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'MEETING THE CLIENT WHERE THEY ARE RATHER THAN WHERE I'M AT': A QUALITATIVE SURVEY EXPLORING CBT AND PSYCHODYNAMIC THERAPIST PERCEPTIONS OF PSYCHOTHERAPY INTEGRATION

GRETA KALUZEVICIUTE-MORETON and
CHRISTOPHER E. M. LLOYD

This qualitative study explored therapists' attitudes towards psychotherapy integration. Twenty-nine psychoanalytic/psychodynamic and cognitive-behavioural therapy (CBT) therapists completed an open-ended survey that focused on their personal understanding of psychotherapy integration, examples from their own practice and reflections on improving integrative therapy. Participants were also encouraged to share attitudes and perceptions towards the other therapeutic paradigm (CBT towards psychoanalysis, and vice versa). Thematic analysis revealed three main themes: (1) Positive perceptions and benefits of psychotherapy integration, (2) Negative perceptions and challenges of psychotherapy integration *and* (3) Proposals for strengthening integration in clinical practice. *While most participants had a strong allegiance to their modality, they recognised the need for flexibility and additional techniques from other paradigms to address individual client needs. However, participants raised concerns about the level of knowledge required for integrative work and the epistemological compatibility between CBT and psychoanalysis. Some responses reflected the ongoing 'turf wars' between the two paradigms, with some referring to 'outdated' psychoanalytic ideas and 'dogmatic' evidence-based hierarchies. Suggestions were made for further development of psychotherapy integration during the training and post-qualification. The study reflects a generally positive outlook towards integration while recognising the challenges as well as the continuing resistances between CBT and psychoanalytic paradigms.*

KEYWORDS: PSYCHOTHERAPY INTEGRATION, PSYCHOANALYSIS, PSYCHODYNAMIC THERAPY, COGNITIVE BEHAVIOURAL THERAPY, THERAPIST ATTITUDES

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INTRODUCTION

Psychotherapy consists of many types of models and theories, currently enumerated to be more than 450 (Manickam, 2013). This diversity began with the founders of major psychotherapeutic paradigms, such as psychodynamic/psychoanalytic (initially developed by Sigmund Freud in the late 19th and early 20th centuries), cognitive (developed by Aaron T. Beck in the 1960s) and behavioural therapies (developed by B. F. Skinner, Joseph Wolpe and Hans Eysenck in the 1950s), to name a few. Each therapeutic model employs a markedly different ontological perspective regarding psychological functioning (e.g., the prioritisation of unconscious processes vs. observed behaviour), resulting in different therapeutic techniques (e.g., free association vs. exposure and response prevention), a different therapeutic setting (e.g., long-term intensive therapy vs. short-term structured therapy) and a different role undertaken by the therapist in relation to the client (e.g., interpretive/expert vs. guiding/co-equal). Given these differences, there are ongoing controversies and challenges regarding the nature of the evidence available to support each therapeutic paradigm (Gilbert & Kirby, 2019).

Perhaps most frequently juxtaposed therapeutic modalities currently are cognitive-behavioural therapy or CBT (and, by extension, other emerging cognitive therapies, such as dialectical behavioural therapy, multimodal therapy, etc.) and psychoanalysis (and, by extension, therapies emerging from the psychoanalytic theoretical framework, such as object relational, existential, humanistic) (Moorey, 2010; Peri Herzovich & Govrin, 2021; Rosner, 2012). This juxtaposition not only creates both rivalry and tension but also invokes a desire for a further dialogue, comparison and possible integration of the two modalities.

According to Peri Herzovich and Govrin (2021), the two theoretical paradigms are at odds in both technical, in the sense of clinical practice, and theoretical, in the sense of the overarching perception towards human nature and psychopathology, level[1]:

> Psychoanalytic theory is marked by a romantic outlook (driven by struggle and conflict), ironic (focused on inner contradiction, vagueness, and paradox), and tragic (underlining danger, terror, the absurdity of human existence). It directs toward reflection and investigation. By contrast, the cognitive-behavioural theory has more in common with the comic view of the world (emphasizing the familiar, predictable, and controllable in humans and social situations). It expresses itself in action (p. 245).

CBT seeks to improve clients' well-being by focusing on cognitive distortions (thoughts and attitudes) and core negative beliefs, which in turn promotes emotional regulation and development of personal coping strategies (McKay et al., 2015). CBT is generally delivered as a short-term intervention (10–20 sessions), in either an individual or group format and often features structured, problem-solving and action-based work with clients (Lloyd et al., 2021). In contrast to psychodynamic and, more broadly, psychoanalytic psychotherapy, CBT often focuses on the present

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(current client issues and symptoms) rather than past (early object relations) and involves elements of goal setting (Lloyd et al., 2019) and psychoeducation, through which clients are trained in the cognitive model of emotion via written resources and treatment sessions, in order to recognise and challenge negative automatic thoughts through reality testing (Lloyd & Antonino, 2022).

Currently, CBT is considered to be a 'gold standard' therapy (David et al., 2018), although is not without controversies surrounding this title (Leichsenring & Steinert, 2017; Shedler, 2020). This is because 'gold standard' does not mean 'the best standard possible'; rather, it indicates that this is 'the best standard we have in the field' (David et al., 2018). The standard of each therapeutic modality in the evidence-based hierarchy relies on three distinct criteria: (1) the availability of outcome research, (2) the availability of comparative studies demonstrating one paradigm's superiority over other forms of therapy and (3) the availability of research on theoretical models/mechanisms of change pertaining to psychological well-being (i.e., the epistemological underpinnings of a therapeutic paradigm). As it stands, CBT hits all three criteria (although it is important to point out that adherence to these criteria may vary depending on specific mental health conditions; for example, treatment outcomes on borderline personality disorder often favour psychodynamic psychotherapy; see Fonagy, 2015) and is currently favoured among the evidence-based forms of treatment (Rakovshik & McManus, 2010). Consequently, institutions such as the APA (USA) and NICE (UK) endorse CBT theoretical models and mechanisms of change as the most mainstream and efficaciously researched paradigms of human mind and behaviour. This has also culminated in the wide-scale training and dissemination of CBT therapists in National Health Service (NHS) settings, as well as a growing body of CBT therapists and psychologists in the private sector.

However, it has been noted that the core CBT therapeutic principles, such as highly structured treatment sessions, goal-setting, psychoeducation, the set amount of sessions and a cognitive focus on clients' reported problems, may not suit all client needs. This is particularly evident with clients who exhibit long-term mental health issues, including childhood-rooted trauma as well as personality, eating and somatic disorders (Fonagy, 2015; Lunn et al., 2016). Such cases generally warrant the presence of a more complex therapeutic relationship, open-ended treatment and less structured sessions. This has led to the development of new therapeutic approaches, such as dialectical behaviour therapy (DBT) and schema therapy, which seek to address the need for longer term interventions within the CBT paradigm. Both DBT and schema therapy extend the duration of therapy and offer unique features to meet the needs of individuals requiring more comprehensive and prolonged intervention (Linehan, 2014; Young et al., 2003).

Psychoanalytic and psychodynamic psychotherapies[2] have recently enjoyed increasing systematic research (see, e.g., Fonagy, 2015; Leichsenring et al., 2013; Leichsenring & Rabung, 2008; Midgley et al., 2021; Midgley & Kennedy, 2011; Solms, 2018), demonstrating positive treatment outcomes for both long-term and short-term psychodynamic psychotherapy targeting depression, some forms of anxiety, eating disorders and somatic problems in particular (Fonagy, 2015). A recent

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meta-analysis by Casalli et al. (2023) highlights the efficacy of short-term psychodynamic psychotherapy for depressive disorders and its comparability with control groups and other treatments. The study results show that psychodynamic psychotherapy was able to significantly reduce depressive symptoms in patients and was mildly more effective compared with CBT outcomes. These and similar studies reflect a change in the discourse of psychotherapy effectiveness research, in which psychodynamic psychotherapy is slowly but surely finding its place.

However, the inherent differences between psychodynamic psychotherapy and CBT have contributed to additional issues in the production of outcome research for psychodynamic and psychoanalytic treatments. As a therapeutic intervention, psychoanalysis (and to a large degree, psychodynamic psychotherapy, although the latter is also sometimes practised as short-term, up to 25–30 sessions duration over 6–8 months) insists that treatment should take a long time (sessions at least once a week, therapy generally lasting several years), involve unstructured sessions and develop a (often complex in nature) therapeutic relationship. To a large degree, psychodynamic psychotherapy remains centred around two classic Freudian notions: transference and free association. Transference refers to feelings, reactions and patterns emerging from client's past relationships, which are re-experienced with the therapist in the here-and-now, whereas free association is the expression of conscious and unconscious processes during unstructured clinical sessions (Høglend, 2004; Levy & Scala, 2012).

These conditions, albeit central to the analysis of early object relations and repressed unconscious material (Gabbard, 2017), may also complicate the implementation of psychoanalytic treatment in public health bodies (e.g., NHS), where time and funding are extremely constrained resources, and private practice, where clients' needs may not always align with the unstructured nature of psychoanalytic treatment or its longevity (Fonagy & Target, 2003). Additionally, psychodynamic psychotherapy has been positioned at the lower end of efficacy research due to unclear causal relationships and lack of generalisability; conditions that have been associated almost exclusively with CBT clinical outcome research (but also criticised as the 'gold standard' criteria for evidence in psychotherapy; see Kaluzeviciute, 2021; Truijens et al., 2022).

Given that CBT and psychodynamic forms of treatment may be utilised to treat different conditions or client groups, it seems plausible that there should be a wider dialogue on the use of psychoanalytic and/or psychodynamic and CBT principles by therapists that goes beyond rivalry, division and competition. As of recently, authors in psychotherapy suggested that CBT and psychodynamic psychotherapy should be viewed as complementary rather than dichotomous. For example, Haverkampf (2017) proposed theoretical integration between the two modalities on an epistemological level, whereas Garrett and Turkington (2011) suggest that both CBT and psychoanalysis should be used as an integrated approach for the treatment of psychosis.

Solms (2018) has argued that, when it comes to predicting good treatment outcomes in psychotherapy, technique overwhelmingly triumphs over therapeutic

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modality. A similar argument, titled the 'Dodo bird verdict' (Rosenzweig, 2002), has been made more than half a century ago. The 'Dodo bird verdict' is a position arguing that all therapies are equally effective or achieving the same goals in relation to human treatment. However, Solms emphasises that the techniques predicting best treatment outcomes are closely related to psychodynamic/psychoanalytic framework: open-ended dialogue between client and therapist; identification of recurring themes in client's experiences; linking client's feelings to past memories; drawing attention to feelings regarded by the client as unacceptable; focusing on the here-and-now therapeutic relationship; drawing connections between the therapeutic relationship and other relationships, etc. It is therefore important to understand how theoretically 'fluid' some of the therapeutic concepts are and whether they can (or do) go beyond the boundaries of distinct paradigms in search for better treatment outcomes.

Despite the literature on the relationship between CBT and psychoanalysis cited above, little is known about how CBT therapists experience and make sense of psychodynamic concepts and vice versa in private practice. This private practice context is significant because evidence suggests that growing numbers of practitioners are moving to or already working in this context (APA, 2017; Brown, 2018). Consequently, this study seeks to qualitatively explore how therapists conceptualise psychodynamic and CBT concepts, and whether they might integrate techniques from different therapeutic modalities in their practice formally or informally, consciously or unconsciously.

In a psychotherapy context, integration is difficult to define, partly because there are different approaches to the extent to which various paradigms can or should be integrated. Generally, psychotherapy integration is characterised by an openness to diverse theories and techniques; it is an attempt to look beyond the confines of one's particular paradigm, modality or school, as a way to learn from other perspectives (Stricker, 1994). Several different forms of integration have been specified in psychotherapy literature. *Technical eclecticism* involves the selection and integration of treatment techniques based on the evidence of what has worked for other clients in the past with similar characteristics (although it is important to note that practitioners employing techniques from other modalities are not necessarily subscribing to the theories that spawned them) (Norcross & Goldfriend, 2019). In *theoretical integration*, theories are synthesised or blended in an attempt to develop an approach that will be more effective than the constituent therapies alone (e.g., the transtheoretical approach) (Norcross & Goldfriend, 2019). *Assimilative integration* is common among practitioners: it involves an affiliation with one dominant theoretical paradigm, accompanied by a willingness to incorporate techniques from other therapeutic approaches (i.e., a single theory is supported by different approaches and techniques) (Messer, 1992). Finally, the *common factors* approach refers to aspects that are present in many (possibly all) therapeutic modalities (e.g., therapeutic alliance and beneficial therapist qualities, such as empathy and positive regard), indicating that a degree of integration occurs due to pre-existing commonalities shared by many therapeutic approaches.

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This study does not seek to identify the specific form of integration (among the aforementioned concepts) that exists between CBT and psychodynamic/psychoanalytic practitioners. Instead, it is interested in whether an integrative dialogue of any form, level or degree exists, how it might manifest and the possible issues or challenges that arise in such integrative processes. It is also important to note that this study does not argue 'for' or 'against' psychotherapy integration between psychoanalysis and CBT (or other forms of therapy). To be specific, the study seeks to capture some of the views practitioners hold towards their colleagues in other paradigms as this directly pertains to the current dialogue (or lack thereof) between therapists from various orientations, especially CBT and psychoanalysis (which, historically, had a tumultuous relationship). Beyond a theoretical dialogue, this also has repercussions on trainee practitioners in the NHS and other institutions who might wish to be exposed to diverse theories but have no choice in this given the current climate between different therapeutic orientations. Thinking about one's allegiance to a specific therapeutic orientation, and considering the flexibility of such an allegiance, may also meaningfully contribute to treatment outcomes and clinical reasoning (Willemsen, 2022).

METHODS

Research design

A qualitative online survey design was utilised for this study in order to explore participants' perceptions and experiences of psychotherapy integration, in their own terms. According to Braun et al. (2021, p. 3), qualitative surveys 'offer one thing that is fairly unique within qualitative data collection methods—a "wide-angle lens" on the topic of interest that provides the potential to capture a diversity of perspectives, experiences, or sense-making'. In contrast to more commonly used quantitative surveys, a qualitative survey consists of open-ended questions, meaning that participants type responses in their own words rather than selecting from predetermined response options. Language, in this sense, is highly important for the qualitative survey method: the researcher seeks to trace terminology and values reflected by each individual research participant (Braun et al., 2021).

In the field of social sciences, interviews are far more commonly utilised than surveys (Braun et al., 2017). This is often coupled with the assumption that surveys are too rigid and are unable to produce data containing rich subjective experiences. However, this assumption has been challenged (Grant & Giddings, 2002): the flexibility and openness of qualitative surveys allows researchers to investigate and explore a variety of research questions, especially when the researched topics may contain diverse and/or opposing views, values and beliefs. In our study, an online qualitative survey was preferable over qualitative interviews due to the following reasons; first, it was deemed that this would be more accessible for participants to respond to, and engage with, in their own time. Second, it was felt that a self-complete survey design would enable participants to be less influenced by perceived researcher background, or theoretical orientation, when responding to open

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questions concerning psychotherapy integration. Third, we felt the use of an online survey would allow us to reach a larger and wider demographic of potentially interested participants and that this would be a useful basis for this exploratory study.

A set of 12 open-ended qualitative questions were devised (see Table 1), covering topics from the following: personal understandings of psychotherapy integration, examples of psychotherapy integration from own practice and reflections for improvement in this area. Demographic questions about participants' therapeutic orientation, age, mode of practice (e.g., face-to-face, online, blended), country of practice, academic/professional qualifications and years of therapeutic practice were also presented. The qualitative survey schedule was piloted with two psychotherapeutic

TABLE 1: *Qualitative survey items.*

(1)	How would you describe your own way of practicing therapeutically? What does it mean for you to practice in this way?
(2)	Have you had any training in or exposure to other therapeutic modalities besides your own? If yes, please list the modalities and the degree of exposure (e.g., learning through training, attendance of clinical workshops, engagement with literature).
(3)	What is your understanding of integration in psychotherapy practice?
(4)	In your view, can integration of different therapeutic modalities prove to be useful in developing therapeutic relationships with patients? If so, why?
(5)	From your experience, are there any barriers or challenges in integrating different therapeutic modalities? Can you give an example from your own practice of any particular challenges or barriers that you may have faced?
(6)	How do you feel about integrating techniques and principles from CBT and psychodynamic psychotherapies?
(7)	If you are a CBT therapist, are there any concepts from psychodynamic psychotherapy that you find particularly helpful or problematic? If so, why? *Concept examples: Transference (occurring when a patient projects feelings and/or reactions experienced with past figures, such as parents, onto the therapist in the here-and-now) and unconscious (processes and mechanisms occurring outside of one's conscious awareness that have significant implications for one's personality, behaviours and relationships).*
(8)	If you are a psychodynamic therapist, are there any concepts from CBT that you find particularly helpful or problematic? If so, why? *Concept examples: Core beliefs (patient's inner beliefs about themselves, others and the world, which determines how they perceive, approach and feel about their life experiences) and psychoeducation (providing patients with explicit knowledge about therapeutic principles to enable the application of CBT beyond the clinical setting and therapeutic sessions).*
(9)	Can you think of examples from your own training and/or practice in which patients could have benefitted from CBT (if you are psychodynamically trained) or psychodynamic psychotherapy (if you trained in CBT)? If so, why?
(10)	What, if anything, can be done to enable practitioners and researchers from different therapeutic modalities to build a common ground and share useful clinical experiences? Can you give some examples?
(11)	Would you consider undertaking additional training and/or incorporating other therapeutic concepts and techniques into your practice if you felt this was useful for patients? If so, why?
(12)	Is there anything that you haven't been asked that you would like to share or comment on?

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practitioners (from CBT and psychoanalytic orientations) in order to refine the flow of the survey and ensure that questions were sufficiently comprehensible.

Research participants

A study protocol was devised and published for this study (Kaluzeviciute & Lloyd, 2021). Following full university ethical approval, the survey was hosted online. Participants were not required to provide their name or any other identifying information; instead, participant IDs were created, with the project abiding by the Ethics Guidelines for Internet-mediated Research (BPS, 2017).

To be eligible to take part, participants were required to be accredited CBT (e.g., BABCP in the UK; NACBT in USA) or psychodynamic (e.g., BPC in the UK; APSAA in USA) therapists with a minimum of 2 years of private practice with adult clients. The survey was open to therapists practicing worldwide.

Recruitment was initially promoted through professional psychotherapeutic social media groups hosting psychoanalytic and/or CBT therapists as well as broader psychotherapist groups. The survey was also promoted in professional newsletters sent by the British Psychological Society as well as several universities. The study was advertised from July 2021 until December 2021, when recruitment was closed. At closure of recruitment to the study, 29 participants had completed the survey. Participants were permitted to provide as much detail as they desired in their responses, with those providing qualitative responses, spending an average of 33 minutes doing so. Participant demographics are reported in Table 2.

Procedure and analysis

Survey data were analysed using thematic analysis (Braun & Clarke, 2006), in order to inductively explore participants' perceptions and experience of psychotherapy integration in their private practice. Thematic analysis is a common qualitative method, which is used to systematically code, describe and interpret qualitative data, by assigning successive parts of the text to developing themes. Thematic analysis was carried out in the following order to identify the relevant themes: (i) *Familiarisation*, (ii) *Generating initial codes*, (iii) *Searching for themes*, (iv) *Reviewing themes* and (v) *Defining and naming themes* (Braun & Clarke, 2012).

Acknowledging the researcher's ideas, thoughts and feelings is essential in qualitative research. In this study, a critical realist approach was taken (Sayer, 1992). Although critical realism acknowledges that our perception of the world is partly socially constructed, it also promotes the idea of developing meaningful interpretations for complex social phenomena existing 'out there' (i.e., in real life). Therefore, analysing how our social and linguistic practices affect research findings is part of critical realist analysis. This is especially important in this study, given that it investigates relationships and perceptions between two distinct therapeutic and theoretical modalities, CBT and psychoanalysis. The research team consisted of a psychodynamic practitioner and researcher (GK) and a psychologist, CBT practitioner and researcher (CL). It was important to ensure that there is a dialogue maintained between the two paradigms

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TABLE 2: *Sociodemographic characteristics of sample (*n = 29*).*

Characteristic	
Age	18–24 years = 1
	25–34 years = 7
	35–44 years = 5
	45–54 years = 6
	55–64 years = 5
	65–74 years = 4
	75–84 years = 1
Main therapeutic orientation (core training)	Psychodynamic = 21
	CBT = 8
Years of therapeutic practice (post-qualification)	1–2 years = 6
	3–5 years = 7
	6–10 years = 2
	11–20 years = 7
	21–30 years = 3
	31+ years = 4
Geographical location	Germany = 4
	UK = 14
	Australia = 1
	The Netherlands = 1
	New Zealand = 1
	Israel = 1
	USA = 7

throughout the study, which allowed to compare contrasting research findings and avoid developing a single causal account, theme or interpretation.

In terms of the analytic process, one researcher (GK) repeatedly read the qualitative data for each successive participant, creating a list of open codes arising from the themes found in the data. Examples included the following: ‘Focus on patient’s individual needs’, ‘Integration requires thinking in different languages’ and ‘Incompatibility between different therapeutic modalities’. This process was also supported by two undergraduate research assistants in psychology who were not, at the time of writing, in any therapeutic training programme. The undergraduate students engaged with all survey responses and generated lists of open codes independently, which were then compared with the codes arising from the main author’s analysis. Once a final version of codes was agreed upon, the codes were subsequently shared with the second author (CL) and refined until it was mutually felt that the codes adequately captured the essence of the data.

RESULTS

Our thematic analysis identified three themes: *Positive perceptions and benefits of psychotherapy integration* (Theme 1), *Negative perceptions and challenges of*

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psychotherapy integration (Theme 2) and *Proposals for strengthening psychotherapy integration in clinical practice* (Theme 3).

Retrieved data from T1 reflect a positive outlook towards psychotherapy integration as a way to address individual client histories, therapeutic needs and presenting complaints. Many respondents have noted that, in their practice, psychotherapy integration happens all the time (although this might not occur consciously) and that learning about other therapeutic modalities can improve one's clinical toolkit and knowledge as well as enrich clinical expertise. T2 demonstrates some cautionary points about psychotherapy integration: clients primarily want highly qualified therapists that they can trust and have less concern about such theoretical nuances as psychotherapy integration, while therapists working in specific paradigms may see other theoretical approaches as less compatible (or completely incompatible) with their own work, which means that integrative work can at times be time consuming and disruptive. Finally, T3 reflects broader proposals and needs surrounding psychotherapy integration: according to some of the respondents, supervision and training should encourage integrative thinking across all therapeutic modalities, with the client's wellbeing (rather than loyalty to a theoretical paradigm) at the heart of the clinical process.

Theme 1: Positive perceptions and benefits of psychotherapy integration

Most respondents ($n = 19$) felt that psychotherapy integration can be useful because a 'one size fits all' approach rarely suits all clients, given the wide range of client histories, experiences and needs. Furthermore, respondents shared that, in their practice, integration (at various degrees) is already occurring on both conscious and unconscious levels; for example, respondents noted that psychoeducation is often an essential element of clinical practice, irrespective of the modality.

> Respondent 4: I adapt the model I use to match the needs of the client. I may even change my [therapeutic] model in the middle of a session if it is seen as appropriate. [I am] very conscious that, for example, work with male clients may [warrant] a more solution focused style. [...] Clients have different needs at a given time and sticking rigidly to a model can be very annoying or irritating to them as their needs may vary in the course of treatment. I aim to empower the client, so psychoeducation is also important.

> Respondent 1: Just to note the reality that we ALL change over time as we move further and further away from our initial training. CBT-ers and PD-ers [psychodynamic therapists] inevitably modify their originally learned techniques—often without being aware of this. On both sides, theory [can be] 'watered down', while others hone and enhance their original skillset to a highly-selective degree.

> Respondent 6: I think pulling from different techniques is a part of the way I work, but having a sound theoretical base that I know grounds me and serves as a point to return to when difficult clinical situations arise.

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> Respondent 21: I absolutely [utilise] psychotherapy integration. The more I have in my toolkit, the more I'd be able to cater to my clients and their individual needs and understanding of their problems. I feel like it'd help me meet them where they are, rather than where I'm at.

Respondents have also noted that learning about other therapeutic modalities can help build a common ground and encourage practitioners to develop a versatile clinical toolkit. For example, although psychodynamic therapy is beneficial for helping clients come to terms with their past, transactional analysis, CBT, narrative therapy and other approaches can usefully provide another lens, helping those clients who may struggle with being in the present. Some respondents have also pointed out that integration indicates a meaningfully compiled treatment plan, in which different therapeutic paradigms are used consciously rather than blended due to one's personal preference (this indicates a difference between eclecticism and integration). The latter process warrants a degree of clinical judgement in how therapy is structured and which therapeutic tools are used.

> Respondent 21: I find that with clients who struggle with the here-and-now may benefit from psychodynamic therapy to make peace with the past before moving forward. I've used transactional analysis and gestalt for this very purpose. I also find concepts of narrative therapy to be very useful in helping the clients set goals for therapy and restructure their beliefs about themselves and their experiences.

> Respondent 11: Therapeutic relationship is a multi-faceted concept and its effectiveness relies on different aspects, which vary in importance for each unique client. Some clients will benefit more from the strong therapeutic alliance, others from a corrective emotional experience, others from transference interpretation, etc. Thus, the therapist's ability to integrate will allow them to emphasise the aspects of the relationship that will be most useful to each client.

When it comes to the possible integration between CBT and psychodynamic approaches, respondents presented various thoughts on how and to what degree this can be achieved. It has been noted that CBT may offer short-term relief but clients with 'deeper' psychological problems (e.g., personality disorders, deeply ingrained defence mechanisms, attachment issues, traumas) can benefit from long-term forms of treatment, such as psychodynamic or psychoanalytic psychotherapies. Respondents highlighted work with unconscious material and transference as two essential techniques emerging from the psychoanalytic framework that can also meaningfully inform therapeutic work in CBT, for example, asking clients to expand after pauses/silence as well as focusing on defence mechanisms and countertransferential processes. Challenging clients' thoughts and worldviews as well as recognising sensations in the body have been identified as useful concepts emerging from cognitive interventions that can also be productively utilised in psychodynamic therapy.

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Respondent 11: I often use psychodynamic concepts to understand what is going on in the therapeutic relationship even if I don't spell them out explicitly. For example, I often try to make space to think about loss, separation, attachments in the therapeutic relationship when a CBT course ends. CBT principles can also be helpful in psychodynamic work: the emphasis on behavioural change can help clients think how they could try a new behaviour in relationships with others.

Respondent 7: Transference and countertransference are useful concepts when therapy presents stickiness or ruptures or when the client's therapy goals are to do with improving relationship skills. CBT is useful [when] interpersonal problems are well disguised, e.g., the person seems to have decent social relationships but they are all very fraught and require thought challenging.

Respondents have also identified instances of their own private practice where they felt that they needed to go beyond their therapeutic paradigm to understand and work with specific clients effectively. Several reasons have been presented for this change, most notably client's unique therapeutic needs or specific diagnosis (e.g., clients with addictions, acute anxiety or on autistic spectrum have been identified by some respondents as reacting better to cognitive interventions).

Respondent 12: One patient I worked with came with a different brief—helping her manage the aftermath of a coercive control relationship. She had had personal therapy before to help her understand herself in relation to the relationship. This meant that our transference work was less central and I was able to bring in more practical ways of tackling her difficulties. This worked well to an extent, but I also needed to use my countertransference of becoming more forceful than usual with her as this was clearly an enactment of exactly the dynamics with which she needed help.

Respondent 17: I had a patient I worked with for some months in a way which helped but not as much as I might have hoped. I gradually became aware that she was most likely on the Autistic Spectrum and could not really use insight-based work in the more neurotypical way. This was not at all obvious at first. I think in retrospect she might have been better placed with a CBT practitioner.

Theme 2: Negative perceptions and challenges of psychotherapy integration

A significant number of respondents ($n = 18$) also raised questions, concerns and discussed limitations regarding psychotherapy integration. Some respondents expressed the belief that there are clinical techniques and/or modalities that are simply incompatible on theoretical as well as political grounds. For example, some cognitive therapists see psychoanalysis as a less adaptive discipline, not only to

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integrative work but also to the changes of modern research and clinical practice as a whole. Similarly, psychoanalytic practitioners see CBT as a dominant paradigm that is also less receptive to other ideas and techniques from 'lesser' (in terms of evidence-based research support) modalities.

> Respondent 10: Cognitive colleagues can be too dogmatic [toward] any different therapeutic approach and may have a misguided understanding of other approaches and their mechanisms of change [...] There can be ignorance and a narcissistic desire to believe their approach is superior to all others.

> Respondent 16: Old school psychologists do not take nicely to what they perceive as competition. Thus, I have a problem whenever I encounter one when I need to collaborate about a patient. They are condescending, and are not really connected to real life troubles. Get the psychoanalysts off their high chair.

On the level of theory, some respondents raised the issue of epistemic integration: since CBT and psychoanalysis emerge from different philosophies (e.g., constructivism vs. constructionism), it might be difficult to integrate the two. Additionally, lack of research evidence-base in the field of psychoanalysis was also listed as a concern by CBT therapists.

> Respondent 19: Positivism is the dominant epistemology in our field. It strongly contributes to the overdominance of CBT, and creates a therapeutic culture in which only therapies that are amenable to RCTs are worth trying. Managed care companies reinforce this in addition to being a barrier on their own.

> Respondent 20: Theoretically [the two paradigms] are too different. It would be confusing for the client and the therapist to integrate, coming from a CBT perspective. There is also little evidence base for psychodynamic therapies.

Respondents have also noted that integrative practice can be time consuming, and, if not done effectively, disruptive, as it requires to think in different clinical languages. The end result of such integrative work, then, can be less effective than specialising in one modality.

> Respondent 7: Clients just want high quality trained therapists that they can trust. Integration can be time consuming and disruptive because it means you have to think in multiple different languages. And for what end?

Several respondents highlighted the idea that integration is not just about the common factors of each modality—it requires understanding and training in various modalities in order to actually integrate different approaches in an effective manner. Therefore, it can be difficult to build a solid theoretical and clinical foundation with little exposure to other therapeutic orientations.

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> Respondent 15: There's a big learning curve for psychodynamic therapy. A lot of behavioural based therapeutic modalities will have three day long trainings to illustrate the basic ideas. Dynamic therapy takes a lot of time/effort to learn. I don't think sitting CBT therapists down and trying to show them "the basics" of dynamic therapy would even be possible. There is no learning "a little" psychodynamic psychotherapy.

Responses also reflect some concern about the possibility of 'too much' integration, when allegiance to one's therapeutic paradigm gets blurred due to a variety of tools used in clinical practice. This may also reflect wider concerns about seeking appeasement and approval from clients by adjusting techniques to provide comfort (rather than work through presenting issues).

> Respondent 3: When clients respond better to particular modalities such as cognitive behavioural interventions, as well as give feedback of liking the interventions more, there is a challenge to the extent of continuing psychodynamic practices or eliminating it all together.

> Respondent 11: The danger for therapist's drift, well-spelled in CBT, is a possible challenge, which is more applicable to time-limited therapy, when a certain number of sessions is authorised. Integration can also make a therapist give up a certain process or task too quickly, thinking that it's not working for the client, failing to address therapy-interfering behaviour. Finally, changing modality could be the result of enactment. For example, I recently found myself fluctuating between psychodynamic and CBT [paradigms] with a client because my countertransference was that I was not good enough and bringing another model in was my way of compensating. I had to take a step back to understand that this feeling was the result of a projection and it was more useful to stick to a model, show confidence within my skills, and help client take ownership of the feeling that she is not good enough and then explore it further with her.

Theme 3: Proposals for strengthening psychotherapy integration in clinical practice

Most participants ($n = 22$) had ideas and suggestions for the improvement of psychotherapy integration in clinical practice. Respondents have identified supervision and regular discussion with other clinicians as two important processes that can bring together various therapeutic modalities and build a common ground in which clinical experiences can be shared and learning takes place. For example, case discussions between different practitioners can be useful for clinical practice as well as increased collegiality between different paradigms.

> Respondent 6: Turf wars are endemic to therapy in my view. I think they can help pressure the field to improve if people are open to it. I think it is very helpful (and I wish it was done more) when a case is presented, and

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practitioners from different orientations talk about how they might approach it. That seems collegial and helpful.

Respondent 10: Clinical and research collaborations, reading groups and case conferences could be important.

Respondent 11: The more complex the case, the more likely that there is some need for integration, so perhaps a complex case workshop?

Respondents have also noted that clinical training—irrespective of one's modality or paradigm—should at the very least encourage flexibility and open dialogue involving other theoretical and therapeutic modalities.

Respondent 4: Training should never be in just one modality to allow the therapist to think flexibly from the beginning. The training of counselling psychologists always included training in at least 3 modalities but this often leaves out systemic approach which is essential not only for working with families and couples but for individuals as well as each is always a part of a system that is affecting their lives.

Respondent 12: We regularly host seminars from CBT, mentalisation, person centred and medical approaches on our courses. This is useful for students and for staff. This does not happen in most psychotherapy trainings! It would be good if it did.

Research has also been identified by some respondents as an important area of potential dialogue between different therapeutic paradigms. Instead of competing, different modalities should communicate about what works and what does not, especially if this involves a combination of different therapeutic techniques (i.e., a form of integrative practice). Similarly, respondents suggested that there should be more research about the overlap between different paradigms, as the current focus appears to be on the differences. Respondents also highlighted that there should be a pragmatic outlook towards research methods used to measure treatment effectiveness.

Respondent 7: [It is] important to stop slating one another in papers and online.

Respondent 11: For researchers, the common factor approach, process-based therapy, Norcross's and Wampold's work on transdiagnostic factors that can affect treatment outcome is important. Research on what works for whom rather than cold comparison between modalities is essential.

Respondent 19: Bring case studies together with RCT style research. Dan Fishman's pragmatic case study method is a great example.

Respondent 21: I think there are many overlaps in the theories. Sometimes, I feel that different modalities explain similar things using different languages or even perspectives. I think we could start with studies looking at parallels between models.

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Lastly, several respondents have shared that, above all, integration comes from a place of authenticity and comfort within one's main therapeutic orientation, when incorporation of other techniques or ideas does not indicate that one's paradigm boundaries have been trespassed. This reflects the importance of congruence and authenticity with clients in clinical practice.

> Respondent 9: One should not think so much about an allegiance with a modality but to just think of psychotherapy as a general thing and to learn what is important or useful […] I think in addition that authenticity is very very important. Many therapists practise therapy as a collection of techniques and tricks, and I am convinced that, especially with people who have been in therapy many times and haven't been helped enough, it is very important to be authentic. […] I think it has to do with congruence. People can tell when you use phrasings or words that you normally wouldn't use, and therefore can tell you are "intervening" instead of being a real person with them.

> Respondent 23: I think it is the responsibility of each practitioner to remain open to learning from alternative therapeutic approaches. Therapeutic modalities should not be treated as though they were "secular religions".

DISCUSSION

Data retrieved in this study reveal that psychotherapy integration is highly desirable among most of our participants. Several participants revealed that they had at least one instance in which they felt that their therapeutic paradigm and/or techniques were insufficient in addressing individual client needs and histories. Participants noted that this is especially important when considering specific client populations: CBT therapists listed 'deeper' psychological experiences, such as personality and mood disorders as well as attachment issues, as benefitting from psychoanalytic techniques, while psychodynamic therapists saw neurodivergent clients and clients with addictions as benefitting from cognitive interventions. Generally, most participants in our survey shared the idea that their therapeutic approach should meet the client's needs, not the other way around. As such, although most participants had a strong identification and allegiance to a specific modality, it was felt that there was room for flexibility and additional techniques from other modalities and/or paradigms. This is consistent with other studies investigating therapist allegiance to their respective modalities (Feixas & Botella, 2004; Zarbo et al., 2016).

Despite a generally positive outlook towards psychotherapy integration, participants raised questions about how psychotherapy integration can be achieved effectively, and what it should entail. Our data reflect a wider challenge in defining psychotherapy integration: whereas some therapists see it as simply a degree of flexibility in one's clinical techniques and approaches, others indicate that integration should involve a conscious and meaningful relationship between different modalities. The latter, however, should not be equated with therapeutic eclecticism, in which therapists choose interventions based on efficacy rather than theoretical or

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technical compatibility between different therapeutic schools or techniques (Gold & Stricker, 2001). This means that psychotherapy integration requires a degree of knowledge and exposure to other techniques. However, as noted by participants in our study, and as discussed by existing studies (Boswell et al., 2010; Norcross & Wampold, 2018), psychotherapy trainees often do not have sufficient exposure (due to, for example, limitations in their training programme or the preference of the supervising therapist) to different theoretical approaches, which can prevent them from employing a more integrative approach in their clinical practice. The increasing use of manualized treatments (Norcross & Wampold, 2018) has led to a further reduction in the space available for therapeutic flexibility (Westen et al., 2004).

Beyond the more pragmatic issues of psychotherapy integration, our study also reflects ongoing historical differences between practitioners in different therapeutic modalities, namely, psychoanalytic (and, by extension, psychodynamic) and CBT. Some of the participant responses reflected the long ongoing 'turf wars' between the two therapeutic paradigms (for a review, see Burkeman, 2016): CBT practitioners may see psychoanalysts as 'outdated' yet still clinging to their 'high chair', whereas psychoanalysts may see CBT therapists as 'dogmatic' and full of 'narcissistic desire' to prove the effectiveness of their modality (as some of the emerging individual perceptions from our study findings, these are, by no means, generalisable on each paradigm as a whole).

Beyond what might be considered a human exchange of resistances and hostilities present between the two paradigms, there are also concerns about epistemic compatibility between different techniques and theoretical coherence. Indeed, one of the most pertinent challenges in psychotherapy integration is to adopt techniques that exclude conflicting epistemic assumptions (Castonguay & Hill, 2012), address individual client needs (Norcross & Goldfriend, 2019) and allow therapists to maintain theoretical coherence between the different theories being used (*ibid*). Our results have two takeaway messages on this point: (1) some central concepts in CBT and psychoanalysis are easier to apply, regardless of the main therapeutic affiliation, than others, due to their flexibility and the general, often trans-therapeutic role that they have in the therapeutic relationship, for example, transference and countertransference (psychoanalysis), psychoeducation and challenging negative thoughts (CBT); and (2) it is important to reflect on the reasons behind psychotherapy integration, particularly if new techniques are used to attune to client's needs (e.g., are new techniques being used in order to 'validate' one's identity as a therapist when working with a demanding client?).

Our study has also reviewed participants' proposals for further development of psychotherapy integration. Supervision and regular contact with colleagues from other modalities (e.g., through case study discussions, conferences, workshops) have been identified as two significant areas for potential exposure to psychotherapy integration. Unsurprisingly, therapeutic training has been specified as the most important area for exposure to integrative work and thinking in clinical practice. Although some training programmes have incorporated elements of integrative practice into their curriculum, including training in evidence-based treatments, cognitive-

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behavioural therapy and psychodynamic approaches (e.g., The Society for the Exploration of Psychotherapy Integration; SEPI), many training programmes are lacking in theoretical diversity and dialogue (Norcross & Wampold, 2018).

Along with the desire for a higher degree of psychotherapy integration to be introduced in psychotherapy training, our study participants have also highlighted an ongoing demand for a higher level of pragmatism in research methods on therapeutic effectiveness and outcomes. Specifically, common factors research has been encouraged as an approach that reviews the core factors leading to positive treatment outcomes (e.g., therapeutic alliance, empathy, goal consensus and collaboration, congruence, mentalisation and emotional experience), irrespective of the specific therapeutic modality (Wampold, 2015). Similarly, a transdiagnostic approach may be useful for therapists employing an integrative approach in their work as it cuts across traditional diagnostic boundaries in psychotherapy, thus allowing for a more open-ended dialogue between different therapeutic approaches (Dalgleish et al., 2020). Finally, our data reveal a further need for a dialogue between different research methods, that is, qualitative strategies, in particular, case studies, and more traditional quantitative strategies, such as randomised controlled trials (RCTs). This call corresponds with existing debates about the 'validity' of current evidence-based research standards in psychotherapy, with many authors asking for a mixed-method approach, in which qualitative methods are seen as just as valuable as statistical studies (see, e.g., Kaluzeviciute, 2021; Truijens et al., 2022).

STUDY LIMITATIONS

This study has several limitations, which should be acknowledged. First, although the qualitative survey design of the present study permitted wider access to a pool of participants, it is well documented that online research surveys are subject to drawbacks (Wright, 2005). Notably, for the current study, relatively little can be verified about the authenticity of those participants who completed the survey. Furthermore, there is an imbalance in the number of participants between psychodynamic ($N = 21$) and CBT ($N = 8$) therapists in our study, which may have influenced our findings due to a higher presence of psychodynamic/psychoanalytic perspectives. Future research may wish to focus on therapist perspectives in more homogeneous samples, for example, by comparing therapist perceptions of integration in one geographic region, by conducting research that includes diverse international samples (for instance, our study does not include Latin American participants, who may have presented a different, more constructivist take on the integrative process from a psychoanalytic point of view) and by achieving a greater balance between participants representing different therapeutic paradigms.

Second, although qualitative survey design was more preferable due to the possible influence by perceived researcher background (given that each of the study authors represents different theoretical and therapeutic paradigms), it is important to acknowledge the methodological limitations associated with a survey design, most notably: *limited response depth* (compared with interview responses, survey

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respondents typically have fewer opportunities to express nuanced or complex thoughts and feelings); *misinterpretation* (respondents may misinterpret survey questions, leading to inaccurate or incomplete responses); *lack of information produced by follow-up questions and probes* (an advantage of the interview method is that a researcher, capable of using active listening, may hear details that are important for the research study but are not clearly elucidated by the respondent; such follow-up opportunities are lost in survey responses due to the absence of a relationship between the researcher and the research participant). Further qualitative studies employing the interview strategy would therefore complement the perspectives conveyed by our survey findings.

In addition, although the present study helpfully generated some wider insights from the therapist perspective into psychotherapy integration, these should also be supplemented with research which focuses on the client perspective regarding what they may find helpful, or indeed, unhelpful regarding different therapeutic orientations and the possibility of psychotherapy integration. Finally, although the present study has presented a useful snapshot of therapist views on psychotherapy integration, qualitative interviews and/or focus groups may usefully enrich the present findings by generating further qualitative data, which explore the often meaning-laden nature of therapeutic processes.

CONCLUSION

This study has implications in terms of understanding how psychotherapeutic practitioners, who work in private practice, regard psychotherapy integration, both during clinical training and post-qualification. Emerging strongly from qualitative analysis was an appreciation for the integration of differing therapeutic approaches, in order to meet client needs. However, how this psychotherapy integration was to be implemented on a pragmatic level was more controversial. Whereas some therapists regarded psychotherapy integration as simply a degree of flexibility in one's clinical techniques and approaches, others indicated that integration should involve a more conscious level of reflection in terms of the epistemological compatibility between different modalities. Participants noted the importance of differentiating between psychotherapy integration and therapeutic eclecticism, in which therapeutic techniques are chosen based on their effectiveness and relevance to a specific case rather than their theoretical compatibility with one another.

Despite the generally positive approach to the idea of integrating different therapeutic degrees and/or paradigms, reservations have also been voiced about how effectively this can be achieved. The relationship between CBT and psychoanalysis in particular is still held in high controversy, as our findings reflect traces of ongoing 'turf wars' between the two approaches. CBT therapists have shared views that, as a field, psychoanalysis may still lag behind contemporary developments in clinical practice and research. Psychoanalytic and psychodynamic therapists, however, have expressed a sense of resistance from CBT colleagues towards ideas that are not emerging manualised or evidence-based frameworks. Beyond these attitudes,

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questions have been presented about epistemological compatibility between the two fields and their central concepts.

Our findings reflect a general need for greater dialogue about psychotherapy integration (and different therapeutic paradigms, as a whole). Therapeutic training has been identified as the key area for exposure towards meaningful integrative work and clinical thinking. Although there appear to be many questions about what psychotherapy integration should or can entail, especially in the context of CBT and psychoanalysis, a greater dialogue between different approaches is in high demand, as reflected by our study findings. It is possible that greater contact between different therapeutic approaches may alleviate some of the long-standing resistances as well as questions about each paradigm's efficacy in the consulting room with individual clients.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ENDNOTES

1. It is important to note that this article approaches CBT and psychoanalysis on a general level to understand how psychotherapy integration works (if it does) in a broader sense as well as to open up the pool of potential research participants who practice using comparable techniques, although potentially in different contexts. While the description and presentation of CBT and psychoanalysis in the paper functions as a general overview, we are mindful of the recent developments and many different theoretical movements within each of the paradigms (see Hayes & Hofmann, 2017; Kernberg, 2012).
2. In this article, we refer to the practice of both psychoanalytic and psychodynamic psychotherapy (in balance with our conceptualisation of CBT, which also involves a broad overview, and includes different theoretical movements, such as DBT). However, it is important to note that the two have differences: psychoanalysis is a theory of the human mind as well as a form of intensive therapy (in the most classic sense, this involves long-term treatment, often for years, a high focus on unconscious and repressed material, and the use of traditional techniques, such as free association and dream analysis). Psychodynamic psychotherapy shares many of the core psychoanalytic tenets in a theoretical sense (although subscription to these concepts may differ across various psychodynamic schools) but differs on a technical level in

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that it is generally much shorter, and less intense (generally delivered once per week). By using the expression ‘psychoanalytic/psychodynamic approaches’, we do not mean to equate these approaches; instead, we refer to the broader picture of clinical practice, which involves key psychoanalytic models and ideas, and may be employed by many practitioners despite the technical differences of their clinical practice.

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GRETA KALUZEVICIUTE-MORETON is an academic at the intersection of psychoanalysis, psychotherapy, epistemology and mental health, working in the United Kingdom and Lithuania. She is currently an Associate Professor at Vilnius University, Institute of

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Psychology (Lithuania) and Associate Lecturer at College of Health, Psychology and Social Care, University of Derby, Derby, UK. Her main area of research is concerned with knowledge generation practices in the field psychotherapy, with a particular focus on the case study method. Address for correspondence: [greta.kaluzeviciute@fsf.vu.lt]

CHRISTOPHER E. M. LLOYD is a Lecturer in Psychology and BPS Chartered and HCPC registered Counselling Psychologist. He holds a DProf in Counselling Psychology. He has worked in both National Health Service (NHS) and charity services for over a decade and currently works in international private practice. He undertakes university teaching and peer reviewed research and has a particular interest in innovative and novel qualitative methods, such as qualitative surveys and story completion.

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