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Psychotherapy Integration: An Assimilative, Psychodynamic Approach

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Psychotherapy integration is an approach to treatment that goes beyond any single theory or set of techniques. The history of the psychotherapy integration movement is described, along with several approaches that have been developed to integration. We then describe our assimilative approach, based on a psychodynamic model but incorporating techniques from various active approaches to treatment. A case history is provided illustrating the model that we described.

وحدت روان درمانی: همانندی، رویکرد روان پویایی

جورج استریکر و جرالد آر گولد

وحدت روان درمانی رویکردی فراتر از یک نظریه ی منفرد یا یک سری تکنیک درمانی است.در این بررسی تاریخچه ی یکپارچگی روان درمانی همراه با رویکردهای گوناگونی که در جهت یکپارچگی گسترش یافته اند بررسی شده است. سپس رویکرد شباهت دهنده بر اساس مدل روانکاوی با تکنیک هایی از رویکردهای درمانی فعال توصیف شده است و یک تاریخچه ی موردی برای نشان داده مدل ارایه شده است.

Introduction

Psychotherapists always have been interested in, and have attempted to use, new developments in the natural and social sciences, philosophy, theology, the arts, and literature. However, for the most part, we have refused to learn psychotherapy from each other if our ideologies and allegiances are different. This isolationism has been contradicted by a small, but growing, group of scholars and clinicians who have been able to cross sectarian lines. These integrationists have aimed at establishing a useful dialogue among members of the various sectarian schools of psychotherapy. Their goal has been the development of the most effective forms of psychotherapy possible. The integration of therapies involves the synthesis of the "best and brightest" concepts and methods into new theories and practical systems of treatment. Given the rise of publications, journals, and professional societies concerned with psychotherapy integration, it seems that, as Arkowitz (1991) has announced, psychotherapy integration has come of age.

The first approach to psychotherapy integration involved the translation of concepts and methods from one psychotherapeutic system into the language and procedures of another. A brief historical overview1 of this movement

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might begin with an attempt to convert Freudian psychoanalytic concepts into the terms of learning theories. As noted by Arkowitz (1984), whose fine history of psychotherapy integration has influenced extensively this more concise attempt, perhaps the first article of this type was written by Ischlondy (1930), and his work was expanded upon by French (1933) and by Kubie (1934). French was concerned with the correspondences between the Pavlovian constructs of inhibition, differentiation, and conditioning and the analytic concepts of repression, object choice, and insight. Kubie's expansion of these ideas moved him to consider the possibility of such phenomena as conditioning and disinhibition playing an important role in the relationship between the analyst and the analyzed.

These early pioneers in integration were following a trend introduced into psychoanalysis by Freud (1909/1955). He had noted the importance of compelling the phobic patient to face the phobic object actively--a preview of in vivo desensitization--and also experimented with setting time limits on the treatment in order to promote conflict and to gain access to deeper unconscious material.

As learning theorists began to include operant conditioning principles and organismic and complex psychological variables in their systems, such ideas were applied to the dominant psychotherapeutic approaches of the era. Sears (1944), Shoben (1949), and Dollard and Miller (1950) recast psychodynamic and client-centered therapies in the language and concepts of reinforcement and the internally mediated learning that had been studied by neobehaviorists such as Hull (1952). These studies emphasized the reinforcement value of the therapist and, particularly in the case of Dollard and Miller (1950), preceded modifications in psychoanalytic technique that emphasized activity and instruction on the part of the therapist. Procedures that are commonplace today in cognitive-behavioral therapy and in many forms of integrative therapy were introduced by Dollard and Miller, and included the use of homework, role playing, and modeling, as well as active and graded confrontation of fearful situations and internal states. Wachtel (1977) and Arkowitz (1984) have noted that the work of Dollard and Miller was much more influential in general psychology and in learning theory than in psychotherapy studies, and that their direct impact on psychotherapy integration was not felt until much later. Alexander (1963; Alexander & French, 1946) modified his psychoanalytically oriented approach to therapy by experimenting with active approaches to the induction of change that were informed by the then contemporary learning theories. A point crucial to later developments in psychotherapy integration was his introduction of the idea that insight into unconscious processes often followed behavioral

change, rather than exclusively being the antecedent to change. This move away from a unidirectional view of change was highly influential in the thinking of many later students of integration.

A very important trend that was occurring throughout this same time period was the search for generic change factors that were common to all psychotherapies. Although not aimed at integration or theoretical translation in themselves, these studies were crucial in breaking down barriers between adherents of specific theories and methods. Fiedler (1950) demonstrated that observers were unable to differentiate between psychoanalytic, Adlerian, and client-centered therapies, or to identify the therapeutic ideology of different practitioners. Such research, as well as the investigations of Frank (1961) and of London (1964), pointed to the commonalties among the variety of contemporary therapies, and collectively became a voice arguing for a nonsectarian and generalist approach to psychotherapy. These arguments proved to be extremely generative of the more specifically integrative work that followed.

As behavior therapy became more sophisticated and more oriented toward complex clinical problems, some of its theorists and practitioners came to look to psychoanalysis, humanistic therapies, and systems approaches for guidance, ideas, and methods. Some pertinent examples of these truly integrative studies include the works of Beier (1966), Marks and Gelder (1966), Weitzman (1967), Sloane (1969), Marmor (1971), and Birk and Brinkley-Birk (1974) among many others. These students shared a concern for searching out the underlying theoretical links and similarities among behavioral, humanistic, and dynamic methods. Brady (1968), Birk (1970), and Feather and Rhoades (1972) experimented with the technical integration of psychodynamic, systems, and behavioral methods within single cases. Goldfried and Davison (1976) acknowledged the utility of, and the need for, concepts and methods drawn from other systems of therapy.

If the history of psychotherapy integration had a single watershed moment, it was the publication of Wachtel's (1977) Psychoanalysis and Behavior Therapy. This volume remains the most frequently cited work in psychotherapy integration, and has served as a model of integration at both a theoretical and a technical level. Wachtel offered a theory of personality and psychopathology that fully integrated critical aspects of psychodynamic and behavioral theory into a unique and synergistic model. Just as important, this new and integrative theory also allowed interventions from a broad range of positions to be used clinically in a way that was predictable and comprehensible.

Norcross and Newman (1992) identified eight interacting variables that have encouraged the growth of psychotherapy integration. These include: 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 to predict pathology, personality, or behavioral change; 4. the growth in number and importance of shorter term, focused psychotherapies; 5. greater communication between clinicians and scholars that has resulted in increased willingness and opportunity for therapeutic experimentation; 6. the intrusion into the consulting room of the realities of limited socioeconomic support by third parties for traditional, long term psychotherapies, accompanied by an increased demand for accountability and documentation of the effectiveness of all medical and psychological therapies; 7. the identification of common factors in all psychotherapies that are related to successful outcome; and 8. the development of professional organizations2, networks, conferences, and journals that are dedicated to the discussion and study of psychotherapy integration.

Recently, there has been an explosion of integrative works, and of impassioned debate about the possibility and advisability of integrative efforts. Of particular note during this period was a collection of dialogues between supporters and opponents of psychotherapy integration (Arkowitz & Messer, 1984). A final sign of the evolving maturity of psychotherapy integration was the almost simultaneous publication of two recent handbooks that collected the work of the major contributors in single volume sources (Norcross & Goldfried, 1992; Stricker & Gold, 1993).

The Modes of Psychotherapy Integration

There are three generally accepted ways in which the methods and concepts of two or more schools of psychotherapy may be combined or synthesized. These modes differ from each other with regard to the hypothesized point at which the component therapies meet and meld with each other. They also differ in terms of the respective emphasis placed at each level on technique, change factors, or broader theory (Norcross & Newman, 1992).

The three most commonly discussed forms of integration are technical eclecticism, the common factors approach, and theoretical integration. Technical eclecticism is the most clinical and technically oriented form of psychotherapy integration. Techniques and interventions drawn from two or more psychotherapeutic systems are applied systematically and sequentially. The series of linked interventions usually follows a comprehensive assessment of the patient. This assessment allows target problems to be

identified and then clarifies the relationships among different problems, strengths, and the cognitive, affective, and interpersonal characteristics of the patient. Techniques are chosen on the basis of the best clinical match to the needs of the patient, as guided by clinical knowledge and by research findings. Technical eclecticism need not be guided by an original or integrative theory of personality or of psychopathology. Instead, it usually is based on existing theories and goes beyond this conceptual foundation on a case by case, clinical basis, by adding new techniques and clinical strategies as they are needed. When theory is not involved, this style of psychotherapy integration converges with an eclectic approach.

The common factors approach to integration stems from the assumption that all effective methods of psychotherapy share to some degree certain critical, curative factors. Common factors approaches start from the attempt to identify the specific effective ingredients of any group of therapies. This effort is followed by exploration of the ways that particular interventions and psychotherapeutic interactions promote and contain those ingredients. The integrative therapies that result from this process are structured around the goal of maximizing the patient's exposure to the unique combination of therapeutic factors that best will ameliorate his or her problems.

The search for common curative factors in cross-sectional studies of psychotherapy has a long and distinguished history. The research and scholarship of such leaders in psychotherapy as Jerome Frank, Carl Rogers, and Hans Strupp were central to the establishment of the common factors approach as viable and important. Rogers (1961) attempted clinically and empirically to identify the necessary and sufficient factors that led to therapeutic growth. According to Rogers, personality change for the patient followed from a relationship in which the therapist reacted to the patient with accurate empathy, unconditional positive regard, and self-congruence. Frank's (1961) work contained a cross- cultural perspective on healers and psychotherapists and led to the conclusion that the remoralization of a defeated patient and the provision of hope were central to all psychological and moral helping relationships. Strupp and his colleagues (e.g., Strupp, Wallach, & Wogan, 1962) pioneered the empirical study of psychodynamic psychotherapy. They (Strupp, Hadley & Gomes-Schwartz, 1977) came to very similar conclusions with regard to the effective ingredients of analytic therapies.

Contemporary common factors investigators have built on these earlier efforts and have been able to demonstrate that most therapies do share a pool of curative ingredients. These common factors are relational and supportive, in that they stem from the therapeutic relationship. They also are technical,

deriving from the provision of new learning experiences and the opportunities to test new skills in action (Lambert, 1992; Lambert & Bergin, 1994). Each school of psychotherapy capitalizes on certain common effective factors, and neglects or excludes others (Weinberger, 1995). The advantage of this common factors integration, then, is to increase the number of these curative factors, common and unique, to which the patient systematically may be exposed.

The last type of psychotherapy integration to be considered here is theoretical integration. This form of integration has been described as the most sophisticated and important by some writers, but has been criticized as overly ambitious and essentially impossible by others (Franks, 1984; Lazarus, 1992; Messer, 1992) because of the scientific incompatibilities and philosophical differences among the various schools of psychotherapy. Those who argue in favor of this form of integration do so because of the new perspectives it offers at the levels of theory and of practice. Theoretical integration involves the synthesis of novel models of personality functioning, psychopathology, and psychological change out of the concepts of two or more traditional systems. Integrative theories of this kind generally attempt to explain psychological phenomena in interactional terms, by looking for the ways in which environmental, motivational, cognitive, and affective factors influence and are influenced by each other. Causation usually is assumed to be multidirectional and to include conscious and covert factors, and most theoretical integrations include a focus on the ways that individual's recreate past patterns and experiences in the present.

The systems of psychotherapy that follow from such theoretical integration use interventions from each of the component theories, as well as leading to original techniques that may "seamlessly blend" two or more therapeutic schools (Wachtel, 1991). At times, the clinical efforts suggested within a theoretically integrated system substantially may resemble the choice of techniques of a technically eclectic model. The essential differences may lie in the belief systems and conceptual explanations that precede the clinical strategies selected by the respective therapists. Theoretical integration goes beyond technical eclecticism in clinical practice by expanding the range of covert and overt factors that can be addressed therapeutically. Subtle interactions between interactional experiences and internal states and processes can be assessed and targeted for intervention from a number of complementary perspectives. Expected effects of any form of intervention in one or more problem areas can be predicted, tested, and refined as necessary. This conceptual expansion offers a framework in which problems at one

level or in one sphere of psychological life can be addressed in formerly incompatible ways (Gold, 1990).

The Assimilative, Psychodynamic Model of Psychotherapy Integration.

Our model of psychotherapy integration is one of theoretical integration. It relies heavily on contemporary psychodynamic theories of personality structure, psychopathology, and psychological change, while freely using methods and interventions from other therapeutic systems. This approach to theoretical integration is described best as assimilative (Messer, 1992) because a single theoretical structure is maintained, but techniques from several other approaches are incorporated within that structure. As new techniques are employed within a conceptual foundation, the meaning, impact, and utility of those techniques are changed in powerful ways. In his discussion of assimilative integration of psychotherapies, Messer (1992) points out that all actions are defined and contained by the interpersonal, historical, and physical context in which those acts occur. Therapeutic interventions are complex interpersonal actions, so that interventions are defined by the larger context of the therapy. A behavioral method such as systematic desensitization will mean something entirely different to a patient whose ongoing therapeutic experience has been defined largely by psychodynamically oriented exploration than it will to a patient in traditional behavior therapy. The process of accommodation is an inevitable partner of assimilation. Psychodynamically oriented ideas, styles, and methods are recast and experienced differently in an integrative system as compared to traditional dynamic therapies. When we choose to intervene actively in a patient's cognitive activities, behavior, affect, and interpersonal engagements, we change the meaning and felt impact of our exploratory work and of our emphasis on insight as well.

These assimilative and accommodative changes have been detailed extensively in the recent psychotherapy integration literature. In earlier writings we have presented a "three tier" model of personality structure and change (Gold & Stricker, 1993; Stricker & Gold, 1988). These tiers refer respectively to overt behavior (Tier 1), conscious cognition, affect, perception, and sensation (Tier 2), and unconscious mental processes, motives, conflicts, images, and representations of significant others (Tier 3). We emphasize theoretically and clinically the exploration of this last sphere of experience, but recognize and use therapeutically the complex and multidetermined interconnections between different levels of experience. Unlike traditional psychoanalysis, which treats behavior and conscious experience as epiphenomenal and as important only in symbolizing

underlying issues, we embrace the realms of behavior and consciousness as areas of important work in themselves.

Our evolving psychodynamic theoretical base inherits the contributions of such psychoanalytic innovators as Ferenczi (1930) and Alexander and French (1946), and interpersonalists such as Sullivan (1953) and Fromm (1955). These authors all challenged the hegemony of insight and interpretation within psychoanalytic therapy, instead arguing that new experience and the corrective interaction between patient and therapist were as important, if not more important, than insight in bringing about change. Our thinking closely resembles, and has been influenced deeply by, innovative psychodynamic theories such as Wachtel's (1977, Gold & Wachtel, 1993) Cyclical Psychodynamics, Ryle's (1990) Cognitive-Analytic Therapy, and Andrews' (1993) Active Self model. These theorists observe that insight and new patterns of relating to the self and to others are linked in circular, varied and shifting ways, with insight following new emotional, interpersonal, and representational processes as often as it causes those shifts in function and style. Insistence on a unidirectional model of change (Gold, 1991) suggests, erroneously, that psychological life and psychotherapeutic effect are straightforward and simple.

One also must rethink a psychodynamic model of the mind when assimilative integration is employed (Stricker, 1994). In particular, the unidimensional theory of change that is emblematic of classical psychoanalysis must be jettisoned in favor of a multidirectional, circular model (Gold & Wachtel, 1993; Stricker & Gold, 1988). We understand change to occur and to begin at any of the three tiers of psychological life, rather than always being caused by changes in unconscious conflict, structure, and motive. We also argue that insight can be the cause of change, the result of new experiences and ways of adaptation, or a moderator variable that intervenes in the effects of other change processes. Often, it is difficult, if not impossible, to identify the places of insight and active interventions in the causal chain of events that preceded a patient's gains.

In attempting to achieve assimilative integration, the selection among alternative interventions is among the most difficult decisions that face the therapist. Most frequently, these decisions are made on the basis of clinical factors, such as theoretical orientation or prior experience. This leads to highly individualistic decisions that rarely are reliable, but often appear to be effective. Nonetheless, the lack of reliability warns us that validity may be suspect, no matter how much faith each individual clinician has in his or her own decision. An alternative approach has been suggested by Beutler (e.g., Beutler & Hodgson, 1993), who is attempting to develop a research-driven

basis for matching interventions with therapeutic issues. Clearly this is a superior basis for action, but the literature currently does not allow a broad enough foundation for action and therefore many clinical situations are returned to the clinician for decision on the theoretical and experiential grounds that always have marked clinical intervention.

The assimilative use of active interventions is based primarily on the therapist's ongoing assessment of the patient's psychodynamic status. This evaluation includes an emphasis on the tone of the therapeutic relationship and alliance, as well as consideration of the most pressing conflicts, defenses, self and object representations, and emotional states with which the patient is struggling. Active methods are chosen and are suggested with two or more simultaneous and compatible objectives in mind: (1) to promote changes in the person's current functioning that (2) will impact on central intrapsychic and characterological processes as well.

When indicated, either on the basis of clinical experience or research evidence, cognitive, behavioral, systemic, or experiential techniques may be introduced to intervene in any or all of these psychodynamic issues. For example, we sometimes will use an exposure based method such as systematic desensitization or assertiveness training to assist a patient in the task of reducing social anxieties. Although the change in overt behavior is highly desirable in itself, it also represents a way to work with resistances and defenses that may not yield to interpretation. When the patient is engaged more completely in previously feared relationships, the underlying intrapsychic contributions to those fears will be accessible to dynamic exploration in an immediate, emotionally vital manner. Similarly, an impasse in the therapeutic relationship that might be brought about by a patient's unconscious, paranoid representation of the therapist's intentions may be resolved only partially by interpretation of the immediate and historical roots of those perceptions. Active testing of the accuracy of the patient's ideas, as practiced in traditional cognitive therapy, often can be highly effective in such a situation. As a final example, interpretive work with a tightly controlled, overly intellectualized person may be helped immensely by introducing affectively oriented, experiential methods from gestalt therapy, such as the two chair technique. The goal here is to combine expanded intellectual awareness of the emotions that were repressed with immediate and powerful experiences of those emotions. This active expansion of the patient's affective life often synergizes with psychodynamic exploration by creating a blend of insight and experience that is less likely to be worked into the patient's intellectualizing defensive structure in a redundant, isolated manner.

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The therapist takes an expanded perspective on the variety of events and process that may affect intrapsychic life. Interpretation and insight still are accorded a central place, but interpersonal, cognitive, and emotional variables are seen as maintaining or provoking wishes, representations of self and others, and complex states of internal conflict (Ryle, 1990; Stricker & Gold, 1993; Wachtel, 1977). As Wachtel (1977; Gold & Wachtel, 1993) has pointed out, disowned intrapsychic states sometimes may reflect the patient's unconscious perceptions of real events and relationships in the here and now, rather than being remnants of early experiences. Whether their derivation is past or present, dynamic issues are shaped, reinforced, and sometimes are modified by the participation of the significant people in the patient's life. This applies to all patients, but especially is germane to therapeutic work with patients whose pathology results from deviations in development. These "character disordered" individuals lack the internal structure necessary for such adaptive tasks as affect tolerance, regulation of self esteem, or self generated initiative (Stricker & Gold, 1988). These gaps in development manifest themselves in severe impairment in behavior, cognition, affect, and interpersonal relationships (Tiers 1 & 2).

Work on these issues must address pathology at all three tiers. To work only at the psychodynamic level would ask the patient to go too far beyond his or her pre-existing adaptive capacities. However, if one ignores the intrapsychic, the therapy may remain superficial and overly simplified. When Tier 3 issues cannot be addressed advantageously through interpretation, this expanded framework allows the therapist to work indirectly on those issues by using them as a "map" for change in the other tiers. Work on overt behavior and conscious ideation and emotion can proceed from any of the three tiers, but will be most effective when the meaning of the behavior or thought is understood completely and the selected interventions are presented and used in ways that are experienced as benign and acceptable to the patient.

Additionally, ideas, affects, behaviors, defenses, and symptoms do not exist in isolated ways or meaningless states. These Tier 1 and 2 phenomena frequently are invested with much symbolism and meaning that is unknown to the patient and to the therapist. For example, a particular cognitive structure, belief, or way of processing emotion can unconsciously be perceived as a crucial part of one's identity, or as a way of identifying with a parent. Thus, active interventions may be experienced as forced wedges that are aimed at prying loose a cherished self representation or object relationship. A complete psychodynamically oriented exploration of these phenomena is necessary to appreciate fully the patient's needs in these

matters, and then to introduce active methods in ways that will seem most benign and helpful to the patient (Gold & Stricker, 1993).

This conceptualization of the mutual influence and interpenetration of the intrapsychic, interpersonal, experiential, and behavioral spheres of life brings our psychodynamic theory closer to recent developments in psychotherapy and clinical and developmental psychology than its traditional psychoanalytic predecessors (see, for example, Greenberg, Rice, & Elliot, 1993; Guidano, 1987; Safran & Segal, 1990; or Stern, 1985).

A Case of Assimilative Integrative Psychotherapy

In the case presentation that follows we attempt to illustrate the use of active techniques. Three of the several assimilated techniques that marked this essentially psychodynamic psychotherapy are mentioned. This therapy lasted for about 32 months with the frequency of sessions moving from once weekly to twice weekly after about one year. The final six months of the therapy also was conducted on a once weekly basis.

Mr. S. was a 37 year old single man who came to therapy complaining of severe anxiety symptoms that had begun at about the time the small company at which he worked had merged with a larger and more impersonal firm. Mr. S. was an accountant who increasingly felt isolated at work, especially after his supervisor retired. He had formed an attachment to this older person that he described as parental, and felt that he had been protected and supported in this relationship. He was preoccupied with the prospect of being fired by his new supervisor, although his evaluations had been more than satisfactory. As a result of this concern, he had been working longer and harder, had ignored any of his few social connections and sources of recreation, and had fallen into a reactive state of irritation and pessimism that bordered on depression. Mr. S's father, with whom he had had a distant and mutually unhappy relationship, had died suddenly about eight months prior. The patient reported this in the first session in a seemingly disinterested way, stating that he had felt little about the loss. However, his associations, the few dreams he remembered having near the time he sought therapy, and his description of his relationships with his supervisor all pointed to repressed grief reactions that were complicated by pre-existing unconscious issues of loss, rage, and unrequited love.

The first phase of the therapy involved a broad inquiry into all relevant experiences necessary to complete an assessment at Tiers 1, 2, and 3. Tier 1 (overt behavior) was marked by repetitive patterns of compulsive involvement with work, impulsive and hasty actions and choices, and avoidant patterns of interaction wherein Mr. S. took care to limit contact

with people to an excessive degree. Tier 2 (conscious cognition and affect) contained rigid and moralistic demands for intellectual control over himself and other people, affective constriction, and a long list of "shoulds" and "musts." His compulsive preoccupation with work yielded a conscious sense of perfectionism, pride and ideas about being better than other people, but he also suffered worries about his self worth and a dimly perceived but ever present sense of shame that he could not explain. Tier 3 (intrapsychic representations) had been shaped by Mr. S.'s relationships with an obsessive and distant father, and a depressed and passive mother. His father had focused exclusively on his highly successful and lucrative career, rarely displaying any interest in his wife or children, whereas his mother cared for the patient in a dispirited and dutiful manner. Mr. S.'s inner world was composed of fragmentary andconflicting identifications with these parents. He unconsciously was caught between a sense of isolated grandiosity and a portrayal of himself as vulnerable, without energy, and unworthy of a father's attentions.

The assessment also revealed the multidirectional relationships among issues at the three tiers. Mr. S.'s psychodynamic issues were symbolized and expressed in his behavior and thoughts, but the way he acted and understood his experiences also confirmed and reinforced his self and object relationships. For example, each time someone made an attempt to befriend him, he felt caught between his shameful sense of unworthiness and his identification with his father's scorn of intimate connections. These conflicts and the defensive need to avoid were then reinforced by the other person's discomfort with Mr. S's ambivalent reactions. When his compulsive behavior and perfectionistic ideas were unrewarded at work, his rage and his sense of failing to achieve the love and approval of a father figure also were reinforced.

As the therapy proceeded, Mr. S. became subtly but increasingly combative, bringing his affectless, perfectionistic, and avoidant style into the therapy. He could not use interpretations effectively and, instead, challenged the scientific validity of the therapist's formulations, general approach, and in particular the therapist's ideas about the connections between the loss of his supervisor, his relationships with his father, his reactions to his father's death, and his current symptoms. These resistive interactions severely threatened an already shaky therapeutic relationship, as an increasingly unworkable hostile atmosphere developed. The therapist became aware that, in his attempts to reach Mr. S., he had become an accomplice to Mr. S: the patient needed to keep the therapist at bay in order to ward off the very psychodynamic issues that the therapist was concerned with. An assimilative

shift was proposed. The two chair technique from gestalt therapy was suggested in order to help Mr. S. test his ideas about the lack of validity of the therapist's formulations. If, as Mr. S. argued, he had no other feelings about his father, his death, and the loss of his supervisor, then these techniques probably would be ineffective as well, demonstrating the therapist's uselessness to him. On the other hand, if some change did occur, perhaps Mr. S. would consider some change in his outlook on his psychological situation and on therapy.

Thus followed an extended period of gestalt work in which Mr. S. uneasily involved himself in the enactment of dialogues with his former supervisor, with his father, and, eventually, with himself as a child and with his mother. Gradually, his affective constriction was loosened, and he became aware of tremendous anger, coupled with a deep longing for contact and a pervasive sense of shame, anxiety, and unworthiness of the love of his parents.

The success of the experiential exercises had tremendous impact beyond the expansion of Mr. S's emotional range. As hoped, he began to review his ideas and feelings about the therapist, psychotherapy, and his relationships in a new and more positive light, with a strengthened bond with the therapist being one result. The hostile transference that had developed diminished significantly, and became the source of fruitful psychodynamic investigation and insight that now could be integrated. As Mr. S. now had experienced success in psychotherapy, and perceived directly that the therapist was effective and on his side, other implications of the transference (such as aspects of mother's helplessness) became apparent. Mr. S. felt himself to have been worthy of help, and in this experience found a basis for making conscious, and for actively testing cognitively and interpersonally, his fears that others would reject him as did his father.

A second example of assimilative integration in Mr. S's therapy occurred when he suffered a severe panic attack when notified of an unexpected internal audit of some of his work. Dynamic inquiry and interpretation were impossible given the paralysis that Mr. S. displayed in the next session. As a result, a move was made toward active instruction in relaxation techniques, cognitive measures for self-soothing, and calming imagery. These techniques were very helpful. As Mr. S. became less anxious, he realized that he was both exhilarated and saddened by these events: the therapist had demonstrated an immediate concern for Mr. S. and an ability to help him that evoked deeply painful memories and images of father and mother. At times when the patient had been distressed in the past, his father's disinterest, and his mother's passive ineffectuality, had convinced Mr. S. of the hopelessness of nurturance and help from others, and had imprinted a vision of himself as

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isolated and reactively self-contained. As these issues were explored, he became able to acknowledge and to integrate a full range of affects that he had long avoided. At the same time that he began to cast off these self and object images, he used this helpful interaction with the therapist as the source of new intrapsychic representations and structures.

A final example of our approach to the integration of active methods is drawn from a situation in which the patient asked for help in designing exercises to be used to overcome his interpersonal distancing behaviors. A series of sessions were devoted to behavioral rehearsal, anxiety management, and to the construction of an in vivo hierarchy of social situations. These procedures had three goals: first and most obvious, the reduction of his social anxiety and improvement in social skills; second, to gain greater access to the psychodynamic issues that were warded off through his avoidance of intimacy with others; and lastly, support for, and reinforcement of, his newly emerging sense of being able to ask for help, and to be deserving of it. Correspondingly, such a request signalled the presence of a benign image of the therapist that required whatever confirmation was possible. The results of this behavioral sequence were analyzed and led to an ongoing expansion of the psychodynamic part of the therapy.

In these and all of the other instances when active techniques were introduced to Mr. S., they were mentioned tentatively and always with concern for his intrapsychic construal of their meanings. The effects of these suggestions on his perceptions of the therapist, their relationship, the therapist's understanding of Mr. S's needs, and Mr. S's reactions all were explored repeatedly before, during, and after the interventions were attempted. These discussions often stood as among the more enriching part of the therapy, as they highlighted all three tiers of psychological life in an immediate and vital way. Empirical Considerations

If our assimilative model of integrative psychotherapy is to be influential and long lasting, it must pass the tests of scientific validation and reliability by which we evaluate all therapies. We hope that our case study is clearly illustrative of our thinking and methods. However, it does not itself demonstrate anything about the model's efficacy, generalizability, or potential for replication by other therapists.

At this point in our work we have been concerned exclusively with clinical and theoretical issues, and have not been able to subject this model to the empirical tests that it requires. Nonetheless, it behooves us to raise the critical questions that only can be answered by research, and also to consider extant research findings that may speak indirectly to the status of our work.

First, and probably foremost, are the questions concerning treatment effectiveness and specificity. Is this therapy as or more effective than its component therapies (psychodynamic, cognitive-behavioral, or experiential) or any other systems of treatment? Linked to this question are the issues of prescription and patient matching: are there particular persons, problems, diagnoses, or psychological characteristics for whom or which this therapy can be empirically demonstrated to be most effective? Inquiry also eventually must be directed at such theoretical issues as our hypothesized revisions of psychodynamic theory and the assumed circular relationships between psychodynamics, behavior, cognition, and affective experience. In particular, this model must be studied in terms of the incremental validity of our expansion of the psychodynamic perspective when compared to its traditional conceptualization. Finally, issues of generalizability must be raised and tested. Will this therapy work, or even exist, when conducted by therapists other than the authors of this report? Can the model be taught? Can we formalize and offer data driven guidelines for when and how to move from one intervention to the next, or must clinical intuition dictate exclusively?

Although we do not yet possess direct and data derived answers to these questions, the research literature does offer some suggestions and reasons for cautious optimism. For example, research on prescriptive psychotherapies (Beutler & Hodgson, 1993) and on the stages of change in psychotherapy (Prochaska & DiClemente, 1992) have demonstrated the maximized effectiveness of psychotherapies that include interventions that are drawn from several different dimensions of psychological life, as does our model. These groups of studies impressively support the idea that technique serves the patient best when interventions are matched to the patient's immediate clinical need and psychological state. This view is central to our model. Clinical trials of integrative psychotherapies that resemble ours in their fusion of psychodynamic formulations and exploration with active interventions have yielded preliminary but positive results. For instance, the integrative, interpersonal psychotherapy for depression developed by Klerman, Weissman, Rounsaville, and Chevron (1984) has outperformed medication and other psychological interventions in a number of studies. Ryle (1990) reports that both short term and long term versions of Cognitive Analytic Therapy (CAT) have been found emphatically to be more effective than purely interpretive or behaviorally oriented approaches. Omer (1992) offers empirical support for integrative interventions that heighten the patient's awareness of his or her participation in psychotherapy, thus improving the impact of the basic exploratory stance of the psychotherapist.

Glass, Victor, and Arnkoff (1993) point out that several systems of integrative psychotherapy have been demonstrated, albeit in limited numbers of studies, to outperform either strictly psychodynamic or cognitive-behavioral interventions.

Perhaps the most impressive and important collection of studies of integrative psychotherapy have been carried out by Shapiro and his colleagues at the Sheffield Psychotherapy Project (e.g., Shapiro & Firth, 1987; Shapiro & Firth-Cozens, 1990). These workers studied the impact of two sequences of combined psychodynamic and cognitive-behavioral therapy: dynamic work followed by active intervention or vice versa. They found that the greatest gains were made, and the smoothest experience of treatment were reported, by those in the dynamic-behavioral sequence. Patients in the behavioral- dynamic sequence more frequently deteriorated in the second part of the therapy, and did not maintain their gains over time as often as did patients in the other group. These findings seem to echo and confirm the guidelines of our model, in which psychodynamic work usually precedes and prescribes more active interventions.

Other research can be found that points to the possibility of empirically validating expansions of psychodynamic theory, and of the construct validity and reliability of clinically generated integrative psychodynamic formulations. One central source of these findings is the work of Andrews (1993) on the Active Self model of personality and psychotherapy. This system, like ours, posits feedback and feedforward relationships between events in various psychological domains, with behavior, affect, cognition, and interpersonal relatedness all serving to express and to reinforce pre-existing representations of self and of others. Content analysis of therapy transcripts has yielded much support for this theory, and for its utility in guiding the selection of interventions in an integrated psychotherapy.

Kiesler (1992) points out that work in personality theory that is derived from the variety of interpersonal circles inventories is supportive of many of the personality theories that drive integrative models of psychotherapy. He notes that much data exist to confirm hypotheses about the back and forth nature of the relationship between intrapsychic and interpersonal variables, and also to support the central focus of many integrative therapies upon interrupting the processes that confirm and maintain pathological representations of self and of others.

Empirical verification for psychodynamic formulations may now be found in a variety of well designed and extensive research projects. Methods such as the Core Conflictual Relationship Theme (CCRT) developed in the Penn Psychotherapy Project (Luborsky & Crits-Cristoph, 1990) can yield valid

and reliable assessment of central dynamic themes. The Mt. Zion psychotherapy project (Weiss & Sampson, 1986) has generated the Plan Formulation Method that yields an assessment of conscious and unconscious goals, pathogenic beliefs and conflictual emotions, plans for testing those beliefs, and necessary insights. These formulations have been employed in a number of studies that impressively have validated therapist and judges predictions about process changes in psychodynamics over the course of psychotherapy (Weiss, 1994). Strupp and his colleagues at the Vanderbilt Psychotherapy Project (Strupp, 1993; Strupp & Binder, 1984) also have demonstrated the capacity to develop valid and replicable psychodynamically informed formulations of a patient's psychological functioning that drive and guide the therapist's interventive strategies. These formulations are organized around a concept called the Cyclical Maladaptive Pattern (CMP), a concept that expands the view of psychodynamic processes in ways that are identical to ours: internal variables are assumed both to influence and to be influenced by interpersonal, cognitive, and emotional states through feed back and feed forward processes.

The findings of these last few research projects also address the questions of generalizability and teachability that we noted above. The Penn Psychotherapy Project, the Mt. Zion group, and the Vanderbilt Psychotherapy Project all have resulted in the production of psychotherapy manuals (see Gold, 1995, for a more extensive review of this work). These manuals offer any psychotherapist explicit and data driven guidelines for formulation of the patient's problems and current functioning. Studies indicate (Weiss & Sampson, 1986; Luborsky & Crit-Cristoph, 1990; Strupp, 1993) that compliance to the manual can be demonstrated and that the level of compliance is linked positively to process variables and to outcome. There is virtually no direct empirical evidence concerning the model we propose, but there are many encouraging developments to suggest that this and other models may become of demonstrable validity, generalizability, and teachability.

Conclusion

An assimilative approach to psychotherapy integration combines the organizing principle of a theoretical system of understanding with the range of technical interventions available to the gamut of schools of treatment. It has the advantages of access to an expanded set of techniques and of the understanding that comes from a coherent set of propositions to justify those interventions. It also stretches the theoretical system in order to understand

better the impact of interventions that ordinarily would not be available within that system.

Our approach begins with a psychodynamic system of understanding, but incorporates behavioral and affect arousing procedures that ordinarily do not follow from such an approach. The success of these techniques lead us to favor an interpersonal rather than a solely intrapsychic psychodynamic formulation, as these techniques are more consistent with such a theory. However, colleagues can begin with any other theory and also will find it helpful to incorporate an expanded range of interventions. This leads us back to our three tier approach. Behavior, the first tier, is the province of the behavioral approaches. The second tier, conscious cognition and affect, often draws the cognitive- behavioral and the experiential theorists. The third tier, dynamics, is the concern of the psychodynamic therapists. However, patients function and malfunction at all three tiers, and it behooves a responsive therapist to draw interventions from all three. We have illustrated one among many possible approaches to assimilative integration, and would recommend that other therapists experiment with alternative combinations of theory and technique, and then test these experiments empirically so that the science and the practice of clinical psychology and psychotherapy can be advanced.

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