is that, even if all of the beliefs are lined in the right direction, and even if the client clearly, rationally, and undistortedly understands that it is better not to eat the cake, the patient may still eat the cake. The psychodynamic insight is that the problem is not always essentially one

of cognition at all; rather action may flow from a desire other than the one attached to the preferred cognition. Cognitivists, like the philosopher Socrates, tend to see humans as having rational thoughts that lead to action; psychodynamicists see that thoughts are often

in competition with each other and that the rational thought does not always win in the competition to cause action. Thus no amount of adjustment of thought insures the solution to a problem of impulsive or self defeating action.

Weakness of will occurs when there is conflict between desires and the best desire does not win. Thus, to deal with symptoms, psychodynamicists attend to internal conflict. One problem in resolving conflict is that desires are not always integrated and rationally judged one against the other. Thus psychodynamicists work on helping people to recognise their conflicted desire and to integrate them within their rational calculus to the degree possible. Because conflict is not recognised as basic by cognitivists, this aspect of mental functioning is essentially ignored. We believe an enlarged

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cognitive viewpoint that assimilates selected insights from the psychodynamic approach in this way offers a fruitful step toward the grander synthesis for which the field is waiting.

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