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Integrative change model in psychotherapy: Perspectives from Indian thought

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ABSTRACT

Different psychotherapeutic approaches claim positive changes in patients as a result of therapy. Explanations related to the change process led to different change models. Some of the change models are experimentally oriented whereas some are theoretical. Apart from the core models of behavioral, psychodynamic, humanistic, cognitive and spiritually oriented models there are specific models, within psychotherapy that explains the change process. Integrative theory of a person as depicted in Indian thought provides a common ground for the integration of various therapies. Integrative model of change based on Indian thought, with specific reference to psychological concepts in Upanishads, Ayurveda, Bhagavad Gita and Yoga are presented. Appropriate psychological tools may be developed in order to help the clinicians to choose the techniques that match the problem and the origin of the dimension. Explorations have to be conducted to develop more techniques that are culturally appropriate and clinically useful. Research has to be initiated to validate the identified concepts.

Key words: Bhagavad gita, Indian thought, psychotherapy, Upanishads

INTRODUCTION

Psychological forms of therapy across the world traversed through different and divergent paths in the twentieth century. The beginning of the last century saw the predominant influence of the psychoanalysis and other analytical approaches in mental health care. The humanistic approach in psychotherapy founded on the theories of Allport and Maslow took a great leap by client centerd approach of Rogers[1] and turned into a major realm of providing psychological forms of treatment. The learning theories also contributed its share in developing different form of psychological therapies. Behavior and cognitive therapies came out with new techniques and manual based treatment packages to treat maladaptive behavior. A number of innovative psychological therapies emerged, each claiming its effectiveness. The biological psychiatry and pharmacological management of psychiatric disorders also had several new and remarkable developments. Based on clinical evidence and research findings different branches in psychiatry emerged, like the psychosomatic approach, transcultural psychiatry, bio-psycho-social psychiatry, and neuro psychiatry. Each form of therapy and treatment claimed its own effects on the lives of the clients or patients. As a result, different change models were propounded to explain the change phenomenon.

INTEGRATIVE EFFORTS IN PSYCHOTHERAPY

In the area of psychotherapy, an active movement achieved momentum towards integration of empirically based techniques and theories in the last two decade.[2-4] Beitman *et al.* identified six factors that fostered the advancement towards psychotherapy integration.[5] In their opinion the proliferation of therapies, inadequacy of single theories, equality of outcomes among many therapies, search for common components, emphasis on patient characteristics and the therapeutic relationship and socio-political

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contingencies compelled exploring the integration of existing forms of psychotherapy. Analyzing the history of psychotherapy integration, Norcross and Newman identified eight interacting variables that encouraged the growth of psychotherapy integration.[6] The variables were: (1) The enormous expansion in the number of separate psychotherapies; (2) The failure of any single therapy or group of therapies to demonstrate remarkably superior efficacy; (3) The correlated lack of success of any theory adequately to explain and predict pathology, personality, or behavior change; (4) The growth in the number and importance of short term, focused psychotherapies; (5) Greater communication between clinicians and scholars that resulted in increased willingness and opportunity for therapeutic experimentation; (6) The intrusion into the consulting room of the realities of limited socio-economic support by third parties for traditional, long term psychotherapies, accompanied by an increased demand for accountability and documentation of all effectiveness of all medical and psychological therapies; (7) The identification of common factors that are related to successful outcome; and (8) The development of professional organizations networks, conferences, and journals that are dedicated to the discussion and study of psychotherapy integration. On the other hand, Goldfried reviewed the different conceptual models reflecting integrative oriented brief psychotherapies that are time limited for experimental validation of the therapy based variables and held the view that it is difficult to discern the common change principles that underlie each of form of psychotherapy.[7] There could be common change principles that might explain the change process and emphasized the need to devote clinical and research energy to learning more about the principles of change in the following five directions. These included, (a) the expectation that therapy can help, (b) the presence of an optimal therapeutic relationship, (c) the client becoming better aware of what is creating problems, (d) corrective experiences, and (e) the client engaging in ongoing reality testing.

DO WE NEED A NEW THEORY AND CHANGE MODEL ?

With the emergence of a large number of therapies, enumerated to be more than 450, it could be confusing, especially for a new entrant to the discipline of psychological therapy. The integration movement has also seen the combination of techniques as well as unification of theories. As a result, different combination therapies like the cognitive-behavioral and psychodynamic-interpersonal approaches emerged and accelerated the movement towards integration in psychotherapy in the West.[3,7,8] As part of integration, Harmar and Myers included prayer and meditation, spiritual form of treatment into the medical model approach.[9] The inclusion of spiritual form of treatment under the rubric of psychotherapy is a significant leap, in the context of negation of 'spirit' and extreme dependence on physiological, learning and cognitive oriented forms of therapies.

While there are efforts to technically integrate divergent methods of treatment to help individual clients,[10] there are opposition to a unified theory.[11-13] Different theories emerged during the last three decades and some of the theories that already existed claimed to be 'the' integrative theory, like the theory behind Rational Emotive Behavior Therapy.[14] However the integration movement was again caught with the dilemma of integration of techniques versus theories.[15]

Change model: Question of mind versus body alone? Anything more? Anything less?

The Transtheoretical (or "Stages of Change") Model, propounded by Prochaska and his colleagues attempted to explain and measure health behavior independent of specific theoretical trappings.[16] Prochaska and his colleagues initially described the process that alcoholic dependent persons go through while giving up drinking, and later the process of smoking cessation.[16] Their research identified five independent stages: precontemplation, contemplation, preparation, action, and maintenance. "Precontemplation" refers to the stage when the person does not even think about the behavior, let alone whether to change it. In the "Contemplation" stage, the individual actually considers changing the behaviour but is not quite ready to take the plunge. During "Preparation" stage, the individual intends to take action immediately and has unsuccessfully taken action in the recent past. "Action" refers to that aspect of the sequence where the behavior change is initiated, whereas "maintenance" is the longer-term consolidation of that change. During either action or maintenance, "relapse" can occur, whereby the individual reverts to the pattern of behavior that preceded the "action" stage. Although the proponents consider this model free from theory, they also noted that the individuals weigh the pros and cons of behavior change before progressing from one stage to the next. An exciting recent development in research generated by this model is the attempt to match intervention approaches to the particular stage of change that an index person is in. For example, imparting information may be the most effective approach to influencing pre-contemplators, whereas skills training and cues work best for moving contemplators to action, and reinforcement keeps maintainers from relapsing.

The change models or explanations of change emerged from the body-mind paradigm and focused on measurable behavior and are 'evidence based'. In order to overcome the blocks in the integration of therapies and to ease the process of integration Arkowitz opined that there is a definite need for a unifying theory.[10] In order to develop a unified theory that could integrate various therapeutic approaches, a

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fresh look at the age-old debate on mind-body or even the body-mind-soul paradigms is required. Eisenberg (1986) observed that psychiatry at one point of time had a long and difficult struggle to divide the person into body and mind.[17] In order to pave way for unification, Goodman proposed the 'organic unity theory'. Synthesizing a bio-psycho-social model and the mental physical identical theory, he aimed the integration of medical science and philosophy. He held the view that the physiological or the psychological interventions could make changes in the organisms that are both physical and mental.[18] However, the unified theory did not consider the spiritual dimension. On the other hand, Ward (1996) acknowledged the importance of the spiritual dimension and included it as part of his theory based on body-mind.[19] Ward conceived that the body is immersed in this physical world, its attention is focused on the physical realities and its actions are directed to the master of nature and to the gratification of feelings. And the 'spirit-body' is perceived, as a 'body' constituted by its intimate relation with God. There are others who go by the three dimensional paradigm of mind-body-sprit, and some others who support a mind-body paradigm, where spiritual dimension is included as a function of the mind.[20] Empirical explorations revealed the 'revival' of soul and spirit into contemporary research in philosophy, psychology, psychotherapy, psychiatry and medicine.[21,22]

Concepts related to spirituality influenced the thinking of William James and Carl Jung and that reflected in their psychological writings in the early part of the last century. Though the middle phase of the century was 'spiritually dark', the late eighties and the nineties saw the resurgence of scientific research related to religion and spirituality.[23] Lawlis explored the relationship of spirituality to human functioning and the practice of psychology, counseling, psychotherapy and medicine.[24] An increasing amount of theoretical, scientific and professional literature focusing on conceptualization and/or measurement of spirituality got published in scientific journals.[21,22,25-28] Harmar and Myers perceived prayer and medication as forms of treatment that could be well integrated with medical approach.[9] Karasu viewed that the terms 'soul' and 'spirit' in the context of spiritual psychotherapy could be distinguished as different transpersonal abstractions, but are inextricably linked.[21] He opined that the soul is related to and aims at revealing the mystery of relatedness and intimacy in everyday life and sprit is related to the divine in universal life. Therefore, in spiritual therapy, the aim of the spiritual therapist is to guide the patient achieve one's own authentic self. Another interesting turn is the change in attitude of the evangelical Christians towards psychotherapy. Till recently, their attitude towards psychotherapy was complex, and of late there appears to be a change in their stance towards therapeutic process, at least in some of them.[29] But from the perspective of Indian philosophical psychology, spirituality cannot be subsumed within the psychology of religion and is conceived not as a separate entity but is part of it, and not fully of it.[30]

PERSPECTIVES FROM INDIAN THOUGHT

There are numerous psychological concepts in the Indian philosophical psychology.[31,32] Some of these are identical to the concepts in the 'Western' psychology. Some others are similar to the existing concepts, but are not exactly same. There are several other concepts that are distinct but have not been explored through scientific methods, but are worth exploring. Yet some concepts are considered, as those that cannot be comprehended through the existing scientific methods. Because of the diversity and complexity, those who got interested in the psychological concepts in Indian thought have identified and researched some of the concepts on a pick and choose manner. The concept within the yoga school of thought is an example. Several experimental studies on yogic asanas and different forms of meditation have been conducted[33,34] and the trend is on the increase.[35]

In the present paper, the Taitriya Upanishadic concept of person is delineated and some other important concepts mentioned in the ancient texts of Indian thought are described. Comprehension of the Taitriya Upanishadic concept of person facilitates the understanding of the integrative change model.

INTEGRATIVE CONCEPTS OF PERSON

The integrative concept of the person is based on Taittirya Upanishad. In the text, the person, is considered more than body or mind or soul or cognitive functions. This is a paradigm shift from the present concept of person in the Western scientific psychology, beyond body, mind, brain and/or behavior. The person is considered as having five dimensions – the physical, the psychophysical, the psychological, the intellectual and the spiritual (approximate English terms). External behavior as well as other unobservable behaviors or inner mechanisms originate from different dimensions and are specific to particular dimensions but are interconnected.

To elaborate further, the Taittirya Upanishad states that the person consists of five dimensions or sheaths – the *annamaya* (closer to physical or anatomical and physiological), *pranamaya* (breathing related to body – psychophysical), *manomaya* (related to mind or mental mechanisms/feelings or emotions) *vijnanamaya* (related to knowledge, higher cognitive functions) and *akasmaya* (transcendence, or the spiritual dimension). All the functions of these kosas are not well defined and stated in the Upansihad. However, there are brief narrations about the kosa and those are described below.

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Annamaya kosa – related to anatomy and physiology, physical body. The uniqueness in structure of the person, including all the physiological systems in the body and their functions are attributed to this kosa. (Taittirya Upanishads II.)

Pranamaya kosa – related to breath, essence of maintenance of life, psychophysical. The prana activates the experience of sensation and the presence of sensation can only be felt. This kosa does not include the sense organs but are related to the primary functions of sense organs. (Taittirya Upanishads II.ii.1)[15,36,37]

Manomaya kosa – related to mind, psyche, and mental mechanisms. This is the psychical constituent of the person and is an instrument of the senses. For prana to function this psychical component has to be active. Manas is active during the wakeful state and dream state, but not during deep sleep. Manas is not involved in the physiological functions of the sense organs. But unless manas is active, the sensation cannot be perceived. (Taittirya Upanishads II.iii.1). By error, manas has been equated to 'self' or 'mind' both in Western and Eastern literature.[38]

Vijnanamaya kosa – related to knowledge, intellect, and consciousness. This kosa is the storehouse of sanskaras or past experiences, and is full of vasanas or predisposition and it is related to the cognitive processes. While processing the cognition, vijnana undergoes transformation. The perceiver is not vijnana, but the whole person, which includes all the kosas (Taittirya Upanishads II.iv.1).

Anandamaya kosa – related to beyond, transcendence or 'spiritual'. The word ananda is related to something, which is beyond explanation or unexplainable. The other elements of the person in different sheaths get dissolved at its functional level. All the functions including the physical sensations, the perceptions and cognition and vijnana all become non-existent. Neither ideation nor intellect functions at this level (Taittirya Upanishads II.v.1).

Many Indian psychologists acknowledged the Taittirya Upanishadic concept of person.[38-44] But the concepts are yet to attain considerable attention of 'experimental' research. Since the Upanishadic text do not delineate the functions of the kosas in an exhaustive manner, the descriptions provided in the later schools of thought have to be scrutinized thoroughly to develop a scientific understanding of the kosas. The scientific knowledge of psychology and neuro psychology can be integrated into the description of the functions of the kosas. For example, the emotions described in the texts of Samkhya, concepts from Buddhist school of thought and some of the concepts delineated in the texts of Bhagavad-Gita would go well with the manomaya kosa, though it has its physical and psychophysical components that are structural, and are regulated by the neural mechanisms.

THE TRIGUANAS OR THREE QUALITIES

Basic concepts

Ancient Indian thought, particularly Sankhya school of thought described three gunas (qualities) – Satva, Rajas and Tamas. Unlike the five dimensions, several studies have focused on exploring, the concepts of satva, rajas and tamas. There is increasing research interest on these concepts from US and it appears that these concepts of Vedic origin have cross-cultural relevance. This is reflected in the development of an inventory on Trigunas and that was published in the journal, *Psychological Reports*.[45,46] Indian psychological researchers have also explored these concepts since an early period. Though the quantity of research does not equal that of the published research related to yoga school of thought or that of psychological perspectives of Buddhist school of thought, the concepts of appears to have significant relevance in understanding the person. However, a unified effort has not been made so far to study these concepts and resulted in development of nine different tests to study the same concepts of satva, rajas, and tamas.[46-55]

Integration

Integration is one of the key concepts of the Indian thought and it is evident in the description of the kosas too. Not only the kosas are integrated within, they are integrated to the Mahabhutas (the basic five elements with which the universe is composed namely, prithvi, jala, vayu, agni, and akash) and with Trigunas. Since the kosas/sheaths as well as mahabhutas are integrated, anything which affects the Brahman or the universe can affect the Atman and vice versa.

The five kosas are not independent. Though they have their separate entity, the kosas are inseparable from each other. The changes in one of these dimensions are likely to affect the equilibrium of all the other dimensions. When one is entirely engrossed in the outer sheaths, the intimate, subjective experience of the self becomes impossible.[56]

Different neo-scholars conceived the integration in almost the similar manner. Svarupa dasa, did not differentiate between body and soul, mind and body, soul and mind.[57] Olivelle observed that modern scholar's subject 'Brahman and Atman', to be pivotal in the Indian philosophies and theologies, and suggested that the two concepts require intense scrutiny.[58] On the other hand Brereton observed that these two terms in the Upanishads do create "an integrative vision by identifying a single, comprehensive and fundamental principle which shapes the world" (p. 118).[59] Olivelle viewed that both these concepts "occupy the summit of the hierarchically arranged and interconnected universe" (p.lv.).[58] However, the psychological methods of the present times are insufficient and inadequate to experimentally research the concept of

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connectedness and it could be one of the reasons why the Indian psychiatrists and psychologists and shy away from scientifically exploring the Indian psychological concepts.

Integrative model of change

The integrative model of change is based on the Indian concept of person, and the connectedness of the kosas, the mahabhuthas and the gunas. Therefore in the therapeutic context, the first task is to identify the dimension(s) or the kosas from which the problem or problems originated. Depending on the origin of the kosa the method for the appropriate kosa has to be applied. In other words, if a persons' symptom or a disorder is arising out of a particular sheath, the appropriate treatment targeted to the concerned sheath is likely to bring about the optimum level of effectiveness. The method of intervention need not be that of Indian origin. Western concepts or techniques that are applicable to the particular dimension could be equally useful. The Indian thought also delineates divergent intervention strategies.

However, due to the interconnectedness mentioned earlier, even if the intervention is not directed to the appropriate kosa, still there could be change. For example, a physical pain that has its origin in spiritual kosa may be relieved by a medicine that acts at the annamaya kosa. Similarly, a pain that arises out of physical cause could show relief through spiritual intervention too. This change phenomenon in therapeutic situation explains why different therapeutic approaches claim equal effectiveness or why therapists with different level of expertise have equal effect on their clients.

STRATEGIES OF INTERVENTION BASED ON INTEGRATIVE MODEL OF CHANGE

Indian thought includes various systems that focus on different sheaths of the person and its connectedness. However, these systems were not conceived as being connected, though each in itself describes the connectedness. There has been no effort to explore the link between the different systems that were available. Three systems that are targeted to the different kosas are discussed here.

Ayurveda

One of the Indian systems of medicine, Ayurveda, is applied based on this principle.[60] Before prescribing a treatment strategy, the Ayurvedic physician, assesses the patient to delineate the origin of the sheath, along with other concepts that are pertinent to the annamayakosa, or the physical functioning. Even though the patients have the same physical symptom, the prescriptions are different for different individuals which is based on the 'personality' dimension of trigunas (three qualities) and tridoshas (three humors, namely, vatha, pitha and kapha).[44] The prescriptive diet also varies from person to person, though the symptoms manifested are same. However the effect of the intervention could alter the functions in all the different kosas. For example, the dietary restrictions and the habitual restrictions prescribed could affect the person even at the spiritual dimension of the person, though that is not the primary target of the intervention.

Bhagavadgita and conceptual schema of psychological therapies

The conceptual schema of psychological therapy that is found in Bhagavad Gita is yet to be explored.[15] Contrary to the current available psychotherapeutic interpretations of Bhagavad Gita text that equates it with different psychotherapeutic approaches in the West, the conceptual framework that is provided has more wider significance. The text is more than behavior therapy or systematic desensitization or client centered approach or cognitive approach or analytical psychotherapy. Three aspects related to the integrative concept of person are manifested in the text. Firstly, it appears to support the integrative concept of person, wherein the text refers to acceptance of the five kosas and its functioning, the three qualities of satva, rajas and tamas and the connectedness. Secondly, the therapeutic relationship is unique and the style of relating is worth exploring afresh. Thirdly, the approach used is distinct and provides a model for the therapist to be free and flexible to use the appropriate style depending on the context and in focusing to kosa from which the problem originated. The extent of variation is from the type of food to be consumed to the spiritual dimension of the person. The therapeutic framework that is provided in Bhagavad Gita directs how a therapist has to be flexible in using different approaches and integrate different therapeutic strategies, depending on the affliction of the kosa.[61]

Yogic asanas

Similarly, for a spiritual problem, yogic asanas or techniques would be most appropriate for promotion of mental health, emotional maturity and fulfilment, provided the problem originates from the 'spiritual kosa'. Rao observed, "The benefits of yoga (asana) include physical and mental health. But its goal is the total spiritual transformation of the individual" (p. 50).[56] Unfortunately, the Western approach towards the study of yoga related concepts had been a 'pick and choose' one.[56] He further observed that yoga hovers between art and science, as well as between science and technology. At the application level, there is a high degree of precision in describing yogic asanas and the consequential state achieved by them.[56,62]

Yogic asanas, is one of the concepts that emerged from the school of yoga and is studied extensively from a Western scientific perspective. The term yoga had been widely used in clinical as well as in non-clinical contexts but was reduced to mean a form of physical exercise like the progressive muscle relaxation. Some researchers considered 'yoga' as biofeedback and as a physical means to attain mental

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relaxation.[63] However the studies on yogic asanas showed positive results,[64] that validated the interconnectedness of body, mind and soul. This in fact is only one of the several 'units' of yoga. But the term yoga literally means 'Union with the Ultimate Truth' or 'Union with God' or 'Union with pure consciousness'. Yoga essentially includes a spiritual dimension and the change, which occurs as a result of the practice of yoga (not only the practice of physical postures or asanas, but also all other components together) leads to an integrative transformation. Transformation occurs at different dimensions, at physical, psychophysical mental, intellectual and spiritual level. Sages and highly motivated and devoted people have lived and achieved this objective at different levels. The transformation is experienced not only by people who have different ailments but also by those who are in the pursuit of achieving higher state of self-realization.

Clinical perspectives

As stated earlier, any intervention targeted to one dimension can affect all, with or without being consciously aware of it. A person, who has a physical illness, when provided with a spiritual healing technique, can be relieved of the physical difficulties. And a person who has a spiritual problem, manifesting as a physical problem can be helped through a physical form treatment like physical exercises or change in food habit or medicines (herbal or other). Hypothetically, a person's problem that has origin in the physical dimension-like a viral infection, can be helped if the appropriate physical treatment is provided. But if the manifestations of symptoms are physical, and if it has originated from a different kosa, the treatment strategies related to that dimension would only be effective. Therefore, it is important to trace the source of origin of the problem – the relevant kosa.[15] Not only in persons with psychological disorders, but even in those persons with other ailments, there are several situations where the clients show changes, but those changes could not be assessed since there is no appropriate tool for measurement. For example the practice of yogic asanas may bring about changes in the kosas related to annamaya kosa rather than the anandamaya kosa, whereas the yogic way of life would bring about changes in the anandamaya kosa rather than the annamaya kosa. To make it scientific a 'tool' may be required to assess the changes in the appropriate kosas.

THE PROCESS OF CHANGE

For a psychological problem, which arises from the manomaya sheath, psychological form of therapy would bring out the optimum benefit. In the treatment of alcohol dependence, integration has been brought in at several levels, taking into consideration of all the Kosas.[65,66] But it requires further research and validation.

For example, a person who is anxious about his sexual behavior, if it has its origin at the physical dimension, behavioral therapies or behavior modification would be of help. If its origin were at the psychophysical dimension, a combination of behavioral and cognitive approaches would be more appropriate. And if it is at the psychological dimension, psycho analytically oriented approaches may help the person achieve a better outcome. Origin at the intellectual dimension would require re-educative forms of intervention, including reality-oriented therapies. If the person has guilt feelings about his sexual behavior, it may have its origin at the spiritual dimension and in order to relieve the person of his guilt, spiritual counseling or therapy would be more appropriate.

Experientially this model of integrative change process appears to be working out well in the treatment of clients with diverse problems. Treatment of substance abuse is a good example where the integrative change model is more explicit. There are clients, who do not have any co-morbid psychiatric disorders. Some of the patients who practice yogic asanas get relieved of their addiction. But there are some others, who achieve sobriety through attending spiritual discourses and observance of dhyana and they are able to maintain their sobriety. There is another group of clients, who are able to modify their behavior through detoxification alone, that are targeted to the annamaya kosa. A group therapeutic approach for the treatment of addiction to alcohol based on the integrative concepts was developed and tried out in different de addiction centers. However, the efficacy of this method has not been experimentally verified.[65]

Basu also held a similar view, based on the concepts of Aurobindo and stated that one needs to understand the origin of different psychopathologies at different 'planes of consciousness viz. physical, vital, mental, subconscious' in order to provide the optimum help.[67] Therefore he used a different diagnostic guideline based on the consciousness perspective for treating the patients though the patients have a conventional diagnosis according to International Classification of Disorders or Diagnostic and Statistical Manual (US based) classifications.

In conclusion, an attempt is made to review the integrative efforts in the area of psychotherapy. Some of the basic concepts from Indian philosophical psychology that could explain the change process are stated and an integrative change model based on integrative theory of person is delineated. Experimental validation of the change model may help ease the therapeutic care of the patients who seek help for their problems.[68]

REFERENCES

1. Rogers C. Client-centered Therapy: Its Current Practice, Implications and Theory. London: Constable; 1951.
2. Goldfried MR, Newman C. Psychotherapy integration: An historical perspective. In: Norcross JC, editor. Handbook of Eclectic Psychotherapy. New York: Brunner/Mazel; 1986.
3. Wiser S, Goldfried MR. Therapist interventions and client emotional experiencing in expert psychodynamic-interpersonal and

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cognitive-behavioral therapies. J Consult Clin Psychol 1998;66:634-40.
4. Levant RF. The empirically validated treatments movement: A practitioner/educator perspective. Clinical Psychology: Science and Practice 2004;11:219-24.
5. Beitman BD, Goldfried MR, Norcross JC. The movement toward integrating the psychotherapies: An overview. Am J Psychiatry 1989;146:138-47.
6. Norcross JC, Newman CF. Psychotherapy Integration: Setting the Context. 1992.
7. Goldfried MR. Integrating Integratively Oriented Brief Psychotherapy. Psychotherapy Integration 2004;14:93-105.
8. Goldfried MR, Raue PJ, Castonguay LG. The therapeutic focus in significant sessions of master therapists: A comparison of cognitive-behavioral and psychodynamic-interpersonal interventions. J Consult Clin Psychol 1998;66:803-10.
9. Harmon RL, Myers MA. Prayer and meditation as medical therapies. Phys Med Rehabil Clin N Am 1999;10:651-62.
10. Arkowitz H. The role of theory in Psychotherapy Integration. Inter Eclect Psychother 1989;8-16.
11. Goldfried MR. On the pursuit of psychotherapy integration: Don't slouch. Inter Eclet Psychother 1988;7:13-15.
12. Lazarus AA. Multimodal therapy: Technical eclecticism with minimal integration. In: Norcross, JC, editor. Handbook of Psychotherapy Integration. New York: Basic; 1992. p. 231-63.
13. Messer S. A critical examination of belief structures in integrative and eclectic psychotherapy. In: Norcross JC, Goldfried MR, editors. Handbook of Psychotherapy Integration. New York: Basic; 1992. p. 130-68.
14. Ellis A. Psychotherapies that promote profound philosophical change foster behaviour change. Inter Eclect Psychother 1988;7:397-402.
15. Manickam LSS. Integrative Psychotherapy: Perspectives from India. California, USA: Unpublished Doctoral Dissertation submitted to Columbia Pacific University; 1992.
16. Prochaska JO, DiClemente CC, Norcross JC. In search of how people change. Applications to addictive behaviors. Am Psychol 1992;47:1102-14.
17. Eisenberg L. Mindlessness and brainlessness in psychiatry. Br J Psychiatry 1986;148:497-508.
18. Goodman A. Organic unity theory: The mind-body problem revisited. Am J Psychiatry 1991;148:553-63.
19. Ward K. The Nature of self: A Christian understanding. World Faiths Encounter 1996;14:51-6.
20. Benson H, Dusek JA. Self-reported health, and illness and the use of conventional and unconventional medicine and mind/body healing by Christian Scientists and others. J Nerv Ment Dis 1999;187:539-48.
21. Karasu TB. Spiritual psychotherapy. Am J Psychother 1999;53:143-62.
22. Shafranske EP. Religion and the Clinical Practice of Psychology. Washington, DC: Am J Psychological Association; 1999.
23. Gorsuch RI. Psychology of religion. Annu Rev Psychol 1988;39:201-21.
24. Lawlis GF. Transpersonal Medicine-Anew Approach to Healing Body-Mind-Spirit. Boston: Shambhala; 1996.
25. Hood RW, Spilka B, Hunsberger B, Gorsuch R. The Psychology of Religion: An Empirical Approach. New York: Guilford Press; 1996.
26. Ingersoll RE. Spirituality, religion and counseling: Dimensions and relationships. Couns Values 1994;38:98-111.
27. Richards PS, Bergine AE. A spiritual strategy for counseling and psychotherapy. Washington, DC: American Psychological Association; 1997.
28. Scotton BW, Chinen AB, Battista JR. Textbook of Transpersonal Psychiatry and Psychology. New York: Harper Collins; 1996. p.
29. Esau TG. The evangelical Christian in psychotherapy. Am J Psychother 1998;52:28-36.
30. Zinnbauer BJ, Pargament KI, Cole B, Rye MS, Butter EM, Belavich TG, *et al*. Religion and spirituality: Unfuzzying the fuzzy. Sci Study Relig 1997;36:549-64.
31. Radhakrishnan S. Indian Philosophy. Vol. 1. Ninth Impression, London: George Allen and Unwin Ltd.; 1971.
32. Radhadrishnan, S. Indian Philosophy. Vol. II. Ninth Impression, London: George Allen and Unwin Ltd.; 1971.
33. Nathawat SS, Singhal AK, Gehlot S. Role of yoga in management of psychiatric and psychosomatic disorders: A pilot study. J Clin Psychol 1999;26:200-4.
34. Nathawat SS, Kumar P. Influence of meditational techniques and Jacobson's progressive muscular relaxation on measures of mental health. Clin Psychol 1999;26:192-9.
35. Watts F. Psychological research questions about yoga. Mental Health Relig Culture 2000;3:71-83.
36. Manickam LSS. Development of a personality tool based on upanishadic Concepts: Conceptual and methodological issues. In: Ramakrishna Rao, editor. Yoga and Indian Psychology. Vishakapatanam: Institute for Human Science and Service; 2005.
37. Manickam LSS. Research on Indian concepts of psychology: Major challenges and perspectives for future action. Handbook of Indian Psychology. New Delhi: Foundation Books; 2008. p.
38. Chennakesavan S. The Concept of Mind in Indian Philosophy. 2nd Revised ed. Delhi: Motilal Banarsi Das; 1980.
39. Ramachandra RS. Development of psychological thought in India. Mysore: Kavyalaya Publishers; 1962.
40. Ghorpade MB, Kumar V. Introduction to Modern Psychotherapy. Bombay: Himalaya Publishing House; 1988.
41. Manickam LSS, Suhani BT. Psychotherapeutic usefulness of SIS-II in a male client with somatoform disorder: Case Illustration. SIS J Proj Psychol Ment Health 2003;10:209-18.
42. Parker CM, Manickam LSS. Psychology Dimension, I and II. Oxford: West Minister College; 1995.
43. Veeraraghavan V. Psychotherapy: A socio-cultural perspective. Psychol Stud 2000;45:161-6.
44. Wig NN. Indian concepts of mental health and their impact on care of the mentally Ill. Int J Ment Health 1990;18:71-80.
45. Wolf DB. A psychometric analysis of the three Gunas. Indian J Psychol 1996;16:26-43.
46. Wolf DB. A psychometric analysis of the three gunas. Psychol Rep 1999;84:1379-90.
47. Singh R. An inventory from Mahabharath. Indian J Psychiatry 1971;13:149-61.
48. Uma K, Lakshmi YS, Parameswaran EG. Construction of a personality inventory based on the doctrine of trigunas. Res Bull 1971;6:49-58.
49. Mohan V, Sandhu S. Development of a scale to measure sattvic, rajasic and tamasic guna. Indian J Academy of Applied Psychology 1986;12:46-52.
50. Mathew MS. Personality types and probabilistic orientation. The probabilistic orientation of personality. In: Matthijs Cornelissen, editor. Consciousness and Its Transformation. Sri Aurobindo Ashram Pondicherry: Sri Aurobindo International Centre of Education; 1988. p. 179.
51. Das RC. The Gita typology of personality. Indian J Psychol 1987;6:7-12.
52. Das RC. Standardization of the Gita inventory of personality. Indian J Psychol 1991;9:47-55.
53. Pathak NS, Bhatt D, Sharma R. Manual for classifying personality on dimensions of gunas – An Indian approach. Indian J Behav 1992;16:1-14.
54. Marutham P. S.R.T Questionnaire Standardization. Unpublished M.Phil. Dissertation submitted to NIMHANS, Bangalore. 1992.
55. Mathew VG. IAS inventory and manual. Thiruvananthapuram: Dept of Psychology, University of Kerala; 1994. p.
56. Rao S. Salvation: A Hindu perspective. World Faiths Encounter 1997;18:11-20.
57. Svarupadasa R. The nature of the self: A gaudiya vaisnava understanding. World Faiths Encounter 1996;14:55-60.
58. Olivelle P. Upanishads: A new Translation. Oxford: Oxford University Press; 1996. p.
59. Brereton J. The 'Upanishads'. In Wm T, de Bary, Bloom I, editors. Approaches to the Asian Classics. New York: Colombian University Press; 1990. p. 115-35.
60. Dash B, Kahayap H. 'Basic Principles of Ayurveda', New Delhi: Concept Publishing Company; 1980. p.
61. Radhakrishnan S. 'The Bhagavadgita', Seventh Indian Reprint. Bombay: Blackie and Son Pvt Ltd.; 1990. p.
62. Taimni IK. 'The Science of Yoga-The Yoga Sutras of Patanjali'. Madras: The Theosophical Publishing House. p.
63. Balodhi JP, Mishra H. Patanjali yoga and behaviour therapy. Behav Ther 1983;6:196-7.
64. Vahia NS. A deconditioning therapy based upon concepts of patanjali. Indian J Psychiatry, 1973;18:61-3.
65. Manickam LSS, Haritha TA, Sreenivasan KV. Group therapy in alcoholism: A multi modal approach. Creative Psychologist 1994;6:9-4.
66. Manickam LSS. Management of Alcohol Dependence: A Community Based Multimodal Approach; 1999. Available from: http://www.psychology4all.com/SamManickam-Alcoholism Management.htm. [Last Accessed 25th Nov. 2012].
67. Basu S. Integral psychotherapy: Personal encounters. In: Matthijs Cornelissen, editor. Consciousness and Its Transformation. Sri Aurobindo Ashram Pondicherry: Sri Aurobindo International Centre of Education; 2001. p. 89-97.
68. Manickam LSS. Psychotherapy in India. Indian J Psychiatry 2010;52:S366-70.

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