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Response to Commentaries on The Case of Ms. Q: A Demonstration of Integrative Psychotherapy Guided by "Core Clinical Hypotheses"

Where Does the "Core Clinical Hypotheses" Model Fit Among Models of Integrative Psychotherapy?

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ABSTRACT

Stricker (2009), Grinfeld (2009), and Lampropoulos (2009) provide three types of commentary on my case of Ms. Q (Ingram, 2009): feedback on my handling of psychotherapy with this high-functioning client; critical evaluation of my "28 core clinical hypotheses" model; and discussion of where this model fits within four categories of integrative psychotherapy—common factors integration, theoretical integration, assimilative integration, and technical eclecticism. In this response I focus on each topic in turn, and conclude with a discussion of the training of clinical graduate students as integrationally-oriented psychotherapists.

Key words: psychotherapy integration; integrative psychotherapy; case formulation; client treatment matching; clinical psychology graduate training; core clinical hypotheses

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Writing the case of Ms. Q (Ingram, 2009) was an absorbing, enlightening experience. It not only allowed me to describe how I handle choice points in therapy using my 28 core clinical hypotheses model (to be called "28CCHM" throughout this article; Ingram, 2006), but also enabled me to improve my teaching and supervision of clinical psychology graduate students. Reading the commentaries of people who share my core value of providing the best possible treatment for each unique client—two highly-regarded experts in integrative psychotherapy (Stricker, 2009; Lampropoulos, 2009), and an extremely knowledgeable and articulate graduate student who resonates to my approach (Grinfeld, 2009)—has been what I can only call, in the language of humanistic psychology, a peak experience. Their feedback rewarded me with the pleasure of being understood, appreciated, and commended for my contribution; challenged me to sharpen my thinking and increase the clarity of my communication; and invited me to address broad issues that affect the theory, practice, and training of integrative psychotherapy. Throughout this article I will be referring to specific hypotheses by codes, and the charts at the end of Ingram (2009) will provide further explanations.

EVALUATION OF THE CASE OF MS. Q

Writing a case study for public scrutiny, unlike writing an article on theory or research, puts the writer in a vulnerable, exposed position. So it was with gratitude and relief that I discovered that Stricker (2009), Grinfeld (2009), and Lampropoulos (2009) each made positive comments, providing me with the enjoyment of being both understood and appreciated. Stricker praised things that I had not even recognized as praiseworthy, such as not raising the fee when I moved from a nonprofit training clinic to private practice, and providing the client the choice between individual and marital therapy, instead of assuming that individual therapy was the treatment of choice. He recognized my emphasis on empathy and the therapeutic alliance, even though I had not made that explicit in my case report; appreciated my focus on strengths; and described my ongoing monitoring of progress as "probably the most evidence-based treatment that is available at the present time" (p. 46). Lampropoulos noted "the level of sophistication in assessing, conceptualizing and treating a client integratively via the use of the 28 core hypotheses," and recognized that tailoring the conceptualizations to the "needs and dynamics of the client at many different levels" increased the chance that "the client would find them meaningful and beneficial in therapy" (p. 53). Grinfeld approved that I was "monitoring responses to interventions so that those that the client does not find helpful can be abandoned while those that resonate are pursued" (p. 59). She also commended my approach for incorporating the three components of the APA's Evidence-Based Practice in Psychology (EBPP; APA Presidential Task Force, 2006): (1) research evidence, (2) clinical expertise, and (3) patient characteristics, culture and preferences.

All three of the commentators gave me credit for the comprehensiveness of the 28 hypotheses, and the fact that the hypotheses incorporate domains that are usually neglected in clinical practice. Lampropoulus honored me with the statement "she has done an important job in presenting the gist of major theories and concepts that an integrative/eclectic student or clinician ought to know to practice integratively at a basic level" (p. 53). Both Grinfeld and Stricker appreciate my inclusion of hypotheses from two of the seven domains, *Existential and Spiritual,* and *Social, Cultural, and Environmental*; and Grinfeld, additionally, noted the benefit of the *Crisis, Stressful Situations and Transitions* category.

Delight at reading the commentaries came not only from positive feedback but also from discovering new language to describe my approach. From Stricker I learned the succinct term "local clinical scientist model" for what I have been describing as "empirical validation through single case design." I have been using the term "intermittent" to describe therapy with multiple episodes, and henceforth I will prefer to use his term, "extended sequential therapy." I was especially gratified by the way Grinfeld grasped and described a level of the process in my treatment of Ms. Q that I was completely unaware of:

> Ingram's choice to follow the client's "orientation preference" … seems … to constitute an *empathic attunement to process* [my italics] as well as to content, furthering not just the working alliance but also Ms. Q's sense that her needs can be acknowledged and met (p. 63).

Those words elegantly described my intentions and their impact, and, incidentally, demonstrated unmatched empathic attunement to *my* content and process.

I greatly valued the criticism and suggestions from the commentators. For instance, Stricker rightly said that it would have been desirable to get the client's explicit permission and have her review the document (unfortunately this was impossible given the length of time since the termination of therapy), and Lampropoulus pointed out the disadvantage of not providing standardized quantitative measures as did Clement (2008) in his case study in a prior issue of this journal. Grinfeld made the excellent point that most clients, unlike Ms. Q, will not directly provide feedback about which hypotheses resonate and which do not, and may in fact prefer straightforward explanations from a therapist who takes a more authoritative role. For those clients, the most empathically attuned process would be for the therapist to function in the role of confident expert who makes treatment decisions from a single model, as, in fact, would occur when there is a specific empirically-supported treatment that is the best match for the client's problem.

Stricker posed challenging questions that allowed me to clarify my thinking on issues I had not previously addressed directly:

> How important is such external confirmation [of her talent for writing]? 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? (Stricker, 2009, pp. 45-46).

These were not rhetorical questions but ones that are open for debate, and the answer must be grounded in specific case data. In the case of Ms. Q, I believed that it was vitally important to determine that her aspirations were realistic rather than being grandiose fantasies or utopian goals. In a different case—say, a client who talks with pleasure about her beautiful new house—I would not take a drive to her address to see if I agreed with her opinion. In the latter example, it is a question of values, taste, and personal definitions. Moreover, it is a fait accompli; the client has already made a choice, and she is satisfied with it. In Ms. Q's case, she was faced with making decisions that would have dramatic repercussions for her marriage, her child, and her lifestyle. Moreover, the issue was one of defining outcome goals, and the importance that goals be realistic and attainable. (This topic is discussed in detail in Ingram [2006] in Chapter 12). I believe that an important task of a therapist is to help clients set goals that are not only possible, but also, when attained, will increase their life satisfaction, enhance their self-worth and self-efficacy, and not result in unexpected collateral damage. For me, failing to challenge a client's unrealistic goals would be equivalent to failing to mention a banana peel on the person's path.

Questions about external verification of the clients' beliefs allow me to elaborate on the importance I place on working jointly with the client to gather data about "reality" so that the client (not just I) can ascertain the fit of her "model of the world" with the evidence of experience (meaning both her sensory, lived experience, and the "reality" that receives consensual validation from outsiders.) In his article, Stricker wondered if I had gathered details about her impulsivity and inclination to flee situations, noting the importance of distinguishing

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between an internal state that has never been acted on, and a tendency to action that has been demonstrated in the past. This client told a highly detailed narrative of her life, including specific episodes that she labeled "fleeing," including leaving home without advance preparation at 18 and leaving her ex-boyfriend without communicating her intentions. Had she not been so forthcoming, I would have asked questions like, "How do you define 'fleeing'?" "Have you ever done that before?" "Can you give me an example?" "Please tell me the story of that experience, from beginning to end." My knowledge about data-gathering questions comes in part from what Bandler and Grinder (1990) called the "metamodel," defined as a set of linguistic information-gathering tools, and described in my book (Ingram, 2006, pages 40-44) as an essential interviewing skill. Questions that require the client to check his or her cognitive map against the data of their personal experience are necessary for evaluating the extent to which that map is faulty (**C2**—Faulty Cognitive Map). Questions that allow the therapist to evaluate the client's information processing skills **(C3)** not only identify weaknesses, but also "hook into" the reality testing part of the client's mind and reveal strengths in scientific thinking skills. Answers to those detail-oriented questions allow the client to flesh out and evaluate her personal narratives, as well as modify faulty thinking such as overgeneralization ("Can you think of an example when that didn't happen?") and self-imposed limits created by "can't" and "should" ("What stops you?" "What would happen if you did?" "What would happen if you didn't?").

Another challenging question from Stricker was this: "Does the 'historical truth" of the observation [about early childhood experiences] matter if the 'narrative truth' is meaningful to the patient?" He proposed that "coherent and credible attribution for feelings and actions … can be the vehicle for therapeutic progress even in the absence of historical correlates" (Stricker, 2009, p. 48). Reading this, I felt comfortably in the terrain of Jerome Frank (1961) who suggested that the common elements of successful change interventions were a *plausible* explanation, and a logically-connected ritual. I believe that while the lack of verifiable historical data is not an impediment to successful therapy outcomes, credibility and plausibility are enhanced when there is confirming evidence from past experience, and the search for evidence is hugely beneficial for building clients' ability to evaluate and update their cognitive map **(C2)** and reframe the experiences that led to maladaptive repetitions of past experiences **(P2).**

This discussion leads me to pose a question to myself: "How do I reconcile my view that the client is the director or collaborator in the direction of therapy with my belief that I have a responsibility to clear up illusions or misconceptions?" Stricker pointed out my judgmental position when Ms. Q. decided not to leave the state to enroll in a writing program, but instead to rent an apartment near her child, and live on her own while pursuing her writing career. He comments, "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?" (Stricker, 2009, p. 47). While Stricker would be comfortable putting his preferences aside as long as the outcome of the client's choices were not obviously destructive, I would be integrating several hypotheses to help the client enhance the quality of her decision by correcting faulty information processing **(C3)**, liberating herself from the need for defensive processes **(P4)**, reducing the need for conditioned emotional avoidance **(BL2)**, and realistically appraising the consequences of choices in terms of values and responsibilities **(ES2).** Stricker is correct that I did approve of Ms. Q's choice, and even showed my approval, because it seemed to be a good compromise between fulfilling her need for

freedom and embracing her responsibility to consider the emotional impact on her son. I confess that my tendency to judge according to my own values has been my biggest countertransference challenge, and has put at risk the safety and acceptance that clients need in order to express everything they think and feel. (I have learned that growing up with a mother who believed "I know what is best for you" was not the best preparation for a psychotherapist.)

EVALUATION OF THE 28 CORE CLINICAL HYPOTHESES

One of the weaknesses pointed out by Grinfeld was that the list of 28 hypotheses was not as comprehensive as I believed, citing the omission of process variables and treatment approaches. Grinfeld's comments give me a chance to clarify the importance of distinguishing core clinical hypotheses and "treatment approaches that have been shown to be effective in therapy." The hypotheses are building blocks for the assessment (also referred to as conceptualization, formulation, or explanation), which is (a) consistent with the data of a specific client; and (b) focused on explaining the cause, maintenance, and potential resolution of specific problems. The treatment plan then (a) follows logically from specific hypotheses, (b) is focused on attaining outcome goals; (c) specifies in detail strategies, techniques, and therapeutic process dimensions; and (d) is a good match for the specific client's values, preferences, and abilities.

Grinfeld points to omissions in the list of 28, such as: transference and countertransference, attachment theory, and acceptance-based therapy (e.g., Hayes' [2004] Acceptance and Commitment Therapy and Linehan's [1993] Dialectical Behavior Therapy). I believe that my hypotheses, explained in detail in Ingram (2006), incorporate these ideas.

Transference and Countertransference. Psychodynamic hypotheses (Ingram, 2006, Chapter 8) lead to the use of countertransference and transference as opportunities to discover, in the here-and-now of the therapist-client relationship, the early childhood origins, repetitious patterns **(P2)**, and unconscious feelings and conflicts **(P4)** that have led to the client's current difficulties. When **P3** is applied, the transference represents the activation of unmet early childhood needs, rage over failures of empathic attunement, and the mobilization of hope that the client's needs for mirroring, soothing, and someone to idealize can be met in a close relationship. Furthermore, the conversation between client and therapist about perceptions and feelings that can be classified as transference and countertransference help build communication skills **(BL3)** and foster a healthy, authentic relationship **(ES1)**.

Attachment theory. This topic is addressed in my book (Ingram, 2006, pp. 302-303) in the section on hypothesis **P2**, Reenactment of Early Childhood Experiences. The relationship difficulties of adults can be described in terms of different attachment styles, which have their roots in early childhood experiences with caretakers**.** Furthermore, attachment theory contributes to an understanding of the dynamics in family systems **(SCE1).**

Acceptance and Commitment Therapy. Hayes's Acceptance and Commitment Therapy (ACT) can be "unpacked" to illustrate that it is an integration of several hypotheses from my list. Acceptance stems from a set of beliefs (**C2**) about what can or cannot be changed by the efforts of the client, and is achieved by using mindfulness strategies, which I describe in my discussion

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of hypothesis **B3** (Mind-Body Connections). When clients are taught to "just notice," in a detached way, their private events, especially the most distressing ones, they are learning a different way of processing information (**C3**) and are quieting disturbing self-talk **(C4)**. The instruction to clients to access the part of the self that is observing and experiencing (rather than identified with thoughts, feelings, sensations, and memories) is consistent with the Internal Parts hypothesis **(P1),** which embraces theories such as Psychosynthesis, Gestalt Therapy, and Transactional Analysis. If ACT helps clients to clarify their personal values, take action on them, and bring vitality and meaning to their lives, then it clearly incorporates the existential hypotheses (ES1 and ES2). I assume that once the individual commits to a goal and begins to take action to achieve it, then issues of conditioned emotional avoidance (BL2) and skill deficits (BL3) can be addressed.

Linehan's Dialectical Behavior Therapy: Linehan's (1993) approach is described in my book (Ingram, 2006, p. 434) as an excellent model for defining problems in terms of "skill deficits," which can then be treated with various skill-building approaches (**BL3**). The skills of "emotional regulation" (p. 182) are also discussed in the section on hypothesis **B3**, Mind-Body Connections, as tools for coping with stress and achieving self-management of arousal level (pp. 91-92).

On the other hand, I accept that the list of 28 is a work in progress. Whenever I discover a new theory, treatment approach, or orientation, I seek to "unpack" the bundled and branded model, to find the component hypotheses. It is my hope that as people discover and familiarize themselves with my chosen list of hypotheses, there will be fruitful collaborative work to refine, expand, and reorganize the list, as needed.

The analogy of a computer directory system will increase understanding of the structure of the model of clinical hypotheses and its potential to be expanded to embrace all knowledge relevant to planning effective mental health interventions. The seven domains (Biological, Cognitive, Psychodynamic, etc.) are like directories in a computerized information system; each hypothesis is like a subdirectory; and within each hypothesis subdirectory there are additional subdirectories which contain files with information about the hypothesis, its associated treatments approaches, when it is a good match, and with which other hypotheses it easily integrates. Some files have only a paragraph, others comprise the content of books or the experiences of extensive training.

Significantly, the same files can be found within the subdirectories of different hypotheses: this is why it is expected for there to be overlap among hypotheses, and the criterion of mutual exclusivity is not met. Here is an illustration of a small part of one of the domains.

- Biological Domain
    - Mind-Body Connections Hypothesis (B3)
        - Treatment approaches
            - Acceptance and Commitment Therapy
            - Dialectical Behavior Therapy
            - EMDR
            - Relaxation Training

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With this framework in mind, we can see that there is room to conceptually incorporate all past, present, and future models of psychotherapy, as long as we are willing to unpack each theory into its component hypotheses, and agree that brand names of theories, and the loyalty they demand, are detrimental to the advancement of effective integrative therapy. (Note that in addition to the component mechanisms and processes underlying psychotherapy theories, there is also the issue of the empirical evidence for the efficacy and effectiveness of a theory. For more on evaluating therapy theories on the basis of the empirical evidence that support them, see APA's Evidence-Based Practice in Psychology web site [EBPP; APA Presidential Task Force, 2006]).

In a related vein, in his commentary, Lampropoulos made an intriguing suggestion—the idea of a group of experts getting together and building a comprehensive framework. I of course like his idea of perhaps starting this process with my list of hypotheses.

THE FOUR MODELS OF INTEGRATION

All three authors described the four models of integration: common factors integration, theoretical integration, assimilative integration, and technical eclecticism, citing, among others, Castonguay, Reid, Halperin and Goldfried (2004); Lampropoulos (2001); Stricker and Gold (2006); and Messer (1992, 2001). In this context, they all offered their view of where the 28CCHM fits. Stricker and Grinfeld classify it as technical eclecticism, which, in Stricker's words, "focuses on a combination of techniques drawn from different therapeutic systems without regard for any specific theoretical approach" (Stricker, 2009, p. 43). I agree that my approach is similar to technical eclecticism because of the pragmatic approach of drawing techniques from multiple models with an emphasis on resolving specific problems. However, it differs greatly in that it requires intervening hypotheses (theoretical ideas) between a data base and interventions, as well as deep attention to the client's complex life history, current life situation, and sociocultural context.

Stricker goes on to describe my approach as closer in style to that of Lazarus's Multimodal Therapy (Lazarus, 2005a, 2005b) than to other examples of technical eclecticism. In Lazarus's approach, a specific technique, drawn from a limited range of theories, is paired with a problem within one of the modalities of behavior, affect, sensation, imagery, cognition, interpersonal relations, and biological functioning. I place high value on this list (along with an additional spiritual modality) as a tool for comprehensive data gathering (cf. Ingram, 2006, pp. 34-40), but disagree that it is similar to my list of hypotheses. With Lazarus's approach, for example, recognition that "depression" is a syndrome would be unnecessary; the therapist could treat sadness, difficulty with sleep, negative thinking, and psychomotor slowness as separate, unrelated problems. Furthermore, anyone with that list of symptoms might be treated in the same way; there would be no interest in the various routes by which people arrive at depression, such as difficulties coping with illness and disabilities (**B1**), stress and trauma (**CS2**), loss and bereavement **(CS4),** repetitious patterns of unhappy relationships (**P2**)**,** loss of meaning (**ES1**), and past and current experiences with discrimination and other forms of social injustice (**SCE5**)**.**

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I felt best understood by Lampropoulos's assertion that the 28CCHM fits in the category of theoretical integration models. He states that it "can probably be most accurately categorized as a comprehensive eclectic model, operating within a broad and clearly defined multitheoretical framework" (Lampropoulos, 2009, p. 53). He describes its difference from technical eclecticism in that it "focuses on the integration of clinical hypotheses (as opposed to interventions)," accurately stating that my intention is the creation of integrative conceptualizations, not the combination of varied techniques.

Stricker notes that my approach lacks "a guiding theoretical formulation" (p 43). However, in my book (Ingram, 2006), I provide bases for viewing the 28CCHM as a stand-alone integrative theory that is based on a problem-solving metatheory. The metatheory has requirements for clear problem identification; specification of achievable and verifiable outcome goals; comprehensive data-gathering; conceptualizations that are creative combinations of ideas extracted from established orientations; treatment strategies that are logically related to the conceptualization and that are matched to the unique needs and characteristics of the client; and a commitment to the process of empirical validation of treatment effectiveness. Furthermore, combinations of hypotheses specifically designed for a single client *is* a theoretical formulation, an idea captured in the title of Grinfeld's (2009) commentary, "A New Therapy for Each Patient." My approach to psychotherapy integration is to allow each licensed practitioner to bring creativity to each unique case, with the requirement that theoretical foundations are necessary to assure coherent treatment plans, and monitoring of client change is necessary to assure evidence-based practice.

Thanks to the commentators, I realize that I need to walk those extra miles to further develop the 28CCHM to meet standards of a good theoretical model. I agree with Lampropoulos's recommendation that "some additional guidelines would be helpful in prioritizing and identifying the possible importance of each of the core hypotheses," and that more guidance is necessary for combining hypotheses to assure that they "are compatible with each other and that the integration is coherent and acceptable to the client" (Lampropoulos, 2009, p. 54). Stricker's suggestion that I attend to the interrelatedness of the domains, and to their cyclical impact, will receive my deepest consideration.

My efforts to decide "Where do I fit?" led me to another question: "Why is it important to hold on to that four-category system?" I don't mean to minimize the wonderful achievement of developing that framework, and the valuable body of literature that it stimulates, but I'm concerned that we may do ourselves a disservice by trying to classify within those categories the new models that are being created. The assimilation model is defined in such a way that the therapist must start with a commitment to a "home base" theory; thus people who combine ideas from equally-valued theories by default are described as technical eclectics. I wonder, perhaps from ignorance, whether the need to uphold this classification system springs less from our desire to improve the quality of integrative therapy, and hence benefit our clients, than from a desire to advance our respectability in the eyes of critics of integrative approaches. Stricker reminds us that "old rigidities hamper rather than aid the treatment process, and there is much we can learn from each other" (Stricker, 2009, p. 49). We need to be careful that we are not building orientations of integrationism that create new rigidities.

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TRAINING OF INTEGRATIVE PSYCHOTHERAPISTS

Two of the commentators pointed out the heavy academic and training requirements for competent application of the 28CCHM. Lampropoulos states "one might expect that learning a complex multitheoretical integrative model at the conceptual and clinical level would require significant time and supervision" (p. 55). Grinfeld contrasts deductive and inductive ways of using this model, and shows preference (as I do) for an inductive approach: "Once a clinician has a fund of knowledge about various theoretical approaches, the 28 Core Clinical Hypotheses can be used to synthesize the information already known by the clinician" (p. 65).

Both these commentators help me emphasize the importance of a broad and deep education for psychotherapists. Without it, the use of the list of hypotheses would be a shallow exercise in labeling and categorizing without the competence to plan effective interventions and evaluate their effectiveness. As a review of the topics in the *Social, Cultural, and Environmental* domain (Ingram, 2006, Chapter 9) will reveal, the educational foundations must go beyond traditional psychotherapy and include knowledge of systems (family and organizational), intercultural competence, social psychology, community psychology, and environmental psychology. I further agree with Zeldow (2009) that competent clinicians need to

> know something about the human condition …. (t)he kind of knowledge [that] cannot come from psychology textbooks or the scientific literature alone. It must come from life experience, clinical experience, and at least some immersion in the humanities. (p. 6)

Only with years of academic education combined with years of hands-on clinical training can a psychotherapist be qualified to engage in creative, integrative, evidence-based practice.. In the graduate program where I teach (Pepperdine University's Graduate School of Education and Psychology in Los Angeles), there are many prerequisites before I teach about the 28 hypotheses in both a "techniques of psychotherapy" course and the clinical practicum on-campus meetings.

Grinfeld's commentary provided the graduate student perspective, describing her frustration in educational environments where "reification of theory is the norm" (p. 59). Her descriptions of her own graduate training attached concrete images to my assertion of the negative consequences of being forced to choose an orientation. I have taught at Pepperdine for 31 years, and I was happy to note that this semester, when I asked how many students had been told that eclecticism is bad and they would be in trouble unless they chose an orientation, not one hand went up. About 10 years ago, every student would have raised a hand. Grinfeld's story made me realize that my school is not typical of graduate training program.

The assumption that all therapists start by choosing a single orientation is very deeply ingrained. Sticker explained that people "who identify with psychotherapy integration *…recognize the value of orientations other than their own"* (my italics; p. 45). The implication is that we all start with "our" orientation. That makes sense for perhaps the majority of senior therapists, whose roots were watered in psychoanalytical institutes or cognitive behavioral laboratories. I believe it may be appropriate to question the necessity of having a "home base"

orientation. The current cohort of clinical graduate students may be likely to have teachers with different orientations (including integrative therapy) and to rotate through practicum and internship placements with exposure to multiple ways of working with clients. They see something of value in every approach they learn, and in the process of learning different orientations they may be very comfortable developing integrative treatment plans. I think this is a good thing.

I cannot find better words for closing this article than to quote what Grinfeld said at the end of her article, when she offered the opinion that the 28CCHM "provides graduate students … the opportunity not only to pursue psychotherapy integration within a structured and practiced framework, but also to pursue identities as 'integrationally-oriented' therapists" (Grinfeld, 2009, p. 66). If she is representative of her peers, then we can foresee a future where integrative psychotherapy is widely viewed as the treatment of choice.

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