

***Commentary on The Case of Ms. Q: A Demonstration of Integrative Psychotherapy*
Guided by “Core Clinical Hypotheses”**

A Contribution to Psychotherapy Integration

GEORGE STRICKER^{a,b}

^a Argosy University, Washington, DC

^b Correspondence should be sent to George Stricker, Argosy University-Washington DC,

1550 Wilson Boulevard, Ste. 600, Arlington, VA 22209

Email: geostricker@gmail.com

ABSTRACT

Ingram (2009) presents a case study conducted within her model of psychotherapy integration, a systematic approach that takes several factors into account. Within the integration field, Ingram’s model can be classified within the bounds of “Technical Eclecticism,” and is more encompassing than other similar approaches. The approach can be improved by greater attention to cyclical factors among her categories, but it remains an important contribution. Her interesting case study demonstrates how her system can be applied.

Key words: psychotherapy integration; technical eclecticism; integrative psychotherapy

Ingram (2009) has described the interesting case of Ms. Q using her particular integrative approach, which I will hereafter refer to as the “Integrative Psychotherapy” model (see Ingram’s [2006] detailed book on the model). I am pleased to be able to comment on this presentation and, in doing so, will divide my remarks into two sections. The first will place Ingram’s contributions within the general corpus of psychotherapy integration, and the second will be reserved for specific comments about the case.

PSYCHOTHERAPY INTEGRATION

Within the field of psychotherapy integration, there are four general types of models (e.g., Castonguay et al., 2004; Stricker & Gold, 2006). These include Theoretical Integration, which strives to encompass previously quite different theoretical perspectives within a single, coordinated theory; Assimilative Integration, which maintains a single orientation but incorporates techniques from other orientations; Common Factors Integration, which strives to find and develop common elements from across different theoretical points of view; and Technical Eclecticism (also referred to as Technical Integration), which focuses on a combination of techniques drawn from different therapeutic systems without regard for any specific theoretical approach. Ingram’s Integrative Psychotherapy can be classified within this last category. Ingram’s model is far more specific in its details than a Common Factors approach, and her model’s lack of a guiding theoretical formulation rules out Theoretical or Assimilative Integration.

In Technical Eclecticism, therapeutic procedures are not attached to treatment methods or models, and this is clearly true of Ingram's Integrative Psychotherapy. It is comparable in approach to Prescriptive Psychotherapy (Beutler, Consoli, & Lane, 2005) and Multimodal Therapy (Lazarus, 2005a, 2005b). In comparison to these two, Ingram's model is much closer in style to that of Lazarus and Multimodal Therapy.

Ingram and Lazarus both begin with a careful assessment of the client and are guided by a comprehensive set of categories. For Lazarus there are seven modalities of human experience and functioning that include the dimensions of Behavior, Affect, Sensation, Imagery, Cognition, Interpersonal, and Drugs/Biological—which as a whole Lazarus refers to with the acronym "BASIC-I.D." For Ingram it is a combination of four treatment models (Behavioral and Learning; Cognitive, Existential and Spiritual; and Psychodynamic) as well as three other areas that also generate hypotheses about causation (Biological; Crisis, Stressful Situations, and Transitions; and Social, Cultural, and Environmental). I prefer Ingram's list to that of Lazarus because of her willingness to acknowledge the potential contribution of Psychodynamic concerns and the explicit attention to Existential and Spiritual issues.

I also note the similarity of her approach to the three-tier approach that Gold and I have developed (Gold & Stricker, 1993; Stricker & Gold, 1988; Stricker & Gold, 2005) within our assimilative psychodynamic integration approach (Gold & Stricker, 2001; Stricker & Gold, 2002; Stricker & Gold, 2005). In the three-tier approach, we divide our concerns into behavior, conscious experience (perception and cognition), and unconscious dynamic factors. Ingram has anticipated a clear difficulty in our approach by acknowledging the important role of Social, Cultural, and Environmental factors, and we will include these in future works. I also applaud her explicit concern for Existential and Spiritual issues, which might fit within our tier concerning conscious experience, but deserves the specific attention that she gives to them.

One area with which Ingram (and Lazarus) does less well with is an acknowledgment of the interrelated nature of all of these areas of concern. It is important to recognize that Ingram's seven categories are not seven independent areas to be explored, but rather that each one impacts the other. As a result, we become clear that it is of little concern where our initial intervention occurs because of the synergistic effect that each area has on the other. Without the concepts of interrelatedness and cyclical impact (Wachtel, Kruk, & McKinney, 2005), a more mechanical pattern of interventions arises.

It is interesting to note Ingram's experience in choosing her integrative theoretical approach in treating Ms. Q:

Prior to this client, I had effectively integrated ideas and treatment methods from cognitive and existential approaches in my work as a staff member and part-time independent contractor for university and community clinics. After taking a course in the [Self Psychology] work of Heinz Kohut at a psychoanalytic institute, I decided to enroll in a postdoctoral training program to learn more about this theoretical model. When I started seeing the client, my intention was to put aside my prior methods and techniques, and wholeheartedly embrace the psychoanalytic approach that I was studying. Instead, I discovered that I was constitutionally incapable of not being integrative. Fortunately, I had a supervisor for this client who saw me in his private practice office and who accepted that I

was seeking to integrate what I was learning rather than to convert to a new orientation. (pp. 1-2)

This description precisely reflects the experience of many people who identify with psychotherapy integration, in that they recognize the value of orientations other than their own, but want to work in a variety of ways that best serve the client rather than to convert to a new set of narrow convictions. Ingram thus clearly belongs in the tradition of psychotherapy integration, as she recognizes, and it is now time to turn to the application of this imaginative system to the particular case that she presented (Ingram, 2009).

THE CASE OF MS. Q

Before beginning a review of the case of Ms. Q (Miscue?), there are several important issues to cover. First, Ingram notes that she has changed several details to protect the anonymity of Ms. Q, “in the extremely unlikely event that she should read this article.” The changing of names and of inconsequential details is common practice and raises no concerns. However, this ordinarily is done to protect the client from being revealed to others who may read it, a less unlikely scenario. As for protecting the client herself, in my view the much better action is to ask the client, if available, for permission to use her data for a case report, allowing her to read it if she wishes, and abiding by whatever her wishes might be. I have done that several times, have always received permission (a question may be raised about whether there is implicit transference coercion, although I always try to minimize it), and usually there is a positive benefit from this obviously mutually respectful and collaborative intervention.

The structure of the sessions with Ms. Q varied over time and setting. Treatment followed the increasingly common pattern of extended sequential therapy rather than a single continuous episode. As such, this may be viewed as two or three therapy episodes rather than a single one. There is some value in this emerging pattern, for it allows the client time to consolidate therapeutic gains and focus on new issues. Usually, as in this case, this pattern is brought about by external factors, such as payment policies and changes in living arrangements, but it rarely is destructive to the flow of treatment. The point I want to note is that Ingram continued the treatment at the same fee. I applaud her for this decision. All too often, I have seen candidates in psychodynamic training settings, such as Ingram in this case, or young therapists moving from clinic settings to private practice, who agree to continue with their patients but only at an increased fee. Given the powerful nature of the therapeutic relationship, there is the potential for exploitation in this offer, and it is noteworthy that Ingram resisted the temptation to do so. I also have some concern (about typical candidates, not Ingram) when the patients, who are being treated at a reduced fee, are made to feel in a second-class status by the juggling of their appointment times in favor of more privileged full-fee patients.

Ingram notes that her sources of data, besides what the client told her, included external information about Ms. Q’s writing and about her husband. There are no ethical issues raised by this as long as Ingram did not seek out information from others about the husband (and there is no indication that she did), but there is a very interesting therapeutic point that it raises. How important is such external confirmation? As long as Ms. Q is committed to a career in writing, must we (can we) judge how talented she is? As long as she sees her husband as stifling her

growth, does it matter whether he really is doing so? I certainly can see arguments that claim that such information is important because they would help to introduce reality into the treatment planning, but there also is a point of view that suggests that the only reality that matters is that of the patient. My position is somewhat intermediate, but it matters less what I think; what is most important is to raise awareness and encourage discussion of this issue within the psychotherapy community.

Finally, at least for these pre-treatment comments, it must be noted that a case study inevitably leaves out data and changes some things that are included to protect anonymity. As a result, any of my comments may turn out to be incorrect because of a lack of sufficient information, and Ingram may have done exactly what is suggested but failed to record it for reasons of space or privacy.

For Ingram, psychotherapy begins with a thorough assessment and the establishment of outcome goals that are directly related to the identified problems. No specific mention is made of necessary attention to the establishment of a therapeutic alliance, but the goals and tasks that are mentioned are two of the necessary components of an alliance (Bordin, 1979). The third component, the bond, although not specifically mentioned, almost surely was established given the description of the case.

It is critical to establish mutually determined goals that can be altered in the course of therapy, as this strengthens the bond, provides the basis for a treatment plan and subsequent interventions, and allows for feedback about progress. In terms of this monitoring of progress, Ingram notes that “the ineffectiveness of a technique does not invalidate the usefulness of the [case formulation] hypothesis” from which it was deductively derived. I agree, but it is equally important to note the logically parallel point that the effectiveness of a technique does not necessarily validate the usefulness of the hypothesis from which it was deductively derived, since frequently a particular technique can be effective for a variety of potential reasons. This is a less frequently noted aspect of treatment, and important to keep in mind.

Ingram indicates that she places a great deal of importance upon an ongoing monitoring process. Although she doesn't mention it, this monitoring process is probably the most evidence-based treatment that is available at the present time, especially in actual practice settings. Rather than a series of highly controlled, experimental studies indicating some limited support for the use of techniques that, themselves, only contribute a relatively small amount of variance to change (Wampold, 2001), the process of feedback has significant demonstrable value (Lambert, 2007). In addition, it places the clinician within the local clinical scientist model (Stricker & Trierweiler, 1995; Trierweiler & Stricker, 1998), as information learned within the therapy session is used to advance treatment, both with the same patient and with future patients.

In terms of Ms. Q's treatment goals, it isn't clear how the attainment of subjective goals such as making good decisions can be evaluated without a judgmental dimension entering into the treatment. Other problems, such as Ms. Q's lack of confidence and frustration, are better divided into two so that they can be worked on and evaluated separately. In regard to the judgmental dimension, this is particularly apparent in the instance when Ingram asked Ms. Q

about her child's feelings when she failed to tuck him in at night. She appropriately referred to as an example of countertransference.

This occurs again when Ms. Q decided not to enroll in the writing program, but instead to rent an apartment and live on her own while pursuing her writing career. Ms. Q was very proud of this choice, and it seems as though Ingram agreed as well. However, was this a good choice? Who can say? I would be inclined to support the patient's choices whether or not they agreed with my preferences, as long as they weren't obviously destructive. However, here again, the threshold for perceived destructiveness will vary as a function of the attitudes of the therapist. The acceptance of the approach of the client is consistent with Client-Directed Therapy, a new and interesting common factors approach to integration (Duncan, Sparks, & Miller, 2006).

One obstacle to blending cognitive and psychodynamic approaches is that the former is more directive and the latter more expressive. Providing direction, such as with Ingram's regard for the welfare of Ms. Q's son, may serve to compromise a stance that encourages free expression. This is an inescapable concomitant of an integrative approach, and it is necessary to recognize that techniques that mean one thing within a home approach may mean something entirely different within a different or more integrated approach.

I applaud Ingram's focus on strengths, as this too is often overlooked. It is the patient's strengths that can be the basis of constructive developments within treatment, and also the recognition of strengths is helpful in promoting the therapeutic bond and increasing the patient's hope of success, which often is integral to therapeutic gains. The strengths that are listed include both internal strengths, such as Ms. Q's intelligence, and intra-therapeutic strengths, such as her ability to provide feedback within the treatment. It is important to keep both in mind, as they both contribute to success in the treatment.

During the first session Ingram asked Ms. Q to consider both individual and couple therapy. This is an often overlooked aspect of treatment that should be required as part of informing the patient about the risks of treatment. Ms. Q clearly preferred individual treatment and valued her growth more than her marriage, but that is a choice each patient should be allowed to exercise, and the only correct answer is the one that is consistent with the patient's goals. Problems arise when the patient is not alerted to the difference between the two modalities, and to the likely effect of the choice on the patient's individual growth and relationships.

I do have some concern with what appears to be Ingram's willingness to accept Ms. Q's words for her problems without asking for details. Thus, we have goals concerning Ms. Q's impulsivity and her inclination to flee situations, but it isn't clear from the material presented that either of those are present. For example, I often see patients who are frightened of their anger, but when asked when they acted in an angry way, they are at a loss for examples. I do not deny that anger is a concern, but it is an impulse rather than an action that is to be feared. In Ms. Q's case, I suspect her declared inclination to flee also is more an impulse than an action, and so the solution would rest more in understanding the impulse than in coping with its expression.

Ingram does use the technique of asking for examples when Ms. Q thought her husband would become symptomatic if she were to become more successful. This was very effective in correcting a misperception of the consequence of success. Interestingly, Ingram refers to this as cognitive therapy, and it is, but it also is an intervention that would be very comfortable for a psychodynamic therapist.

Similarly, in discussing Ms. Q's feelings toward her husband, Ingram used techniques that she accurately sees as consistent with Greenberg's Emotion-Focused Therapy (Elliott & Greenberg, 2007), which, in turn, is a derivative of Rogerian thought. It is interesting to note that the work of Kohut (1977), which also influenced Ingram, is very similar to that of Rogers (Kahn, 1985). They agree on the central role of empathy in the therapeutic relationship, a point also emphasized by Ingram in her description of the treatment. Very often techniques from entirely different theoretical orientations are similar to each other, and this makes the task of integration a good deal easier if one is not caught up in the rigidity of any single system. However, the previous caution about the changing meaning of similar techniques when placed in different theoretical systems is particularly appropriate here.

The use of chair work, a technique familiar to humanistic therapists and often integrated in the work of therapists with other approaches, was resisted by Ms. Q, but the patient's idea of accomplishing the goals of chair work without changing seats was accepted by the therapist. This is a good example of flexibility, as the goal of the technique is more important than the actual execution. The goals were consistent with Ingram's "inner parts" hypothesis, and often chair work is used whenever ambivalence is an issue.

Ingram uses a technique of cognitive labeling that I find very useful. It helps to normalize some behavior, as it did in the case of Ms. Q, and also to help her to develop better skills. I also have found that labeling serves many other purposes. By identifying and naming an emotion, it conveys empathy and thereby strengthens the therapeutic alliance. It also gives the patient a sense of mastery, as a named emotion is also an acknowledged and thus owned one. Normalization takes the feeling out of the realm of the mysterious, which tends to reduce the helplessness that accompanies the unknown.

During the second phase of treatment, Ms. Q was able to access a sense of never having gotten anything without having to work for it. I can imagine that this was an important insight and very moving for the patient. However, I also wonder whether she had been given a good deal without having to work for it before her brother's birth, and it was the contrast between her rich early years and the subsequent deprivation that was so difficult for her. This brings up some fascinating questions. Is this reformulated insight superior in any way to the one that Ms. Q achieved? Does the "historical truth" of the observation matter if the "narrative truth" is meaningful to the patient? (On this distinction, see Spence, 1984.) In line with the latter, I am inclined to think that the most important thing is to provide the patient with a coherent and credible attribution for feelings and actions, and these can be the vehicle for therapeutic progress even in the absence of historical correlates.

In the last phase of treatment, Ms. Q indicated that her husband's infidelity made it easy for her, as he had made her decision for her. This may be, and much might have been untold

about this episode, but I would have preferred to see Ms. Q take responsibility for her decision. However, it doesn't matter much what I (or any other therapist) would have preferred; if this construction is what enabled Ms. Q to move on with her life, who is to say that she should view it differently? That brings about a very important question, as to the extent to which a patient's vision should take precedence over that of the therapist. There is an exciting new approach (Duncan et al., 2006) that suggests that the patient is always right, and so the patient's theory of change should be placed before the therapist's. Although I am not completely sold on this extreme formulation, there is much to recommend it, and it certainly is worth considering in this case. It also should be noted that Ingram appears to have taken Ms. Q's formulation into account, and the therapy progressed from that point forward.

Given the apparent success of the treatment, I would have been very interested in asking Ms. Q, at the last session, what she felt were the mutative factors in the process. I routinely do that with my patients and never fail to be surprised by what they say. They often mention events as being critical that I have long forgotten, and fail to remark about what I saw as turning points. There is no right or wrong about this at our current state of knowledge, but it does give one cause to pause and to reconsider strongly held beliefs. Perhaps this disparity is consistent with the notion of client-directed treatment (Duncan et al., 2006) referred to above, and should give us more reason to listen to our patients at least as much as we would like them to listen to us.

I find it fascinating that Ingram wrote the following:

At the time, I was trying to learn a psychodynamic orientation and frequently felt embarrassed and annoyed at myself for violating the rules: I spoke too often, I "broke the frame" by giving opinions and validation of her strengths, and I destroyed opportunities for transference to develop by being too spontaneous, self-disclosing, and genuine. (p. 25)

At the initial meetings of the Society for the Exploration of Psychotherapy Integration (SEPI; <http://www.cyberpsych.org/sepi/>), this sentiment was repeated frequently. Therapists trained in several different orientations had found themselves doing things that they would have been reluctant to confess to supervisors, yet that were effective for their patients. The heart of psychotherapy integration, the movement within which Ingram clearly belongs, is that old rigidities hamper rather than aid the treatment process, and there is much that we can learn from each other. Ingram's notion of the "ever-evolving itinerary" within treatment captures the sense of psychotherapy as a process, which is the essence of psychotherapy integration. Ingram has made an important contribution to psychotherapy integration with her clearly presented approach, and some of her embarrassment, although understandable, might better be seen as a point of pride.

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