Cognitive psychotherapy and integrative psychotherapy

Stefan Leder, Maria M. Siwiak-Kobayashi

Summary

In the first part of the paper, Stefan Leder presents the history of the formation of the cognitive approach in psychotherapy in Poland and the world. In the second part, Maria M. Siwiak-Kobayashi describes the aims and practical applications of behavioral and cognitive learning in integrative and intensive short-term therapy, based on social learning.

cognitive approach / social learning / cognitive psychotherapy / behaviorism / psychotherapy integration

INTRODUCTION

The text presented below, consisting of two complementary parts, was written almost three years ago as a chapter for a book on cognitive therapy. As the publication of the book was continually delayed, a week before his death Professor Leder asked the book editor, Andrzej Kokoszka, if he didn't think it suitable to publish at least parts of the book separately, since the publication date was increasingly vague. I was a witness to this conversation, and so a few weeks after Professor Leder's death I thought that publishing the text in *Psychotherapy* – a publication created mainly by Professor Leder many years ago - would be the right way for him to say goodbye to his readers, while at the same time it would symbolically remain a sign of the active presence of his thought in this publication, which is mostly a discussion forum for his colleagues. I made sure again that the editor of the monograph on cognitive therapy did not mind a separate publication, and decided to submit one of the chapters to the *Psychotherapy* editors.

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The part of the paper written by Professor Leder is an exceptionally valuable presentation of the history of the cognitive approach in psychology and psychotherapy. It includes information difficult to find anywhere else, as for most people cognitive therapy begins only with Beck or Ellis. Professor Leder offers a broader historic overview of this approach. The paper also gives Professor Leder's readers the opportunity to examine some of the sources of inspiration for his work as a founder of the Neurosis Clinic at the Institute of Psychiatry and Neurology in Warsaw. I, on the other hand, in my part of the paper, have tried to show how some elements of cognitive therapy are used effectively in the integrative, intensive form of cognitive-social psychotherapy applied at the Neurosis Clinic.

HISTORIC CONDITIONING OF THE COOGNITIVE APPROACH AND INTEGRATION IN PSYCHOTHERAPY

Stefan Leder

Psychotherapy as a separate treatment method has been used in the world for only a little more than a hundred years; a relatively short

period, especially against the background of the long history of medical science. The beginnings of systematic theory and clinical practice were dominated by psychoanalysis, widespread at the turn of the 19th and 20th centuries, and in the first decades of the 20th century. In Poland, before World War II, psychotherapy as a separate specialist treatment method was not particularly popular. Moreover, a lot of the psychiatric personnel were killed during the war and the Nazi occupation, which was one of the hindering factors in the development of psychotherapy. In fact, during the war, almost all links were severed with contemporary thought in psychotherapy and replaced with shallow and simplified interpretations of Pavlov's theory. A few psychiatrists continued to popularize and teach psychotherapy, amongst them such academic teachers as Tadeusz Bilikiewicz, Stanisław Cwynar, Adrian Demianowski and Kazimierz Dąbrowski, while individual psychotherapy was practiced by Dr. Zofia Szymańska, Dr. Mazur and Dr. Zajączkowski.

It was only in the mid 1950s that the first centers using psychotherapy as their basic treatment of neurosis were founded. At the same time, some of the clinics and psychiatric hospitals applied various forms of psychotherapy in support of medical treatment. It is not an easy task to summarize the theoretical background of the therapy practiced in those and other centers during that period, e.g. the team in *Rasztów* along with other individual psychotherapists, who worked in the 1950s, borrowed from the psychoanalytical and psychodynamic concepts, while the psychiatric team in *Klinika Krakowska* (Professor A. Kępiński) referred to eclectic theories. In the Neurosis Ward of the Psychoneurological Institute, where the first efforts to practice group therapy in the psychiatric clinic were undertaken (Leder, Wolska), further research and work was carried out gradually to create a theoretical model identified as eclectic, but based on the principle that psychotherapy with non-psychotic patients is a learning and overlearning process, aimed at changes of attitudes, improvement of skills in solving internal and external conflicts and an increase of the ability to function well in social roles. In their clinical practice, the authors of this program referred to a few concepts well known in the literature, such as:

– the theory and practice of P. Dubois [1] – in psychiatry handbooks referred to as the creator of the persuasion method effective in the treatment of psychoneurosis,
– psychagogics – A. Kronfeld [2]
– the views of J. Frank presented synthetically in "Persuasion and healing" [3]
– psychogenetic therapy of W.N. Miasiszczew [4],
– the attitudes concepts of G. Allport [5],
– research into characteristics of group dynamics in K. Lewin's school
– Pavlov's concepts of increased neurological activity and the role of secondary signal system.

At the time, we thought that influencing a person's psyche through verbal and non-verbal signals was a common element of these concepts; in treatment, the psyche of a suffering and helpless patient is looking for help, relief, support from a "healer" attributed with authority, knowledge, competence and social status. A healer provides the desired support himself or with the aid of a group of people, addressing the emotions, consciousness and behavior of the person in need, which are often altered and made ill through the impact of a whole array of factors: biological and psychological but also social and cultural. These factors shape the individual personality traits of a person, making each person's perceptions, emotional life, and responses to difficult situations such as illness, suffering, danger, chaos or loss of control different. A "healer" provides help by identifying the illness, explaining the reasons behind it, and offering potential for change and healing. He recommends treatment and specific procedures, including medication. He addresses the patient's consciousness, his or her mind and reason, based on the principle that they are decisive factors determining personal actions, emotions and feelings.

In general, most of the psychiatry handbooks mention S. Freud and P. Dubois as the founders of the first coherent theoretical concepts in psychotherapy at the turn of the 19th and 20th centuries. It seems that the latter was particularly important in the formulation of subsequent cognitive theories.

It is worth quoting a few of Dubois' thoughts. He was a general practitioner and a professor of neurology in Brno and, amongst many oth-

er publications, the author of a very popular medical book published before World War I, "*The Psychoneuroses and Their Moral Treatment*" (1904) [1]:

"It's true that my impressions and views are based on, I daresay, credible observations and considerations […] *but they are still lacking the victorious recognition by scientific authority* […] *I am astounded at how easily one can eliminate sick states of the soul, which for decades might have been for a patient a foundation of ominous and erroneous beliefs with regards to his own bodily and mental malfunctioning, and lead to clear thinking and a healthy philosophy of life* […]. *The patient's vulnerability increases with his suffering. If you can prove to him that his mental state and, the frailty of his soul and character play a significant role in the development of his illness, and that it is necessary to change this condition in order to be healed, then we know that we have a talented pupil. He will become an enthusiastic follower of therapy as a result of the understanding that the change it brings is only in his best interest* […] *It is easy to show him that he himself builds on his suffering with his fear and anxieties, that he even breeds fear and anxiety this way* […] *It is fear which is the main error of those who are weak in their souls".* But *"the handling of psychoneurosis cannot be restricted to dealing with current symptoms or breakdowns through somatic or spiritual treatment, remedying just its immediate causes. To prevent any further incidents of illness, it is necessary to change the patient's mental disposition. I must emphasize here that this educational task is much easier than it is commonly conceived, especially when it concerns ethical issues and lifelong values* […] *It is only through an intimate and friendly conversation that one can gain knowledge about one's patients* […] *it is crucial to make them believe in themselves again, teach them to overcome doubts and to master self-control* […] *All our emotional tribulations are directly linked to some intellectual perceptions, controlled by the mind* […]. *Self-improvement should lead us to ethical insight, which controls our emotional impulses until they are reviewed and accepted by reason* […]. *This can be achieved only through the continuous training of reason. Patients can be taught this; and indeed not through mathematical deduction but through ethical dialectics* […]. *It is the ancient Greeks who said that knowledge is virtue".*

Even if Dubois' language is a little archaic, a lot of his thinking indicates that he shared the ideas of the Enlightenment and its belief in progress. He believed in free will, the feeling of responsibility, and the inner strength to make conscious choices, develop rational thinking and gain self-knowledge and self-improvement. Psychotherapy, understood as "moral orthopedics", can assist this process. This direction in thinking about neurotic disorders *"which damage the whole personality, the most basic elements of the patient's self"*, and their effective treatment, assumed the closed proximity of the psychological curing process and upbringing, even if the latter is considered to be the basis for the education of children and teenagers. And this is how the term "psychagogics" came into being.

Kronfeld's work [2] *Psychagogik oder Psychotherapeutische Erziehungslehre,* published in Berlin in 1927; *Die Psychischen Heilmethoden,* edited by K. Birnbaum, was a considerable contribution to a more in-depth understanding of the differences between education and psychotherapy. The author also discussed the development of psychoanalysis which, in his interpretation, emphasized the importance of intellectual and emotional insights. His work certainly provided a counterbalance to the general tendency to reduce psychotherapy to rather primitive and mechanical school-teaching. It is worth quoting Kronfeld on this occasion, to illustrate the transformations that took place at the time in the understanding of neurosis and psychotherapy, as a result of the development of psychoanalysis, suggestive and behavioral methods. These transformations have also been related to the knowledge acquired during World War I about the sources of disorders and treatment mechanisms: *"All procedures and methods which arose from psychotherapy belong to the arsenal of psychagogics, the art of medical and humane treatment of a suffering person* […] *Therapists who don't follow this path are in no way independent therapists* […]. *Psychagogics* […] *the knowledge and skill of "healing" must make use of all changing procedures and methods, depending on the character of disorders and symptoms* […] *Using psychotherapy, a doctor can't just restrict his work to the medical field but, at least within the educational goals that he is trying to achieve, go beyond these boundaries.* […] *There is also the task of bringing a suffering person closer to the community, to reconcile the two externally and if possible also internally. It's not about conversion but about bring-*

ing a patient closer to reality. Psychotherapy sets out to achieve four goals: for patients to become stronger, more responsible, independent and healthy [...]. The influence that a therapist has on his patient makes the process easier, amongst other ways, through appealing to the patient's honesty, to the need to face the truth and gain insights about one's life."

We can easily see now that psychagogics was a rather ambitious project, with many tasks and goals that made use of the findings of other trends in psychotherapy, and various procedures for achieving these goals. From today's perspective, this approach would be classified as integrative.

A. Adler, once he broke up with orthodox Freudianism, especially the thesis of the decisive role of the libido, and also in consequence of his experience acquired in work with another group of patients of social security facilities in Vienna, clearly noticed the relevance of sociocultural factors in the origins of neurosis.

He emphasized the role of "*the striving for power"* in competitive society. He was one of the pioneers of group therapy for patients with neurosis, sexual disorders, alcoholism, and for their families. Looking at the origins of these problems, he was trying to make an impact on attitudes and approaches to the problems that life brings i.e. he tried to influence the *"lifestyle and life plan" "compensating for one's deficits"* and *"escaping into illness".* This last term in particular gained a certain pejorative meaning after the introduction of social security in Germany in 1874, and especially after the experience and observations related to the treatment of "*trauma*", "*claim*" and "*war*" neurosis during World War I. Passionate disputes were held amongst German psychiatrists about the origins and treatment method for these complaints, which reflected the more general clash of the two concepts of a human being: reactive and cognitive, reflected in the views of Kretchmer, also known in Poland at the time.

In the attempt to explain the mechanisms of hysterical disorders encountered in soldiers in situations of imminent and dramatic danger at the front, Kretchmer emphasized the relevance of primitive, biological forms of adaptation (hypoboulic) and so he recommended treatment which joined together the directive, training (protreptic) methods with fractionized hypno-

sis and, quite notably, with psychological analysis aimed at working out a certain intellectual insight. This treatment method was directed at changing the patient's motivation through awaking the "*will to be healthy*".

After World War I, especially after the emigration of many German psychoanalysts to the USA, a new cultural psychoanalysis movement emerged that took into account the work of Ernst Mayer. The movement highlighted the role of environmental conditions in the origins of such feelings as lack of security, alienation, loneliness and helplessness and, accordingly, these feelings contributed to generating various internal conflicts and resulted in personality dysfunction, which found self-actualization an impossible project so instead focused on the pursuit of an idealized unreal self. "*Reorientation*" through "*self-knowledge*" was stressed here, in order to recover or discover ways of reconciling life's conflicts and taking responsibility, through an increased capacity and ability for making choices and decisions.

The introduction of the National Health Service in England in 1948, together with the development of social psychiatry in the Anglo-Saxon countries and Germany, played an equally significant role in the transformations of psychoanalysis and evolution of various dynamic movements. These new developments meant that the number of patients to be treated increased, the duration of treatment had to be reduced and both long-term psychiatric and somatic patients had to be provided with opportunities for re-socialization and rehabilitation. This was when various new experiments with new forms of therapy came to light, also those that assumed an active co-operation of patients in the treatment process and shared responsibility. These ideas were implemented through group activities, the democratization of hospital structures and changes in relationships between various groups of hospital personnel and personnel – patient relationships. This new concept in therapy created the basis for the whole idea of the "therapeutic community". It was also closely linked to the new understanding of the group, taking it to be one of the basic causal factors behind disorders as well as one of the treatment tools, which affected the degree of co-operation of doctors with various other profession-

al groups. Doctors also entered patients' places of work and homes. New groups, such as the local community, family and self-help groups were being created; new clubs and associations of former patients were founded, and various action groups were initiated in the companies employing people with disabilities and in rehabilitation centers.

This process went together with the need to integrate groups and ensure continuity with groups of other types, working within other organizational structures. Groups that were associated with patients or medical personnel were used everywhere, for example Balint Groups for doctors and nurses or training groups for medical and administrative personnel. The main ideology behind their activities referred to psychodynamic, humanist concepts (meeting groups), the theory and practice of small groups (K. Lewin's T-groups) and the principles of didactic-psychological groups. These group forms of training for psychiatrists, psychologists and psychotherapists were also increasingly widespread in Poland.

In the Soviet Union, group activities were introduced in psychiatric hospitals for patients with various diagnoses, based on the concept of rational, active psychotherapy in conjunction with sociotherapy and occupational therapy. The activities of didactic-psychological groups included lectures and discussions, which referred to the problems experienced by the patients. Various additional materials such as anonymous patient histories, films and pictures were used at the group sessions.

This was also the time of the development of professional and psychological counseling, which employed psychologists, pedagogues and social workers, often with academic degrees. The fact that various forms of psychotherapy and counseling developed alongside one another contributed to the enrichment of counseling with psychotherapeutic techniques, used to achieve quick behavioral changes, modifications of some environmental factors or increasing the ability to use one's potential better and improve one's functioning in many aspects of social life.

Many authors tried to overcome the simplifications and limitations of therapy i.e. in relation to psychotic patients or patients with personal-ity disorders, by employing existential philosophy and personological concepts (V. E. Frankl, R. May, C. Rogers), Gestalt and role theories (F. Perls, E. Berne), learning theories (L. Krasner, A. Bandura, M. Lazarus), communication concepts (G. Bateson, P. Watzlawick, R. Brandler) and cognitive techniques (G. Kelly, A. Ellis, M. J. Mahoney, D. Meichenbaum, A. T. Beck). What many of these theories have in common is focusing on the humanist dimension of man, revealed in his desire and pursuit of development, self-actualization and self-determination, to create close and positive relationships with people and be active and creative in one's life. These theories regard "*being in the present*" as the constructive starting point of development, defining disorder as the hindered or blocked potential of a person by external factors. Learning how to overcome these barriers is therefore understood to be the essence of treatment, as is making it easier for patients to become free of pressures and fetters, in order to broaden their consciousness, which will enable them to make choices based on their own system of values, thus attaining freedom. Some of these authors work with both psychodynamic and cognitive models but they identify their belonging to a school or theory in different ways. In fact, they discuss the same phenomena using different terminologies. Most often, they acknowledge the significance of innate or biologically determined needs in the origin of disorders, treating them as the main factors behind the individual's motivation system. At the same time, they stress the importance of socio-cultural conditions that affect the unconscious and conscious processes that form this hierarchy, with the emphasis on the subject's active and creative role.

What these authors also have in common is their view of the usefulness and efficacy of displaying, identifying and abreacting emotions, becoming conscious of one's needs and pursuits, role playing, communication methods and modification of interaction models. They also agree that clearly identified goals are easier to achieve in a group, although they have different views on the roles of the group and the therapist and choices of techniques.

Similar deepening, enrichment and transformation processes took place in behaviorism, prominent in the USA in the first half of the 20th

century, following the work of Watson, Skinner and others, and based mainly on the reactive model of man. In the 1950s various learning-centered treatment methods became popular (Wolpe, Eysenck, Franks, Rahchman). Their efficiency was justified by the empirically-based S-R (stimulus – response) model. Some positive effects of these treatment methods produced overblown expectations, which resulted in a certain degree of disappointment prevailing in the 1960s. The inadequacy of the S-R model was revealed, with an "O" (organism) factor thrown into the bargain. Further attempts were being made to improve treatment methods by taking into account the "O" variable, which included the transformation of incoming impulses (information) and their integration with the symbols and cognitive schemata coded in the memory. This process lead to the introduction of heuristic rules of learning, changes of behavior, self-control, problem solving and completing tasks (Łuria, Wygotski, Galperin, Meichenbaum, Goldfried et al.). This newly experienced proximity of the behavioral approach and cognitive concepts was facilitated not only by the dominant participation of psychologists in creating the integration but also through the growing popularity of the founder of rational-emotive therapy – Albert Ellis. Ellis drew to a large extent from Dubois' work, making his ideas more precise and developing them into his own concepts. He expanded on Dubois' ideas, emphasizing relations between thinking, emotions and behavior.

Similar motives can be found in the later work of Meichenbaum, Mahoney and many other American psychologists although, generally speaking, they were either unfamiliar with the ideas developed by their European predecessors or belittled their achievement, which is clearly visible in their bibliographies. At the end of the 1970s, one of them, namely Mahoney [6], described the condition of cognitive therapy in the following way "*At present, most approaches to the cognitive concept of learning are no more than a bundle of relatively varied principles and procedures, which are still in need of being molded into a uniform system or model. While agreeing on some basic principles, the advocates of these approaches demonstrate a wide array of views, varied in specific accents and procedures. It seems that they have the following beliefs in common:*

1 – people develop adaptable and non-adaptable behaviors and affective patterns through cognitive processes (e.g. selective attention, symbolic coding etc);

2 – the functions of these cognitive processes can be, in principle, activated by the same procedures that are commonly used in the human learning laboratory (although there may be other procedures that also activate cognitive processes).

3 – the task for a therapist is that of a diagnostician and pedagogue who evaluates dysfunctional cognitive processes and arranges such learning experiences that transform the existing cognitive patterns, and correlate them with behaviors and patterns of experiencing things"[6] .

We think that some of the advocates of the American behavioral-cognitive model have in the past 20 years consistently realized the last recommendation. As a result, some of the factors and mechanisms that create dysfunctional cognitive processes have been defined more and more precisely, and the stock of procedures used for their modification, correction and activization has been expanded. At the same time, this situation is leading, to a large extent, to the absolutization of their meaning and the role of techniques, which ignores the efficiency of other approaches or the transformations that occurred in social science and the humanities. This position is also counteracting the creation of the integrative model of psychotherapy.

These tendencies are partially supported by the antagonisms between individual schools, the ambitions of their supporters, their financial motives and various advantages resulting from the monopoly of some approaches and procedures in the services market. The latest attempts to introduce certain standards of psychotherapeutic procedure, setting priorities which testify to the alleged superiority of some methods and creating handbooks "cook books" and other sets of instructions for psychotherapeutic effect, are well established in this climate. We think that the efforts of this type are above all relating to attempts to make medical procedures subordinate to the economic tools of evaluation. The result is rather obviously a limitation of the therapist's creative thinking and hindering further searches for other evaluation criteria for fulfilling the basic functions of psychotherapy.

In the last 20 years various discussions have focused on the philosophical, anthropological and hermeneutic issues regarding to the essence of being a human being, but they have also been organized around social, economic, cultural or genetic personality forming conditions, personality structure, psychological phenomena and their functioning. There is also a lot of interest in system approaches, research into thinking and decision-making processes and the regularities inherent in the functioning of small and large groups; also effective learning methods (problem method) and the achievements of information and communication theory. Conclusions are being drawn from various concepts and models and more effort is being made towards their integration.

More and more therapists think that an effective psychotherapy requires a varied diagnosis of patients' problems and deficits, and its main objectives are: the modification of cognitive patterns, ways of experiencing things and behaviors, and the development of skills for acting effectively.

It is well accepted that the way in which people's expectations, values, attitudes, constructive aspirations and adequate strategies for reaching goals are being shaped influence people's behaviors and their relations with others. Their ability to control their lives and live independently increases, their view of themselves and of the world becomes more coherent. Psychotherapy not only reduces suffering, symptoms or solves uncertainties, which is its main purpose from a medical perspective, but it also clarifies issues related to understanding the meaning of life, and creates a realistic model of healthy living, of being a human and of improving the social lives of people. It may facilitate a conscious confrontation with these problems and smoothen the progress of the search for the best possible solutions.

To achieve these goals it is necessary to take continuous care of the level of the therapists' education, systematic scientific research into effective methodology, consistently conducted public discussion, monitoring of procedures, methods and achieved results. It is also essential to change the patient's role into a more partnership based relationship with a therapist and medical personnel.

THE INTEGRATIVE MODEL OF COGNITIVE-SOCIAL THERAPY PRACTICED IN THE NEUROSIS CLINIC OF THE INSTITUTE OF PSYCHIATRY AND NEUROLOGY IN WARSAW

Maria Siwiak-Kobayashi

When, in 1956, Stefan Leder began organizing what later became the Neurosis Clinic, starting with a small ward for neurotic patients in the Psychiatric Clinic of the Psychoneurological Institute (IPiN), he understood the pathogenesis of neurotic disorders mostly in psychosocial categories, though with a clear understanding of biological factors [7, 8, 9, 10]. So the theoretical model at the foundations of the therapeutic system, worked out in the Neurosis Clinic of IPiN, was from the very beginning dominated by a holistic understanding of the essence of human being, and a multifaceted grasp of the origins of neurotic disorders. The emergence of neurotic disorders was seen as a result of acquiring certain attitudes, skills and behaviors dependent on individual biological characteristics and certain social conditions [11].

At the time, Professor Leder defined his conceptual framework and treatment methodology as eclectic. What this meant was that he created the method and initiated the process of working out a coherent complex system of therapy, using the work of contemporary or earlier authors, schools of psychotherapy which were just beginning their activities and other current psychological theories. We have to bear in mind that, at the time, the adjective "eclectic" itself did not have the pejorative meaning ascribed to it later i.e. a random collection of techniques rather than a creative use of various sources. In fact, many founders of various trends in psychotherapy in the 1950s and 1960s defined their theories as eclectic. Today, this type of approach is, rather, called integrative. Sometimes, integration in psychotherapy is considered to be a result of not only theoretical thinking but also of many years of practice, which make a therapist aware of the multiplicity of causes behind disorders, and the need to include them in therapy. In fact, working with just one sphere of the psyche or just one period of life reduces the long-term efficiency of treatment; in other words, it weakens the

possibility of preventing further disorders when a new, difficult situation occurs in a patient's life. This comment applies to the situations when we deal only with existing cognitive errors, restricting ourselves to the efforts aimed at changing just one type of behavior (in this case cognitive processes, i.e. thinking), but also when we only get insight into the earliest experiences and conflicts. This somewhat inherent limitation of therapy leaves out a lot of essential areas outside of therapeutic work, which restricts the patient's ability to deal with various difficult situations in the future. Most therapists, therefore, notice perhaps further on in their professional experience the need to be more integrative in their approach. Integration needs to be understood not only as an incorporation of various ways of seeing the patient's problems and applying various methods of treatment, but also an amalgamation of different elements constituting the patient's profile i.e. what is the patient like, who is he, what is his way of thinking, what are his feelings and behavior.

Integration, resulting from practice, is most often based on using various methods with the same patient, in order to achieve a wider range of changes. It is not accompanied and not always preceded by integration, at the level of a theoretical understanding, of the individual human being and his or her disorders.

The theoretical principles of our system of therapy may be called eclectic, in view of the diverse sources of inspiration that Professor Leder, and his colleagues, drew from [12]. However, the clearly defined concept of disorders and aims of therapy, as well as the use of various therapeutic methods, though based on similar assumptions, requires that the method is rather called "integrated" and the treatment model "integrative". We take "integrative" to denote stricter theoretical discipline and consistency of therapeutic procedure than is understood through the term "eclectic", and it seems that it is this meaning that is widely used today.

In the first part of this paper, Professor Leder presented the sources of inspiration for the main assumptions of the theory at the foundations of the therapeutic model used in the Neurosis Ward and later Neurosis Clinic. What strikes us is that, from the very beginning, the multifarious, *holistic, biopsychosocial view of the human be-*

ing and health disorders has continuously been the main theoretical tenet of the system of therapy at the Neurosis Clinic. The integration (at the theoretical level) of biological, psychological and social approaches was and is the founding principle of this model of therapy. The integration of various treatment methods has also been an essential feature of clinical practice at the Neurosis Clinic, as a direct consequence of comprehending neurotic disorders as "damaging to the whole personality, the most basic elements of "self" Kronfled's words on psychagogics, quoted by Leder earlier, illustrate the need to "apply all changing procedures and methods, dependent on the character of the disorder and patient's symptoms" [2].

The second essential element of our theory and therapeutic practice is the principal importance ascribed to learning processes, most importantly *social learning*, as well as widely understood social psychology, especially the theories of roles and groups, quoted earlier by the author of the first part of this paper [13].

In the social learning process Leder [14, 15] distinguished two phases of learning: the first phase based on the placebo effect relating to meeting the patient's expectations and of more passive character; and the second phase focused on an active search for problem solving and social learning with all its attributes.

Concurrently with the principles of social learning being formed in the theory and practice of psychotherapy applied in Neurosis Clinic, new theories of social learning became popular internationally, which had their impact on the practice and research conducted at the Clinic. For example some elements, listed below, of J. Rotter's Social Learning Theory [16] are akin to the principles of our theory:

- broad understanding of the term: "behavior", not only as motoric behavior but also a cognitive activity, emotional reactions etc.
- taking into account expectations as a cognitive variable affecting behavior.
- placing emphasis on the importance of expectations related to the source of the solution to the problem – internal or external locus of control, and
- the significance of interpersonal trust

In Bandura's social-cognitive theory [17], it is the emphasis on modeling, observation and copying in the process of social learning, as well as seeing the essence of learning in acquiring new attitudes through processing data received in social interaction i.e. in social process, that are analogous to our approach. Bandura's theory is, then, a conjunction of social learning theories with cognitive theories.

Some other integral elements of the theoretical assumptions of therapy in the Neurosis Clinic are found in humanist psychology i.e. Maslov's hierarchy of needs and Allport's definition of attitudes, which influenced the perceptions of the etiopathogenesis of neurotic disorders and defining the aim of psychotherapy as a change of attitudes. Leder refers to this issue in the first part of the paper. It seems that Rogers' humanist psychotherapy and existential therapy have also had their impact on the therapeutic practice at our clinic, especially on the perception of therapist-patient relations and a deeper understanding of the therapist's and the group's role in psychotherapeutic process. Behaviorism originating in Pavlov's, Thorndike's and Skinner's theories in the conditioning sense, but also in the attention given to the biological substrata of these behaviors, has also without a doubt influenced the theoretical assumptions and methods of therapy. The Neurosis Clinic was the first center in Poland to introduce behavioral procedures in the 1960s, especially in the treatment of anxiety disorders and obsessive-compulsive disorder [18, 19]. The methods applied at the time involved behavioral training through gradual exposure to stimuli, Wolpe's systematic desensitization method [20], and also the immersion and modeling technique (used mostly in obsessive-compulsive disorder). However, it is the theories that reached beyond the stimulus-response system, based on the learning approaches that have really proved especially significant from the theoretical and practical point of view. It seems that Dollard's and Miller's book, published in Poland in 1956 [21], played a particular role as a comprehensive presentation of the findings previously described in psychoanalytical terminology but now discussed in concepts of learning theory. In fact, thinking of learning as one of the main mechanisms of human development lies at the centre of all cognitive and behavioral approaches.

It is clear from the first part of this paper that the founder of the therapeutic model in the Neurosis Clinic of IPiN has from the very beginning attached special significance to the role of "erroneous convictions and anxiety" in the etiopathogenesis of disorders. He drew from Dubois' views on the significance of insight into the psychological conditioning of illness, as an essential condition for therapeutic change, and the necessity of changing more general "psychological attitudes" of a patient in order to prevent the repetition of disorders.

These assumptions, at the very core of the theory and therapy applied in the Neurosis Clinic, are identical with other contemporary trends in psychotherapy, including cognitive theories.

Cognitive theories, which developed from the end of the 1950s, pay particular attention to false convictions (Ellis) and deformed cognitive processes (Beck) as pathogenic elements in psychological disorders. They do not, however, refer directly to the mechanisms found in the patient's life that led to the formulation of false convictions or logical errors – these are simply all referred to as early experiences.

These increasingly popular cognitive therapies, such as Ellis's [22] rational-behavioral therapy, Beck's cognitive therapy [23], Mahoney's cognitive-behavioral therapy based on so called "personal knowledge" [6], or Meichenbaum's cognitive-behavioral therapy based on learning problem-solving strategies [24], make use of learning techniques and behavioral principles and techniques, such as doing house work, or reviewing convictions through confrontation with reality [25]. In spite of the fact that these theories differ from classic behavioral methods – based on classic or instrumental conditioning, an understanding of the essence of disorders as cognitive, referring to specifically human "behaviors" such as thinking, passing judgment, evaluation, cognitive processing of information – they in fact treat therapy as a process of the changing of erroneous "cognitive behaviors". They neither draw from the patient's past nor aim to achieve an insight into his experiences in order to find the source of wrong convictions; they do not attempt to change the patient's emotions relating to earlier experiences. In fact, they focus entirely on the problems experienced in the treatment period, on erroneous beliefs, problem-solving meth-

ods and logical deformations. In this sense they can be compared to behavioral methods aimed at "overlearning" in terms of symptoms and behaviors. Both these groups of methods are also characterized by a high level of directiveness on the part of the therapist and extensive structuring of the whole therapy and individual sessions.

The assumptions that Leder discusses when quoting Dubois are really at the very foundations of the theory of the therapeutic system used in the Neurosis Clinic of IPiN. They revolve around the significance of "erroneous convictions and fears" and an insight into the psychological conditioning of illness being a necessary condition for changing more general "psychological attitudes" to prevent the recurrence of disorders or dysfunctions. These assumptions are identical with the functions of other contemporary theories, including cognitive theories.

The principles of integrative social-cognitive therapy at the Neurosis Clinic

The system of psychotherapeutic treatments available in the Neurosis Clinic, which developed concurrently and comparably with the main theories in psychotherapy, psychology and medicine in the world, is still based on two main principles: the holistic approach and social learning. It's worth keeping in mind that in the 1950s, when psychotherapy was dominated by psychoanalysis and behaviorism was just becoming internationally popular, that it was humanist psychiatry which was just beginning to take root. Humanist psychiatry - a theory of holistic character, compliant with the biopsychosocial model of health disorders – represented the way of thinking which was going to become popular only in the 1970s, in the form, finally articulated properly in recent decades, of the principles of holistic medicine, conceiving every illness in terms of the correlation of various factors, such as biological, psychosocial, existential and philosophical.

Integrative clinical practice

It is a direct result of the principles discussed above, and is finding its shape in their consequences. It has clearly defined goals, a specif-

ic repertoire of therapeutic methods to achieve them, a specified method of analyzing the patient and his problems, and a definite type and significance of therapeutic contact and group phenomena.

The *therapeutic goals* reach beyond improving the patient's symptoms. They include changing attitudes in Allport's three-dimensional understanding of the term, and are aimed at the expansion and change of mechanisms and strategies for dealing with problems more effectively in the future. [26]. These objectives also require that biological factors causing health disorders have to be taken into account. The methods used in the Neurosis Clinic are characteristic of short-term, integrative, intensive psychotherapy based on cognitive and social learning. The main objective of the intensive, ten-week treatment program is not only the improvement of symptoms but also initiating and giving directions to further changes in the patient's personality, mostly through the modification of attitudes, which according to Allport comprise a cognitive part (judgments, evaluations, convictions) [27], an emotional part (emotional response to internal and external events) and a behavioral part (noticeable behavioral responses). These attitudes refer to various persons or events meaningful to the patient either in his present or past life, particularly from childhood when learning processes are especially influential on one's view of the world, responses and behavior in later life, and so they are to a large degree responsible for later adaptation problems (disadaptation) and difficulties [28, 29, 30].

The aim of the therapy is broader than in the majority of other contemporary cognitive-behavioral schools; it involves not only changes of attitudes or ways of thinking and responding to present events or situations, but also working out an insight into the psychological mechanisms creating disadaptive attitudes. This insight is supposed to help patients to modify their responses and change their "addiction" to the destructive influences of those past events. The therapy process is facing the past, present and future. All patients are treated within the same program of therapy although each patient is treated individually and will have the clinical team involved in his problems and recommending additional forms of therapy if required.

Learning, or rather social overlearning, is happening in various context – from individual (in dual contact with a psychotherapist), through group therapy (contact with a small group of co-patients) to therapeutic community (through participating in the community life of the ward, comprising all patients and members of staff.) [31].

Ways of achieving change include psychological and social treatment based on **social** *learning in various contexts* (individual, group therapy and various other non-verbal group forms, therapeutic community) [32]. These interactions are addressed to various aspects of personal psychological life, defined as cognitive, emotional and behavioral components of attitudes.

Actions through cognitive learning

They are aimed at working out an insight, not only into typical cognitive patterns characteristic of a patient and his perception and evaluation of events, but also at finding interrelations between them and the patient's emotions and behavior. Some of these techniques are more like social learning through imitating, modeling (Rotter, Bandura); others through problem solving or taking on a task, such as writing a diary (see M. Siwiak-Kobayashi, C. Brykczyńska [33]).

Impact on behavior and through behavioral techniques

It involves *various forms of behavioral training directed at changes in the sphere of symptoms* (gradual exposure to anxiety-generating stimuli, immersion techniques, desensitization, behavioral modeling and *active exercising of social behaviors* through social role playing, solving immediate interpersonal problems, supported by assertiveness training or a similar technique of constructive dispute.

Applying social pressure – in tune with the group of therapeutic community dynamics is also a catalyst for changing social behaviors and learning understood as a broad term. Participation in occupational therapy affects, amongst other things, changes of behaviors and habits related to work.

For the last few years, a lot of patients who have specific problems in life have been encouraged to *make use of various self-help groups outside of the clinic*, even while they are undergoing treatment at the clinic (e.g. AA, ACoA or OA groups). This particular strategy is designed to make it easier for patients to define the problem and its conditioning through social learning in another group comprising people with similar problems. Its task is also to encourage patients to use this form of help and support, which is usually unknown to them otherwise, in the future.

Impact on emotions and through emotional responses

It is a well known fact that every therapeutic situation is emotionally charged. Cognitive, behavioral and social treatment methods also involve many emotions. Cognitive techniques especially, focused on the observation and naming of one's emotions, are aimed at achieving change in emotional response both in its intensity and the quality of the emotions accompanying various situations.

The simplest behavioral training also promotes a lot of change, not only the reduction of the anxiety that accompanies symptoms but also by bringing increased satisfaction, joy, confidence, or the feeling of being in control.

However, in our integrative model of therapy we use procedures which particularly "attack" emotions. These are above all *non-verbal methods such as psychodrawing, music therapy or choreotherapy.* Once words are switched off and patients undertake a specific activity, such as listening to music, playing music, painting, sculpting or dancing, their contact with the emotions they have at the time is increased and rationalizing mechanisms, which very often deform our responses, are switched off. Discussing the task once it is complete often enhances the patient's self-knowledge. [34]. These classes are also excellent for discovering one's unknown motives, sometimes talents or interests; they enrich the patient's life, aid self-realization and make it easier to cope with difficulties in future.

The next method for freeing emotions and revealing unconscious motivations is *psychodrama and psychopantomime.* This method has developed

gradually from role playing during group therapy to separate weekly classes taught using the Moreno psychodrama rules by qualified psychodramatists. The psychodrama and pantomime techniques have always had "projection" tasks ascribed to them. They make it easier for patients to express emotions and represent difficult facts from their own life within the boundaries of role-playing form. Talking about these tasks helps the workings of cognitive insight. Other elements such as modeling and change of attitudes through active role playing of behaviors difficult to accept in real situations, and "trying out" new behaviors, are also significant in this form of therapy.

Impact through biological means

It is achieved most often through pharmacotherapy, used only in the cases justified by the character of the disorder i.e. psychiatric or neurological diagnosis and the patient's somatic condition. Sometimes patients are medicated for a period of time if their symptoms intensify and prevent them from active participation in the therapy. In the case of *patients with double diagnosis* it is important not only to prescribe medication related to their somatic illness or other disorder, but also to initiate an overall change of their emotional attitude towards illness and treatment and alter their convictions with regards to the necessity to follow the prescribed medication and procedures [35].

Significance of diagnosis

Treatment in the Neurosis Clinic is, in many aspects, formally identical for all the patients. The ten week stay as an admitted patient or eight week visits to a day clinic is identical for everyone. Everyone is obliged to participate in individual therapy, all forms of group therapy, meetings of the therapeutic community and to take up their roles in the community according to the regulations. At the same time there are groups of patients with specific disorders (e.g. eating disorders), who follow an additional cognitive-behavioral program, strictly related to the character of their complaints, and individual patients who are prescribed additional behavioral training or behavioral-cognitive tasks adequate to their individual problems. Other patients may

also have to follow their own pharmacological or rehabilitation program.

Due to all these considerations, patients' individual symptoms, and the multifaceted character of our understanding of the origins of neurosis, we attach much significance to giving the most precise diagnosis possible, both *medical and psychological,* and to *the diagnosis of patient's current situation and inner mechanisms of his personality,* his attitudes and reasons why he or she finds it difficult to cope in difficult situations.

These mechanisms may involve factors of an external character, such as traumatic events and serious difficulties, but they also entail internal aspects – those relating to the patient himself, his biological characteristics, genetic conditioning, features acquired as a result of the impact of earlier physical conditions [10], and also aspects of emotional responses and thinking acquired in the development process through upbringing, learning and social conditions starting with the earliest childhood experiences [30].

These acquired attitudes and behaviors have an impact on the effective and satisfactory, or frustrating and ineffectual, ways of coping with difficult situations [8, 36, 23].

We pay particular attention to identifying a clear *plan and aims of therapy* for each patient, which is necessary in the case of intensive, short-term therapy which comprises a series of integrated treatment methods.

Therapeutic relation

Our personnel work in therapeutic teams consisting of three psychotherapists i.e. both psychiatrists and psychologists. At least one of the team members is a physician. Each team takes care of 10 or 11 patients comprising a therapeutic group.

Each of the 32 patients admitted to the ward have their own individual therapist – a medical doctor or psychologist, who takes care of their individual therapy and is responsible for the overall treatment [11].

Individual psychotherapy

It is structured on the basis of the theoretical assumptions discussed above, allowing the pa-

tients to co-create and experience a therapeutic relationship - a creative emotional contact with another person, which is so essential in the process of therapy and learning. This relationship provides grounds for acting out emotions felt for significant persons in one's life, especially those that played a similar role to the patient's parents, working with these emotions and building up an insight into typical functional mechanisms and their contribution to the internal and external conflicts which result in symptoms.

At the beginning of the treatment patients also acquire a lot of information through individual contact with a therapist and learn in a more "passive" way [13] [14], which fulfils their expectations for help, care and information [37]. In the second phase of working out an insight, patients actively solve their problems with the aid of a therapist. Dual contact with an individual therapist also creates the possibility of individualization in using additional psychotherapeutic techniques, such as the introduction of additional behavioral or cognitive techniques, or sometimes (though very seldom) such methods as hypnotherapy. This relationship also supports pharmacological or detoxification treatment when necessary. In cases where the individual therapist is not a doctor, all medical problems are referred to the doctor working on his team.

Looking back at the influence of practice and theory applied to the therapeutic relationship in the Neurosis Clinic, it appears that at the beginning the role of the individual therapist was very much in tune with the widespread practice in all areas of psychotherapy, and the model used was that of therapist as authority.

It was closer to the role of an expert doctor, who identified problems and recommended various courses of action (including the analysis of the charactereological causes and psychological mechanisms behind disorders), or to the role of the psychoanalyst – an anonymous authority producing interpretations in strictly defined theoretical categories, or - as psychagogics and certain contemporary American cognitive schools would have it – the role of a diagnostician pedagogue.

The humanist schools of the 1960s and existential theories influenced the change of the authoritarian model of a therapist. Without depriving therapists of authority the new views required that "unconditional approval" (see Kronfeld's words, published a few decades prior to the emergence of humanist psychiatry, quoted by Leder earlier, about "medical –humane" "guidance given to a suffering person") all the way to "common existence in the world of two human beings" proposed by existential psychotherapists. In this last case it seems that the specifics of the particular roles of a searching patient and a therapist who gives help might be lost.

In the therapy system used in the Neurosis Clinic, the *therapeutic relationship is seen realistically, as a therapeutic alliance and co-operation.* It is not perceived in the psychoanalytical categories of transference i.e. the unrealistic redirection of early childhood conflicts, although we appreciate the significance of patients' early experiences as a source of knowledge about the way they had learnt to evaluate themselves and the people close to them and the way they had learnt their emotional responses and behaviors. These experiences affect their later interpersonal relationships in all kinds of situations, including the therapeutic relationship; the phenomenon which allows us to work on changing perceptions, evaluations, responses and behaviors.

A therapist remains in his role as a professional providing help but he is also trying to acknowledge the patient's autonomy, stimulate an independent search for the origins of disorders, for naming emotions, observing relationships with significant others throughout the patient's life, looking into the patient's experiences, convictions, emotions and their role in the origins of disorders. Individual therapy sessions are not structured in the same way as in most cognitive therapies. They follow a set plan but their subject and structure is dependent on the problems most essential to the patient in a given moment of therapy. The individual therapist is in continuous contact with other members of the treatment team, which allows for close integration of various treatment methods.

Impact through the therapeutic group

Group psychotherapy is one of the main methods of therapy in the clinic. It creates an opportunity for active social learning in verbal contact

with group members and therapist. It is based on the process of group dynamics. The therapist plays the role of a moderator, sometimes inspiring various group activities, putting forward hypotheses or interpretations but avoiding being in the center of attention for group members.

The issues discussed at the meetings include the work on the "here and now" set of problems and the life story of each patient. The group tries to form perceptions of emotional responses and behaviors characteristic of and repetitive for a given patient in various situations, at present and in the past. Members of the group are learning through cognitive analysis and attempts to solve the problems discussed during the session but also, and above all, through interactions, modeling and group dynamics [38, 39, 31, 40, 13, 41]. One of the crucial elements of group dynamics, considered to be a key medium of therapeutic change is group cohesion [42, 43, 41]. Social perception is an important element affecting cohesion and so essential to group dynamics [44]. Group cohesion makes group therapy easier in other sessions conducted with the same clients such as psychodrama, pantomime, psychodrawing, music therapy, choreotherapy and occupational therapy. Integration of all therapeutic activities in this model of psychotherapy takes places in conditions of a *therapeutic community involving all patients and personnel*, as mentioned.

Throughout their treatment, patients play various social roles, they consecutively become members of the patients' council for at least a week, they become formal group leaders for a week and have various duties on the ward. The participation in self-government activities gives patients the opportunity to practice management skills, organizing various events such as parties, excursions, but also to discuss training, appoint and coordinate persons on duty, chairing community meetings etc. Other duties, such as the cleaning or preparation of rooms before classes, or serving as a trainer in behavioral training, help to exercise actions that are beneficial to others. The weekly community meetings provide a forum for an exchange of information and discussion on common work and issues involving the whole community. Every week, the meeting begins with the summary of the groups' work for the previous week to exchange infor-

mation about things that are important to the whole community. What follows is a discussion on the current affairs of the whole community and of its individual members. The atmosphere of these meetings and issues discussed are dictated by community dynamics and they vary depending on group members and the progress of the therapeutic process [32].

The comprehensive and integrative character of the treatment are, on the one hand, unquestionably beneficial, if only because of the variety and wide range of treatment which increases the effectiveness of short-term, intensive therapy in the hospital ward. However, the fact that the activities are organized concurrently in three social contexts often produces a "conflict of interests" – e.g. the interests of individual patient vs. the interests of the whole group and the therapeutic community. Problems are often caused by far fetched individualization while, in principle, the same complex of methods is used in the treatment of all the patients.

In the last few years, more and more patients diagnosed with anorexia and bulimia have been hospitalized, as a result of the more frequent occurrence of eating disorders. With this special group of patients we have to take care of their somatic condition, while also facing up to the challenge of introducing a special behavioral program of therapy. The program is aimed at changing the patient's habits relating to eating and cleansing. It requires a separate contract, which puts this subgroup of patients in a different situation, restricting their participation in some of the activities of the therapeutic community, often creating additional problems and tensions. The attempt to integrate the treatment of patients with various diagnoses, each requiring a specific handling, produces a serious challenge and creates problems, especially if one diagnostic group is prevailing in the community. This aspect reveals one more meaning of the term "integration' in relation to an institution applying a specific model of psychotherapy.

All these challenges put a lot of demand on the team of therapists. They not only refer to the specific psychotherapeutic skill, but also to the ability to work in the team, transfer information, work out and modify co-operation methods and coordinate various specific methods in service of a specific aim. It is a difficult task and it often

generates various tensions in the team, which we are trying to solve with varied degree of success. Sometimes we introduce the elements of own work or elements of supervision.

In the last years, when Professor Leder retired and was not directly involved in the work in the clinic as a team member, he was often - regularly or when required - involved as a group supervisor, helping to understand and solve the team's emotional problems.

When, in the 1970s, the systematic theoretical training of psychotherapists was supported by the training groups, the employees of the clinic participated eagerly. A system for training of the new employees was worked out: they took in the training groups, first as members of the group trying to feel the dynamics of the group, experiencing their own role as a group member, and then as the observers, co-trainers and trainers. This is how, based on social learning they gained skills allowing them for a fuller understanding of a role of a therapist, through experiencing the emotions of a patient and the group dynamics form the member level.

I hope this presentation makes it clear that the integrative approach in psychotherapy, treating patients as individuals but also members of a community, and also approaching the problems and tasks facing the therapists, produces a lot of challenges and difficulties but at the same time it seems irreplaceable in intensive, short-term psychotherapy offered by an institution such as the hospital ward or daytime clinic.

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