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Psychotherapy Integration and Beyond: The MCM Model

A. Ka Tat Tsang, Ph.D.

Factor-Inwentash Faculty of Social Work, University of Toronto

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MCM stands for Multiple Contingencies Management.

In clinical practice, we find ourselves dealing with human issues presented in widely varied forms, ranging from florid psychotic symptoms to a quest for meaning and self understanding. There are people who are dealing with major traumatic events such as genocidal warfare, murder, and torture, and those who are dealing with less drastic transitions in life, such as starting university education in another city. Our clients may be struggling with severe, debilitating conditions such as addiction or a long history of depression, or managing psychological consequences of a stressful job, a difficult intimate relationship, or the loss of a loved one. The individuals who seek our service can be male or female, and we also work with people who are transsexual or transgendered, as well as people whose gender is the very issue that they are having a problem with. Our clients may be individuals who are attracted to men or women, and we also have clients whose object of sexual interest is considered a problem by society, and/or by herself or himself. Our clients may be physically

healthy or dying. Many of our clients have disabilities or developmental challenges. Our clients may come from any ethnic or cultural group, and can be affiliated with any religious system. They can be rich and powerful, and they can also be among the most marginalized and oppressed social groups. This list can go on and on.

At the same time, we are presented with an equally perplexing array of intervention models, treatment approaches, or specific clinical procedures, each associated with their own claims to efficacy and specific appeals to our epistemological and value preference. These claims and appeals are often presented by charismatic leaders or advocates, sometimes echoed or reinforced by enthusiastic colleagues, sometimes demanded by our clients, or people who pay for their service. Some of these approaches are supported by clinical or research data, and some of them are recommended by teachers, mentors, supervisors, or trusted colleagues. We find ourselves making difficult decisions based on our desire to give the client the best service, our own experience, value orientation, and preferences with regard to

explanatory and practice theories as well as our personal style. It is not uncommon for such decisions to be made within a context of heavy caseload and shrinking resources, inadequate support for supervision, consultation, research, and professional development. In most practice contexts we are also required to respond with sensitivity and competence to an increasing list of diversities including gender, ethnicity, culture, sexual orientation, faith, differential abilities and special needs, class, and lifestyles. These complexities all put additional strain to an already challenging task that requires us to engage with our clients with understanding, empathy, professional competence, skill, accountability, discipline and commitment.

The MCM Model will be useful for helping professionals who do psychotherapy and/or counseling as part of their practice. Clinical practice is used here as a generic term that includes psychotherapy, counseling, clinical social work and other forms of psychosocial interventions with a focus on mental health and related personal and interpersonal issues. There is now an increasingly body of professionals who are involved in clinical practice, including social workers, psychologists, physicians, nurses, counselors, educators, and therapists from other health care professions. Each of these professions brings in their own perspectives, special emphases, and specific models and procedures. There is, however, a common core that is shared among these professions in that they seek to bring about changes in the ways their clients or patients think, feel, act, relate to other people, and live their lives. This is usually done through interaction with the client or patient within the context of a professional relationship.

Development of the MCM Model is a result of my own attempt to figure out a

way to practice psychotherapy that can accommodate these demands. I arrived at MCM by synthesizing knowledge and experience gained through years of direct practice, research, consultation, training and educating in a diverse range of contexts. It is hoped that the sharing of the lessons learned will be helpful to practitioners taking a similar, but at the same time different and unique, journey towards clinical competence. My wish is to provide a conceptual framework, a way to think about clinical practice, which takes into account major developments in theory, research and practice.

While doing this, I have the practitioner in mind, focusing on the needs and challenges we experience in our day to day practice. Historically, theory and research development is sometimes articulated in ways that are not most helpful to the practitioner, and it is not surprising that many practitioners do not rely on the academic and research literature in their work. The current fascination with evidence-based practice, for example, needs to pay attention to critical issues related to the production of knowledge through research; and the transfer of empirical knowledge to the practice situation, which is often different from the research situation. My premise is that theory and research should support practice, and ultimately serve the best interest of our clients. The contemporary practitioner has to navigate through an overwhelming array of theories and treatment options, as well as an ever-growing body of research reports. Clinical decisions are not only made on the basis of actuarial data, but also with regard to unique individual circumstance. Very often it is not only picking a treatment of choice, but finding appropriate responses moment by moment. My hope is that the MCM Model will directly address the concerns of

practitioners. Theory, research, and academic discussions are integrated into the model with regard to their relevance to clinical practice.

As a practitioner, I understand that very few of us enjoy mechanical application of established models or systems. We always bring in our own style, experience, and habits. Our practice is inevitably shaped not only by our education, professional training and knowledge, but also by our own beliefs, judgment, in-session clinical sense, professional and personal experience, values and preferences, and sometimes even by situation-specific factors and circumstances. The fact that clinical practice is an interactional process involving clients adds another set of important variables for consideration. My experience in process research, which involves listening to session audiotapes and reading transcripts carefully, reveals a practice reality characterized by complexity and diversity. It is also a humbling experience to see how positive clinical outcome does not follow a simple, uniform pathway, but goes through a myriad of shifts and turns, sometime surprising ones not anticipated by the practitioner, or the theory one espouses.

I am, therefore, not trying to advocate for yet another system, and add another product to the already saturated supermarket of therapies. Instead, I wish to assist the practitioner in becoming more efficient in obtaining what is needed for each client, without being overwhelmed by the sheer quantity of options or resigning to the use of a limited range of familiar procedures that might not be sufficient to address the multiple contingencies we encounter in clinical practice.

In a way, I am proposing a meta-model that is built upon the current body of

knowledge and clinical experience, aiming at generating a set of pragmatic principles that can assist the clinician in managing the multiple contingencies encountered in clinical practice. The conceptual model is based on a number of key formulations:

- (1) *A comprehensive model for understanding human experience and action, and their relationship with the environment and social realities.* This model covers the key domains of our lived experience: biology, motivation, emotion, cognition, behavior and action, and environment. The model attends to reciprocal shaping and conditioning between the individual and the environment, both in its physical and social form.
- (2) *Rejects assumptions of universal human experience and recognizes the multiple contingencies.* Different systems of therapy try to argue for the primacy of selected domains, such as cognitive therapists emphasizing cognition, bio-medically oriented clinicians focusing on drugs, and emotion-focused therapists privileging emotional experience. They tend to minimize the reciprocal and interactive relationship among the domains. MCM does not assume that the domains are equally important for all persons at all times across all situations. Multiple contingency thinking recognizes individual uniqueness, change over time, and variation across social situations, along with other dimensions of diversity such as gender, age, ethnicity, culture, sexual orientation, and so on.
- (3) *Equifinality and variability in the clinical change process.* Equifinality refers to the fact that people can arrive at the same final outcome through different

pathways. In clinical practice, clients achieve positive outcomes through different processes. Some clients spend more time working on understanding their needs and motivations, others work more on changing the way they process information, and some focus on learning new behavior and action strategies. Many clients actually work on more than one domain. There are clients who start with a behavioral learning program (e.g., pain control, effective help-seeking) and later start to engage with existential issues (e.g., end-of-life). There are clients who are in for couple counseling, and move on to work with their personality disorder after the initial crisis has been resolved. In MCM practice, we recognize the fluid and dynamic process of clinical change, and the different phases clients have to move through, and do not allow a practice model to restrict the client's range of options. We build a practice model that fits the client instead of expecting the client to fit our practice model.

- (4) *Clinical procedures are guided by professional understanding, careful analysis, and purpose-driven application of clinical knowledge.* Attention to and accommodation of multiple contingencies does not allow room for undisciplined practice. The MCM practitioner should be able to explain each chosen clinical procedure with regard to its intended clinical effect, and how it can be contextualized within the overall change process experienced by the client. The choice of procedures should be informed by research, theory, practice experience, and due consideration of the client's needs and specific circumstances.

Concluding Remarks

Psychotherapy conceptualization and research in the West have been heavily conditioned by the drug metaphor. We try to find a specific treatment for a given disorder. We try to diagnose and classify accurately and match that with the right prescription. We imagine psychotherapies as having common factors or active ingredients that function in a uniform manner across cases. We expect clients, as human beings, to respond similarly to the same treatment procedures. Experienced clinicians will find these assumptions problematic. In developing the MCM model, I have adopted elements of an alternative metaphor taken from traditional Chinese medicine. The practice responds to individual differences, even when they have a similar complain or condition. The treatment changes over time, typically in response to the clinical progress made by the patient.

MCM is not another system of psychotherapy. It does not seek to be a particular form of integrative therapy. Instead, it tries to help the clinician in mapping out the terrains of clinical practice so as to identify the multiple contingencies coming from all directions, and to provide a conceptual framework for making sense of clinical realities and making sensible clinical decisions.

In the last few years I have delivered lectures and training workshops in different places in North America and Asia. I am currently writing a book on the model. Interested colleagues are welcome to get in touch with me at k.tsang@utoronto.ca.