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Review

Integrated therapy: dedicated training and proposed patterns

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Summary

This study is a review of both the extensive literature on integrated mental health therapy and the author's clinical and training experience in this field.
The study wants to emphasize the need for training dedicated to the themes of therapeutic integration, the importance of some basic principles for making an integrative network and the mental attitude that professionals must acquire to correctly deal with the work involved in integrated therapy.
Those working in psychiatry, psychotherapy, and other mental health fields will be increasingly interested in integrated therapeutic processes in the future.

Key words: Integrated therapies; psychotherapies; existential therapy; personal training in mental health; help professions.

Introduction

Most mental health professionals today agree on the importance of the integrated therapies in psychiatric care, which has the merit, at least partially, of overcoming the stale contrast between classic medical treatments (pharmacological or nutritional), psychological treatments and rehabilitative treatments, as well as stimulating a specific new mental attitude for some new therapeutic choices.
Despite the large amount of attention that the scientific literature pays to this methodology, there is a lack of absolute clarity on what the meaning of therapeutic integration is and how it can be implemented.
This study would like to clarify the concept and propose some principles to realize a correct and profitable integrative methodology.

Integrated therapy (main text)

The therapeutic adjective means that it takes care of a disease

Before discussing the concept of integrated therapy, I believe that it is important to talk about the concept of disease.
There are many words and expressions related to "disease"; four of them appear most frequently and have complementary but subtly different meanings:
Disease: "*The term disease broadly refers to any condition that impairs the normal functioning of the body. For this reason, diseases are associated with dysfunctioning of the body's normal homeostatic processes* [1,2]. Objective disease, not necessarily accompanied by subjective experience.
Illness: The patient's experience of being ill: the sensation, the totally personal and subjective experience of the loss of health, also without a real disease.

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Sickness: Social role of disease, status and negotiation between the sick person and society.
Disorder: *"A functional abnormality or disturbance. The term disorder is often considered more value-neutral and less stigmatizing than the terms disease or illness"* [2].
Using these different terms is needed because of the complexity of the concepts; this rising complexity of the concept of health has undergone change over time; currently, the WHO defines it in the following way: "*Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*" [3].
An inclusive definition of disease could be the following: "*A disease is a particular abnormal condition that negatively affects the structure or function of part or all of an organism, and that is not due to any immediate external injury* [4]*. Diseases are often known to be medical conditions that are associated with specific symptoms and signs. A disease may be caused by external factors such as pathogens or by internal dysfunctions*" [5].
Furthermore, "*the definition of disease is fundamental the principle of transience: each pathology has a term that can be represented by the healing of the organism, by its adaptation to a different physiology (or to a different life condition) or by death*" [6].
People suffering from some kind of disease live with their set of symptoms, feelings, emotions every day; the existential "presence" of the disease affects the way in which those affected see the world:

- there are complex psychophysical anomalies that we call illness;
- there are sets of feelings, thoughts and lived emotions that people experience as a disease;
- there are observable events experienced by those who share existential space with those who have a disease that allow to recognize those people as individuals suffering from a disease;
- there is the possibility that these conditions cause physical, social, emotional damage to others.

Mental diseases clearly share all the aspects of physical diseases covered above in the following aspects:

- the symptomatic expressions of the disease;
- the relationship between illness and individuals;
- the relationship between a sick person and his or her environment;
- the progression of phases of time and states of well-being and illness;
- the relationship of other people with the sick person (at various levels, close family and friends, extended family, fellow citizens, society, etc.);
- the social and functional role of the individual as time progresses in stages;
- the consequences in all existential areas of the action of therapies and treatments or of their total or partial absence;
- social and existential outcomes of a mental illness in terms of stigma, self-stigma, stigma of healthcare professionals, etc.

An integrated approach should respond to all of these health needs.

Semantic clarification

"Integration is a process by which a system acquires and maintains a structural and functional unity, but it conserves the differentiation of the singular components; it is also the product of this process, because it preserves the internal balance of the system, social cooperation, and coordination between roles and institutions" [7].
In this definition, borrowed from the social science literature, we can already identify two important elements: structural and functional unity and the differentiation of the singular components; the need for "coordination" must be added to these elements: *"Integration means building common foundations. [...] Integration is not a simple sum of the components but the result of common management ..."* [8].
Integrated therapy could operate in very different ambits, given all of these elements, by intervening in the existential sphere of a single patient, a group, a disease, a population, a type of treatment, etc. In this sense, integrated therapy can be assimilated with the *"Collaborative Care Management (CoCM)"*, which is "… *a practice-based system of care designed to integrate treatment for common mental health disorders (e.g., depression, anxiety) into primary care settings using principles of chronic disease management* […] [9]. *This approach uses existing pharmacologic and psychotherapeutic treatments in a new way through a team-based approach* …" [10]. The A.I.M.S. (Advancing Integrated Mental Health Solutions) of the University of Washington suggests that evidence-based collaborative care includes five basic principles: "*patient-centred team care, population-based care, measurement-based treatment to target, evidence-based care, and accountable care*" [11]. In therapeutic integration, the "medical-centred" dimension of collaborative care is an integral, but not exclusive, part of therapeutic intervention.
Collaborative medicine takes care of all aspects of the disease and the disorder but fails to be equally effective in all aspects of the sickness, the most social sphere of disease, and in all aspects of the illness, the most intimate and existentially impactful area of the disease for the individual.
In synthesis, the following points are relevant:

- as a general concept, integration is a process in which different skills, knowledge, and cultures organize a common action aimed at one or more outcomes;
- integration in medicine is the choice to fight against disease by intervening with different strategies coordinated with each other, as in collaborative care, but also including non-medical skills, primary secondary tertiary prevention procedures, post-trauma rehabilitation, welfare;
- the specificity of integration in mental health care implies the management of different therapies and treat-

ments; today, the main perspective is one of consolidated work and study; this kind of care includes the existential aspects of the disease (and the existential aspects of the patient) and the effects of the disease in the social world and in relationships with other people.

Integrated therapies in psychiatry

the first period of studies on integrated therapies in psychiatry concerned the integration of different psychotherapeutic approaches: "*Integrative therapy is a progressive form of psychotherapy that combines different therapeutic tools and approaches to fit the needs of the individual client. With an understanding of normal human development, an integrative therapist modifies standard treatments to fill in development gaps that affect each client in different ways. By combining elements drawn from different schools of psychological theory and research, integrative therapy becomes a more flexible and inclusive approach to treatment than more traditional, singular forms of psychotherapy*" [12].

The limited outcomes of psychotherapy limited to a single approach or model stimulated this kind of research.

Clinical practice has welcomed unorthodox paths with eclectic methods of work and good results [13]. However, the combination of different psychological models has generated methodological and interpretative problems; this is an epistemological problem too often ignored or neglected by clinicians: *"The epistemological problem of integration is arising anew, where some methods based on deterministic models of psychological illness come face-to-face and interact among them"* [14].

The operational difficulty due to this epistemological impasse is evident despite the rarity of analytical studies about this topic.

Indeed, "*we are convinced that it is mainly the non-specific aspects of the treatment methods that achieve an effective result, and not the therapeutic procedures proper to the individual models*" [15].

Therefore, many studies have attributed therapeutic validity only to some aspects of psychotherapeutic practice: The *"Journal of Psychotherapy Integration primarily publishes original peer-reviewed papers consistent with five major pathways associated with psychotherapy integration:*

- *common factors (core elements to effective psychotherapy that transcend a specific orientation);*
- *technical eclecticism (application of the best treatment for a specific population and problem);*
- *theoretical integration (combining two or more theories and their associated techniques);*
- *assimilative integration (theoretical grounding in a single orientation with value added techniques drawn from other orientations);*
- *unification (meta-theoretical approaches that place theories, techniques, and principles into holistic frameworks)*" [16].

The integration of biological and psychological treatments appeared later in the scientific literature. It was preceded by some pioneering studies, often critical studies [17,18], or studies about specific psychotherapeutic approaches combined with pharmacotherapy [19,20], including between psychoanalysis and drugs: "*The association of psychopharmacotherapy and psychotherapy is a frequent clinical and often indispensable practice. […] From the psychodynamic perspective, there is the advantage of facilitating the understanding of transference*" [21].

Scientific research has dedicated much work to the study of synergy between drugs and psychotherapies.

Several hypotheses have been formulated, from the ability of both drugs and psychotherapy to modify the functional structure of the mind, conditioning the implicit memory [22], to psychotherapy as an epigenetic "drug" [23] and to a hyper-inclusive ratio that does not exclude social contingencies and the accessibility of the treatments to individuals [24].

Many studies have identified specific pathological conditions that have achieved good results through a combination of pharmacotherapy and psychotherapy treatments [25,26].

From a literature review, we can summarize the following: The integration of the mental health therapy that was applied before with singular psychotherapeutic approaches to tackle the gap of a treatment according a unique model has since been extended to all the possibilities of medical, psychological, social, existential, and rehabilitation intervention, to achieve the best care, prevention, prophylaxis, recovery and quality of life improvement of affected individuals.

In the context of psychotherapies, analysing whether it is better to integrate different reference models or only their different operating methods is a topical problem. Analytical work in this sense is unthinkable, but a different global reading, "lateral rather than vertical" [27], could focus attention on common operational and cultural factors [28].

Integrated care should also involve non-clinical areas (counselling, social assistance, mediation, etc.).

How to implement integration skills

Integrated therapy is an operational methodology that involves many different professions and knowledge.

However, in the international literature, we find very few suggestions about the procedural steps of integrated therapy.

Many authors have considered it sufficient to appeal to the professionalism of individual professionals to improve the integration of practices. This choice, at least in psychotherapy, has sometimes clashed with a number of insurmountable difficulties, including those involving the epistemological incompatibilities of the psychological models; some studies have addressed specific procedural, methodological or theoretical tools to overcome these difficulties, but they are very rare.

The integration among different health and non-health professions appears to lack simplicity: "*Integrated care is defined as health services that are managed and delivered such that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation, and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector and, according to their needs, throughout the life course*" [29].

Individual professionals have to intervene in all steps of the integrative procedure: **sharing the income, focusing, building the integrated care in such a way that it can be followed, sharing information on the intermediate results, developing new focuses and new ways of information sharing, determining processes that will be repeated several times, managing a common outcome and follow-up procedures, conducting a common analysis of the outcome.**

It would be useful to develop codified patterns and be provided with fluid and continuous communication instruments among professionals. However, it should not be a static, pre-coded team but rather a multidisciplinary one, a sort of "virtual nursing home" in which the operators belong to a single firm offering all of the assistance. Real clinical practice presents us with very different situations, often impromptu, that include relationships among the different professions that must be built in that moment according to the needs of those being treated.

We believe that it is useful to share some operating and methodological principles:

1. Design of the integrative network:
   a. an integrative network is never a static building or a team prepared in advance that welcomes people with care needs. An integrative network is a network that is created extemporaneously, often motivated by the first clinical evaluation of an individual; each professional is predisposed to the possibility of referring their patient to experts from other professions who will potentially be integrated into the network to facilitate the temporary aggregation of skills;
   b. a network should identify a leader; we propose the psychiatrist as the leader because his or her attendance is a punctiform one, spaced out over time and based on a general clinical evaluation and verification of the results.
2. Improvement of integration skills:
   a. each professional needs clarity on the operations and methodologies of the other professionals who are participating in the integrated therapy;
   b. a basic "training" on the specific operating methods is useful for all who are preparing to help and/or become care professionals.
3. Organization of inter-professional communication:
   a. an integrated therapy programme should provide adequate and immediate information both for all professionals participating in the current phase of the supplementary programme and for those who may be involved in a subsequent phase;
   b. mental health professionals should be trained in effective communication in a clinical/therapeutic context beforehand, establishing the "golden rules" for mutual information exchanges.
4. Selection of a target:
   a. there are two ends on a continuum of choices:
      i. pre-organizing an integrated working group with targets in a specific condition (i.e., DCA groups or psychotic onset groups);
      ii. keeping a network of professionals ready to intervene in the integration with an individual patient whenever it is necessary.
5. Intermediate checks and possible new designs:
   a. it is necessary to create valid interdisciplinary verification tools;
   b. among these, development rating scales or rating scales on quality of life that have already been validated are preferred [30,31].
6. Out-come pattern:
   a. the problem of evaluating the outcome of integrated care often depends on the mental attitude of individual professionals. A "collaborative spirit" is preferred to a "competitive" one; unfortunately, I am obliged to use the conditional tense;
   b. an outcome procedure should be entrusted to an "ad hoc" packaged tool to avoid assessments that attribute different merits or responsibilities to the different professional approaches. This kind of instrument is not yet present in the scientific literature.

Which professionals should be selected for integrated care?

As we have already pointed out, professionals who participate in an integrated care project must have a background with some specific skills and attributes.

The first is the correct mental attitude, which means that the individual professional:

- does not consider his/her own competence to be more or less important or essential than that of others;
- accepts the possibility that his/her own reference model may dialogue with other reference models;
- was trained to suspend his/her judgement in favour of sharing views with other people (ἐποχή by Husserl) [32];
- will know to modify his/her work plan in compliance with the various supplementary projects.

We believe, on this basis, that it is not possible for a young professional who will participate in future integrative work can limit his/her knowledge to the competences of only his/her profession; he/she also has to know something about the fundamental aspects of the disciplines with which he/she has to integrate.

Some principles of psychopathology and psychiatric clinic must obviously be known by psychiatrists, psychologists

and psychotherapists but also to counsellors, educators, social workers, nurses, rehabilitators, sociologists, etc.
In addition, psychologists and psychotherapists, as well as other professionals, cannot ignore the effect of drug therapies on patients' symptoms, nor can clinicians ignore the fundamental terms of welfare, the administrative and legal procedures for granting indemnities or benefits, the legal instruments for forms of protection for people with mental problems, etc.
In this field, a common language or a communication system that allows the permeability of languages to acquire common skills is needed.
Communication practice between different professions and skills will facilitate the emergence of a language without cognitive barriers because professionals training will be designed for integration.
Many problems can arise among professionals who currently work with integrated therapy who have not received structured training for doing so; indeed, they may approach integrative processes starting from their own cultural positions, with communication mistakes possibly being made as a result.

Conclusions: professionals' training

Finally, this is the core goal of this study: to stimulate the reader to consider that integrated therapy in psychiatry (but, I believe, in every other branch that deals with therapies as well) requires professionals who have been trained to share a vast wealth of knowledge with other professionals in the care field.
Training dedicated to those who will work in integration will face many difficulties in achieving a common practice. Philosophical patterns, especially epistemological principles, are very important in creating a system of integration care that has received adequate procedures and communication methods.
A common practice also implies the need for lifelong continuous learning that expands to all of the professional fields involved. Imagine, therefore, a class of trainers who will dedicate part of their working space to a specific training programme for therapeutic mental health integration.
Finally, and importantly, I believe that constant self-reflection about one's own work and about the sense of belonging to a therapeutic project is necessary for each individual professional (even through working with a supervisor therapist, e.g. a Personal Existential Analysis) [33]. Professionals also need to conduct a self-reflection on their own existential space, as competent persons and persons in continuity with the world of others, with other things, and with him/herself.
All of the people who choose to become mental health care professionals need to participate in this kind of training: not only psychiatrists and psychologists but also professional nurses, educators and psychiatric rehabilitation technicians. Indeed, almost all conditions of psychological distress probably require integrated treatment.
In a nutshell, a training and operational plan for therapeutic integration professionals should include:

- the building of intermediate and outcome-verification tools to be made available to professionals;
- a basic training programme that includes:
  - principles of epistemology and methodology for operational and psychological models;
  - the basic principles of all professional areas possibly subject to integration; and
  - regulatory frameworks and social structures that can support supplementary programmes;
- a specific training programme for integration that includes:
- training about effective communication; and
- training about logical tools for creating a therapeutic integration network whenever necessary; and
- personal training that aims to implement one's own capability of suspending judgement [34] and self-reflection to reach the correct mental attitude.

The philosophical measure of one's own presence in the world and in the space of the care of the other people is a characteristic that each of us, as health professionals, should learn to exhibit.

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