Integrated Psychotherapy

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How should we go about planning treatment for patients? What kind of therapy would be helpful: expressive or supportive forms of dynamic psychotherapy, cognitive-behavioral therapy, psychopharmacological treatment, or a combination?

What are the guidelines for choosing among different treatment approaches? This is an everyday issue for psychiatrists and other mental health practitioners. Clinicians' choices have a profound effect on the patients they treat. In the 1950s and 1960s, therapists generally worked within an exploratory dynamic or psychoanalytically informed approach, and patients were treated accordingly. However, therapists sometimes found themselves deviating from the analytic model when they believed that a patient seemed to require a different technique.

In this column I review factors to consider when choosing and combining appropriate treatment approaches for individual patients.

Background

Current psychotherapy approaches are much more varied than they were 40 or 50 years ago and include cognitive-behavioral therapy based on the work of Beck (1) and Ellis (2) and interpersonal psychotherapy as developed by Klerman and associates (3). The psychoanalytic approach also shifted from a focus on drive-conflict to the use of ego psychology, object relations theory, self psychology, and interpersonal and relational models. However, all of the analytic approaches are useful and can be conceptualized as connected with one another and applicable to adult functioning. Accordingly, a person who is functioning at a high level and who has conflict-based problems may be treated more effectively from a drive-conflict perspective, whereas a person with borderline or narcissistic problems may benefit more from an emphasis on object relations or the use of self psychology.

With the development of multiple psychotherapy models and better outcome research, it is now feasible to use a differential therapeutics approach. For example, cognitive-behavioral therapy has been shown to be efficacious for many symptomatic disorders such as depression, panic disorder, posttraumatic stress disorder, and obsessive-compulsive disorder. Specific cognitive-behavioral techniques, such as exposure (4) for posttraumatic stress disorder and exposure and response prevention (5) for obsessive-compulsive disorder, are particularly beneficial.

Comorbid conditions

However, most patients do not present with a single problem but rather with comorbid conditions. Addictive disorders are common among psychiatric patients, and comorbid psychiatric problems are frequently present among patients with substance use disorders. Patients with personality disorders often have axis I disorders, and many patients with axis I disorders have a second axis I disorder. Given such high levels of comorbidity, the use of an integrated approach that brings together targeted interventions for different types of behaviors, problems, or symptoms should be advantageous. The following case illustrates the use of such targeted interventions.

Mr. B, a 33-year-old unmarried businessman, entered treatment complaining of long-standing depression accompanied by sleep problems, lack of energy, feelings of futility, and difficulty concentrating as well as major problems sustaining relationships with women. When a relationship with a woman began to develop, he would become fearful, provocative, and rigid and would eventually succeed in driving the woman away. For Mr. B, an integrated approach that used cognitive-behavioral techniques, such as identifying and examining automatic thoughts, for addressing his depression and a dynamic-analytic approach for focusing on interpersonal issues related to his personality and relationship problems might be best.

Health-sickness psychotherapy continuum

Use of an integrated approach allows the clinician to tailor the treatment to the patient, which provides for a differential therapeutics approach. Conceptualizing dynamic-analytic psychotherapy along a health-sickness or psychopathology continuum can further enhance the use of differential therapeutics. The health-sickness continuum is superimposed on a psychotherapy continuum ranging from supportive to expressive interventions.

After an overall assessment of the patient, which addresses level of psychopathology, adaptive capacity, ability to relate to others, and self-concept, a decision can be made about titrating the amount of support and exploration a patient will require. The health-sickness continuum is conceptualized as extending from the most impaired patients and moving toward more intact and healthier individuals. Impairments consist of symptoms and behaviors that interfere with an individual's ability to function in everyday life, form relationships,

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think clearly and realistically, and behave in a relatively adaptive and mature fashion. When these kinds of structural impairments are severe, the patient will be on the left end of the continuum and should be treated with a supportive approach.

Individuals at the other end of the continuum generally function well, have meaningful relationships, lead productive lives, and are able to enjoy a wide range of activities relatively free of conflict; they generally can benefit most from expressive or exploratory psychotherapy. At the center of the continuum are patients whose adaptation and behavior is uneven, so that they have significant problems maintaining consistent functioning and stable relationships. A patient's position on the continuum can vary over time depending on factors such as physical illness, maturational growth, environmental stresses, and psychiatric treatment.

Diagnosis can provide a general idea of a person's position on the continuum, but the actual position varies depending on the level of psychopathology and adaptation. For example, patients with a diagnosis of schizophrenia or bipolar illness will generally be on the left end of the continuum, whereas patients with adjustment disorders or cluster C personality disorders will tend to be on the right end.

Matching psychotherapy techniques to an individual's position on the continuum related to psychological structure and psychopathology is of crucial importance. Recommended for patients on the left end of the continuum are supportive approaches, which include cognitive-behavioral interventions directed toward improving stability of the patient's psychological structure, a sense of self, and relationships. For patients on the other end, expressive therapies that generally use an interpersonal-dynamic-conflict model are more suitable; they may include cognitive-behavioral approaches for symptoms of depression or anxiety. If problems in structure are significant, it is less important to work on conflict issues, and the therapist should focus instead on repairing or building structure, relationships, and self-esteem. Patients who have relatively intact structures generally benefit more from a focus on relational and conflict issues.

In practice, most individuals are not at either end of the continuum but instead have both conflict and structural problems. Therefore, the vast majority of patients require work in both areas, generally beginning with building psychological structure and then perhaps moving on to conflict and relationship issues. In addition, as noted, symptoms such as anxiety and depression generally are best treated with cognitive-behavioral techniques.

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Assessment, case formulation, and trial therapy

A thorough patient assessment and case formulation are essential for deciding on the proper treatment approach (4). The initial evaluation is also important in setting the tone for establishing a therapeutic alliance, which may be the most important element of successful psychotherapy. Case formulation depends on an accurate and complete assessment of the patient. Explanatory in nature, formulation is a statement about an individual's psychological functioning and helps promote understanding of and empathy for the patient. The initial formulation is tentative and must be modified as more is learned about the patient during the course of treatment.

During the evaluation, the clinician should use trial therapy (4). Trial therapy employs different therapeutic techniques, such as clarification, confrontation, interpretation, exploration and testing of automatic thoughts, self-esteem enhancement, and empathic statements. As the therapist gathers more information, the technical approach is adjusted to the patient's structural level. The more intact the structure, the greater the use of expressive techniques such as confrontation and interpretation, which are more challenging. The patient's response to confrontation and interpretation is an indicator of the suitability of this type of expressive approach and further determines the patient's ego strengths and weaknesses. For patients who have structural deficits, emphasis is on clarification, enhancement of self-esteem, strengthening adaptive defenses, reframing, and other supportive interventions. The use of trial therapy enables the clinician to decide on the appropriate type of treatment with greater accuracy and to provide patients with a therapeutic experience. The following case shows the use of trial therapy.

Ms. S, a 38-year-old unmarried woman, entered treatment complaining of anxiety and depression accompanied by waves of nausea and dizziness. As the therapist began to explore her difficulties, Ms. S became exceedingly distressed and disorganized. Her speech became rambling and difficult to follow. The therapist quickly realized that Ms. S could not tolerate an exploratory process and moved across the continuum to a more supportive approach. On the other hand, if an exploratory approach enables a patient to become more organized, less vague, and better able to tolerate anxiety, the patient has demonstrated that expressive treatment is a suitable approach. A full discussion of case evaluation, formulation, and trial therapy is presented by Winston and Winston (4).

Combined treatment

During the evaluation, the use of medication should always be considered, and medication should be a core ingredient of an integrated ap-

proach to treatment. Many patients do not require medication; however, when medication is indicated, an approach that combines drug treatment and psychotherapy is often beneficial. There is no evidence that the use of one approach interferes with the other. Evidence indicates that medication can increase motivation for psychotherapy and psychological mindedness and help prevent patients from dropping out of treatment. In addition, psychotherapy can improve medication compliance and reduce relapse and readmission rates.

Therapeutic alliance and rupture resolution

In an integrated treatment, a wide variety of techniques are used, which calls for flexibility on the part of the therapist. As the therapist moves back and forth between different approaches, a great deal of attention to the therapeutic relationship is necessary to maintain the alliance. Patients can become dissatisfied or confused when the therapist makes transitions between approaches, which can lead to a misalliance or rupture in the therapeutic relationship. This issue is of particular concern in brief treatment, because the amount of time available to repair problems in the alliance is limited.

Clinicians have long recognized the centrality of the therapeutic relationship and the importance of working in this relationship. Writers who describe the dynamic, interpersonal, and relational approaches have emphasized the importance of the therapeutic relationship, and in recent years its significance has also been noted by cognitive and behavioral writers. Indeed, research on many different types of psychotherapies has indicated that the therapeutic alliance is the best predictor of psychotherapy outcome (6). The key components of the alliance appear to be the ability of the therapist and the patient to work together with a sense of committed participation in a helpful and hopeful process, with shared goals for the therapy and for the bond between the two participants.

Misunderstandings or ruptures in the therapeutic alliance are not uncommon, especially in the case of therapies that use challenging confrontations and interpretations and with so-called difficult patients, such as those with significant personality problems. Two kinds of misalliance have been described: confrontation and withdrawal. In a confrontational misalliance the patient may directly express anger toward the therapist or criticize the therapist or therapy. For example, a patient may confront his therapist by saying, "That's a pretty pat response." In a withdrawal rupture, the patient removes him- or herself from the therapist. For example, a patient may start to come late to psychotherapy sessions, may stop initiating topics to be explored, and may become more and more quiet.

All types of misalliance should always be explored. In some instances, exploration will proceed easily and the patient will be able to directly express underlying needs or feelings toward the therapist. However, if the patient is heavily defended, the exploration of misalliance will be blocked. Blocks can be based on beliefs and expectations about the therapist or on the patient's self-critical and self-doubting processes. When a block interferes with exploration of a misalliance, generally it is a good idea to first address the patient's avoidance and then explore the patient's belief system or behavior that is causing the block. This approach will facilitate the expression of the underlying feeling or need that led to the misalliance. The end process in the repair of misalliance is the patient's free expression of feelings or needs to the therapist, who authenticates and confirms the patient's communication. In the course of this exploration, the therapist should be mindful of his or her contributions to the rupture in the alliance and should openly communicate such concerns to the patient.

Conclusions

A major challenge for our field is to provide patients with effective and comprehensive treatment. An integrated psychotherapy that includes dynamic, analytic, interpersonal, relational, and cognitive-behavioral techniques as well as medication when indicated appears to offer such treatment. The new psychotherapy training requirements for psychiatry residency programs may help produce psychiatrists who can work with a number of psychotherapy approaches, but they will need to learn how to integrate different psychotherapy models and techniques. ♦

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