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Review Article

Psychotherapy Integration: Its Implications for Psychiatry

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Background. The proliferation of psychotherapies has been balanced by an equal and opposite tendency towards integration. Integrative approaches are particularly relevant to psychotherapyin psychiatric settings.

Method. MEDLINE manual literature searches yielded over 250 articles on psychotherapy, integration, which are reviewed in the light of the authors'experience in a district psychotherapy service.

Results. Psychotherapy integration is an umbrella term covering a wide range of meanings: *rapprochement* between different theoretical positions; convergence of ideas and techniques; eclectic selection from many different methods; and integration proper in specifically integrative therapies. Many effective psychotherapeutic treatments for psychiatric disorders are integrative, including those for depression, schizophrenia, bulimia nervosa and borderline personality disorder.

Conclusions. Integration at the level of practice is common and desirable. At the level of theory, clarification and creative conflict are essential. Different therapeutic approaches should work closely together but retain their separate identities.

The “pharmacopoeia” of psychotherapy is vast: Garfield & Bergin (1994) claim that there are now over 400 varieties of therapy. Classification is not easy since therapies may be defined in several diferent ways: by theoretical basis or 'model' (analytical, behavioural, systemic, humanistic, etc); method of delivery or 'mode' (individual, group, family); frequency of sessions; temporal length (very brief, brief, time-limited, open-ended); or any combination thereof (for example, brief individual psychodynamic therapy). In addition, specific therapies often develop their own appellation or 'brand name': e.g. interpersonal therapy, neurolinguistic programming, cognitive analytical therapy (CAT), or transactional analysis. A further complication is the 'trades description problem', which dates back at least to Freud: the discrepancy between what psychotherapists say they do with their patients and what they actually do (Norcros *&* Goldfried, 1992).

Psychotherapy thus provides ample scope for the traditional taxomonic conflict between 'lumpers' and 'splitters'. Scott (1995), for example, recently divided psychotherapeutic approaches to depression into four main types: behavioural, cognitive, analytical and systemic. Margison & Shapiro (1996) objected, arguing firstly that this classification fails to capture the eclecticism and diversity of psychotherapeutic *practice,* and secondly, from a *theoretical* perspective, that therapies can be combined (or integrated) into two main categories: cognitive-behavioural and dynamic-interpersonal.

Definitions

Integration in psychotherapy is not easy to define. It should be seen in the context of two polarities: purity versus integration, and integration versus eclecticism. Beitman (1989) delineated a spectrum of integration ranging through (a) *rapprochement,.* or cordial relations between different approaches; (b) convergence of ideas and practice; (c) eclecticism, a pragmatic stance in which therapists use whatever they think may be helpful to the patient; and (d) integration proper, as seen in self proclaimed 'integrative therapies'. The purpose of the present review is to examine the different meanings of integration and their relevance to the theory and practice of psychotherapy.

Prochaska & DiClemente (1992) distinguished sharply between eclecticism, which produces mosaic therapies combining elements from many different sources, and integration, which attempts to produce

a new approach based on the blending of different ideas. Beitman (1989) described eclecticism as both a "worn out synonym for theoretical laziness" and "the only means to a comprehensive psychotherapy". The therapist must be an "authentic chameleon" (Garfield & Bergin, 1994), yet eclecticism can be little more than a "mish-mash of theories, a hugger-mugger of procedures, a gallimaufry of therapies" (Eysenck, 1970).

An emphasis on purity or integration in part reflects the developmental life of a particular psychotherapy. In infancy, uniqueness and differences from other types of therapy tend to be emphasised, but with maturation similarities and overlaps can be allowed to emerge. The same is true at the level of the individual therapist who usually needs to start by mastering one specific technique, but with experience becomes more flexible and integrative, illustrating Piaget's digestive metaphor of "accommodation" "and "assimilation" as a model for intellectual maturation. Nevertheless, the tension within psychotherapy between advocates of purity and integration continues, and a distinctive field of 'psychotherapy integration' has emerged, with its own literature (Norcros & Gold-fried, 1992). We shall discuss in turn integration at the level of theory; as it affects clinical service delivery; and in relation to specific psychiatric disorders.

Theoretical basis

A central challenge for psychotherapy research is the so-called "equivalence paradox" (Elliott *et al,* 1993) based on the robust research finding that, despite widely varying theoretical rationales and practical procedures, different psychotherapies produce roughly similar outcomes. Psychotherapy intcgrationists have theorised about this finding in at least four ways.

The Tower of Babel in psychotherapy: translating psychotherapeutic languages

One commonly followed route towards the assimilation of one therapy to another has been the attempt to find a common language which encompasses different theoretical perspectives. Thus, for example, in the language of behaviour therapy transference could be seen as exposure to the feared stimulus, and the process of dynamic therapy a prolonged desensitisation to difficult thoughts and feelings. Conversely, there are obvious parallels between the search in cognitive-behavioural therapy (CBT) for underlying rules, expectations and assumptions and self schemata in relation to significant others, and the psychoanalytical notion of a 'representational world' populated by internal objects which is the focus of dynamic psychotherapy (Fonagy, 1995).The explicit paradoxes of systemic therapy and the implicit ones of psychoanalysis can similarly be aligned**.**

These linguistic and conceptual translations, while interesting, do not in themselves lead to change in practice. Esperanto has never caugt on as a universal language; most practitioners cling to their native psychotherapeutic tongue, and relatively few psychotherapy trainings make any systematic attempt to introduce therapists to the range of different psychotherapeutic aproaches.

Common factors in psychotherapy

All psychotherapies have certain 'non-specific' characteristics in common which apply across both theories and cultures. These include: 'remor-alisation',or instillation of hope; the development of a trusting relationship; the presence of a 'healing setting'; and a rationale or conceptual schema which explains the palient's distress. From an integrationist perspective these are the important change agents in psychotherapy, despite the fact that practitioners tend to emphasise their own specific contribution, whether it be acurate interpretation, behavioural prescription or cognitive challenge. To use a pharmacological analogy, it is as though the vehicle for delivering a drug were the active agent rather than the drug itself.

While no doubt representing a healthy check on therapeutic narcissism, the_common-factors approach has not gone unchallenged. There is certainly overwhelming evidence that a strong therapeutic bond predicts good outcomes in therapy. While this might be seen to vindicate a common-factors position, critics have suggested that such findings are in fact tapping into early good outcomes, and that the secure bond is a result rather than the cause of psychological change. In addition, the outcome literature convincingly demonstrates that active therapy generally produces better results than placebo therapy – which might be thought of as common-factor therapy in its pure form, uncontaminated by specificity. Also, there is no doubt that for some conditions there is differential effectiveness, the relative success of ehavioural ompared ith nalytical approaches

in phobic disorders being a commonly cited example.

Feedback loops In psychotherapy: the procedural sequence model

The 'common factors' position is essentially an empirical finding, and needs to be assimilated to a more complex theoretical schema, Ryle (1990) based his integrative stance around what he called the "procedural sequence model". He argued that mental life - intentions, desires, choices, relationship patterns - is maintained by a circular sequential series of steps: perceptions, appraisal and planning, enactment, evaluation of the consequences of enactment, revision of plans, further perception, and so on. Psychological difficulties can occur anywhere along this chain: faulty perceptions, appraisal based on archaic assumptions, difficulties with enactment, inability to revise plans, and so on, and these tend to be self-perpetuating. Equally, psychotherapeutic intervention directed at any one point will have consequences throughout the entire loop. Thus behavioural therapy might enhance a patient's ability to put his or her plans into action; this in turn will, via revision of plans, lead to changes in assumptions and self-appraisal ("I am no longer a person who cannot go out of the house"). Conversely, psychodynamic therapy directed at appraisal and assumptions will in time lead to changes in enactment ("Now I feel better about myself I have discovered that I can go out of the house"). Teasdale *et at* (1995) similarly argued that low mood is "locked in" in depression by an interrelated combination of specific propositional meanings (CBT's negative assumptions), implicit meanings (akin to analytical therapy's unconscious guilt) and postural feedback loops (emphasised by 'humanistic' therapies). In contrast to Ryle, however, Teasdale suggested that therapy may have to tackle a/l of these levels if it is to be effective.

Stages of change: the assimilation model

The notion of the sequencing of psychological processes is not new. Caplan's Crisis model used a Piagetian schema in which crises lead in turn to arousal, disorganisation, attempts at mastery, finding new solutions and finally resolution, Attachment theory similarly sees a sequential set of stages in response to loss: denial, protest, searching, despair and acceptance. Freud's notion of 'working through' implies that insight alone in dynamic therapy is not sufficient and needs to be followed by further stages of consolidation and practice (Bateman & Holmes, 1995).

The assimilation model proposed first by Stiles *et al* (1992) proposed an overarching psychotherapy whose task is to assist the patient in the "assimilation of problematic experience". They described a developmental sequuence from 'warded off' feelings, through the intrusion of unwanted thoughts and vague awareness of difficulties, to problem clarification, understanding/insight, application or enactment, problem solution and, finally, mastery. The assimilation model provides a theoretical rationale for theoretical integration. In their view, different stages of this common sequence.Based on the Sheffield Psychothejrapy Project, in which therapists are trained to be equally proficient in psychodynamio-experiential and cognitive-behavioural techniques, Stiles and colleagues have shown how dynamic therapy impacts mainly at the stage of evocation of warded-off (i.e. repressed) thoughts, while CBT focuses more at the level of enactment.

Clinical Integration

In clinical practice, integration can be achieved in a number of different ways: in choice of psychotherapy model, by the way in which psychotherapy delivery is organised, and through the techniques of the individual practitioner.

Hybrid models

Many 'brand name' (often acronymic) therapies are genuine hybrids, bringing together elements from different practical and theoretical perspectives. Cognitive-analytical therapy, for example, combines a therapeutic *framework* that has many cognitive-behavioural elements - the use of formfilling, homework assignments and a collaborative stance - with session *content,* which is psychodynamic in flavour,emphasising the significance of loss in an unashamedly time-limited therapy, but only focusing on transference when appropriate. Dialectical behaviour therapy (DBT) appears to produce good results in controlled studies of the traditionally very difficult group of people with borderline personality disorder (Linehan, 1993). DBT explicitly combines here-and-now anxiety control training with more traditional cognitive techniques, and a strongly behaviourally-influenced emphasis on the therapeutic contract. It is 'dialectical' in that it offers the patient apparently

contradictory messages of both 'no change' (focus on the present moment) and 'change' — the patient's task being to synthesise these antitheses. There are many other hybrid models currently in , use, often associated with a particular charismatic practitioner, a point which in itself warrants further research.

Cormorbidity/combined therapy models

Most patients have several defferent kinds of psychological dificulty. Some integrarive therapists argue that each needs to be tackled in its own right. A packag of treatments, is required if all the patient's deficits and difficulties are to be addressed. The more ill the patient - and thus the more likely they are to be treated within a publicly-funded healthcare delivery system - the more likely this is to be so. A particular patient, so it is argued, might need specific help with alcoholism, agoraphobia and low self-esteem, each of which will require its own therapeutic strategies. Clearly there are dangers in that a melange of potentially competing treatments may confuse the patient, especially with those suffering from borderline personality disorder who may be adept at splitting or setting one faction off against another.

Most specialist psychotherapy settings, such as psychotherapeutic day hospitals and in-patient units, follow the comorbidity model in that they offer a combination of: the 'living/learning' milieu itself; creative therapies such as psychodrama and art therapy; and specific therapies, usually psychodynamic individual or group therapy. The latter areusually held within the culture of the unit to be the active ingredient of change, although to date there are few controlled studies that specifically tackle this question.

Integrated psychotherapy units

Until fairly recently, most psychotherapy departments in the UK were predominantly psycho-dynamic in orientation. A major question for psychotherapy research is the attempt to define the differential effectiveness of different psycho-therapeutic approaches, depending on the diagnosis and personality of the patient. Translating the research findings into practice will enable different models of therapy to coexist within an overall context of integration. There is now a distinct movement towards integrated psychological treatment services that offer the full range of psychotherapies - psychodynamic, behavioural, cognitive, systemic, humanistic - and, after thor-. though assessment, can assign the patient to the one most suitable for their problem and personality. Integration will be fostered by organisational arrangements such as common referral meetings, interdisciplinary case conferences and discussion of problematic cases, so that the different psychotherapeutic camps bñecome more aware of each others strengths and weadnesses, theory-practice discrepancies, and so on.

Integration and the Indirldual practitioner

Surveys of psychotherapists in the US show that the majority (68%) describe themselves as eclectic in orientation, and that almost all (98%) see the future of psychotherapy as lying with futher integration (Garficid & Bergin, 1994). Pressure towards eclecticism depends on a number of factors. Therapists working in highly specialist settings, where there has been rigorous pre-tretmente selection, can presumably assume that their clients are suitable for the particular model of therapy that they offer. The psychotherapcutic 'general practitioner', by contrast, is likeyto encounter a variety of clients as they come through the door, and may need to be able to work psychodynamically with one, cognitively with another, and so on, according to need.

A key issue for psychotherapy research is to determine what, if any, is the impact of therapist eclecticism on outcome. So far there are no clear answers to this question. The problem of the discrepancy between therapist intention and actual behaviour has been tackled by 'manualisation' of therapies, which enables tape- or video-recordings of sessions to be compared with a detailed schedule of prescribed behaviours.

As might be expected, results are complex. For example, as mentioned, there is overwhelming evidence that a strong therapcutic alliance early in treatment predicts good outcomes whatever the nature of the therapy or problem of the client. Therapist training, experience and skilfulness influence this alliance, as does the severity of illness of the client. But therapist style interacts in a subtle way with therapist-patient cultural congruence. Culturally dissimilar patients achieve a stronger therapeutic alliance with flexible therapists, while where there is cultural congruence, therapists with 'dominant' styles do better (Henry *et al*, 1994). Thus if, as seems likely, an integrative/eclectic stance is related to 'flexibility',

it is likely to be beneficial in some situations, but not in others.

Similarly, there is evidence that adherence to a treatment manual *and* the ability to deviate from or modify standard technique when required are both associated with good outcomes, as compared with poor adherence and rigidity (Frank & Spanier, 1995). Here too the results need to be interpreted with caution. The Vandebilt studies (Henry *et al,* 1994) suggested that therapists with "hostile/ crontrolling introjects", and who are therefore perhaps more conformist, are better at adherence to manuals, but this does not necessarily improve outcomes with clients. In general, good outcome in psychotherapy depends on a complex mixture of treatment fidelity, integrity, purity, dosage of therapy, level of therapist experience, skill in the delivery of that particular therapy, as well as the real differences in treatment effects depending on diagnostic group and severity of illness. Flexibility is only one of these factors, but it does appear to be particularly important with "difficult" patients- i.e. those who are significantly more severely or chronically ill, or more hostile. These are likely to represent the bulk of psychotherapy referrals within psychiatric settings.

It is well established that the *efficacy* of treatments (as demonstrated by clinical trials conducted under highly structured conditions in specialist centres) exceeds their clinical *effectiveness* (as applied in ordinary clinical settings; Roth & Fonagy, 1996). Advocates of purity may argue that this results from the tendency of practitioners to dilute specific elements with eclecticism, but there is no direct evidence to support this assertion. The key issue is not so much 'purity versus integration', but rather the development of well-defined teachable treatment approaches, some of which will be explicitly integrative, some not. Within a particular treatment method, integrative capacity (in the sense of the ability to deviate from treatment schedules and to bring in other techniques when required) Is also a significant factor likely to lead to better outcomes. This might be seen as an aspect of the therapist's 'maturity' - the capacity to integrate a particular therapeutic approach within a unique personal style, and to move as needed from cognitive-directive to exploratory-psychodynamic styles within a session, depending on client need. This is inherently dangerous, and needs to be a specific focus of supervision if such movement is not to be driven more by countertransference, and hence to be potentially antitherapeutic, than used in the service of greater flexibility and therapeutic responsiveness.

Integrative psychotherapy in specific disorders

Psychotherapy has until recently tended to approach specific psychiatric diagnoses in a procmstean fashion, fitting the disorder to whatever model of therapy the therapist happens to espouse. Unequivocal evidence for the efficacy of psychotherapy combined with the advent of manualisation has meant that psychothcrapcutic treatment packages have,been designed for the treatment of a variety of specific psychiatric illnesses (Roth & Fonagy, 1996). Many of these are explicitly integrative, either in the sense that they combine pharmacotherapy and psychotherapy; or mix cognitive-behavioural techniques to deal with immediate symptoms with psycho-dynamic approaches fof longer-term difficulties; or because they use a variety of supportive techniques as part of a maintenance estrategy for enduring psychiatric disability. Psychiatric aspects of integrative therapy will now be discussed.

Schizophrenia

The demise of psychoanalytical treatment for schizophrenia is a striking example of the passing of the procrustean era already mentioned. By contrast, the effectiveness of family intervention In reducing expressed emotion and relapse rates has been established beyond all doubt (although translating these research findings into routine clinical practice remains problematic). Family intervention is essentially integrative in that it combines: structural family therapy techniques aimed at strengthening intergencrational boundaries; facilitating negotiation and communication; psychoeducation in an illness model of the disorder, and specific behavioural approaches to enhancing desired behaviours and reducing unwanted ones. Recent evidence for the effectiveness of cognitive therapy in modifying delusions in some patients means that CBT may well also be incorporated into an overall integrativc package for the management of schizophrenia, one which will also include long-term supportive therapy.

Affective disorders

Psychotherapy is an essential component of the therapeutic response to depression. In mild-to-moderate depression it is as effective as pharmacotherapy and thus is suitable for those patients unwilling or unable to tke drug. There is some evidence that psychotherapy compared with

pharmacotherapy reduces relapse rates in depression. Chronic dysthymia responds poorly to drugs and can be helped with psychotherapy. Psychotherapy can play an important part in improving drug compliance in manic-depressive psychosis (Scott, 1995).

Interpersonal therapy (IPT; Frank & Spanier, 1995) was specifically designed for the treatment of depression. Its theoretical rationale brings together elements from psychoanalysis and attachment theory. In practice it is also eclectic in that, depending on individual circumstances, the patient is offered modified dynamic therapy if the primary problem is one of loss, behavioural therapy if there are social skills deficits, or family/marital-based techniques if difficulties seem to stem from the patient's immediate relationship.

Eating disorders

Eclectic therapies combining cognitive and psycho-dynamic methods are more effective for older patients with anorexia nervosa, whereas those under 18 do better with family therapy, especially if their symptoms have been present for less than three years. A comprehensive eating disorder service will need to offer psychodynamic, cognitive and systemic therapies if it is to help the full range of patients. In-patient units using re-feeding regimes also incorporate supportive and behavioural techniques.

A further type of integrative delivery is the principle of sequential treatments depending on severity. A time-based integrative approach can be part of the routine protocol for patients with bulimia who are offered in turn: bibliotherapy; time-limited cognitively-oriented group therapy; brief individual therapy; extended individual therapy; and in-patient therapy. Successfully treated individuals leave the programme at each stage, as appropriate (Treasure *et al,* 1996).

Substance misuse

There are few unequivocally effective psychother-apeutic treatments for alcoholism, but therapeutic packages comprising brief counselling, marital therapy and assertiveness training have been shown to be moderately effective, and more so than single-model therapies. In the management of opiate misuse, again a combined package including methadone prescription, group therapy and individual psychodynamic counselling has been shown in controlled trials to produce encouraging results (Luborsky *et al,* 1985).

Anxiety disorders and post-traumatic stress disorder

The combination of exposure, relaxation training, and cognitive techniques appears to be the most effective integrated package for the management for anxiety-based disorders. Generalised anxiety disorder responds least well to behavioural measures (Butler *et al,* 1987), and here a more psychodynamic approach may be needed, since many of these patients have had a history of disrupted attachments, although this remains to be evaluated.

Personality disorder

Patients suffering from personality disorders, as well as needing psychiatric treatment in their own right, also fare less well when offered standard psychiatric treatment for Axis I disorders. Given this, and the fact that personality disorders have by definition a global effect on personality functioning, it would seem likely that an inte-grative/eclectic approach would be helpful. As mentioned earlier, the only controlled trials of borderline personality disorder have been of the explicitly integrative DBT (Lineham, 1993), showing a reduction in self-harm and improvements in social functioning in women with borderline personality disorder. In-patient and day-patient treatment programmes for such people are also inherently integrative. Further evaluation of such packages is urgently needed.

Crisis intervention

Crisis intervention is inherently integrative and commonly uses a three-stage approach based on techniques drawn from systemic therapies, cognitive approaches and short-term psychodynamic therapy. Initially the therapeutic team use behavioural strategies such as contracts, 'time-out' and relaxation training to deal with the immediate problem. This can be followed by a cognitive phase directed at the elucidation and modification of shared familial pathogenic beliefs, attitudes and assumptions. Finally, in the third phase, emotional and dynamic issues are identified and presented as a formulation, and the warded-off affects, motives, fantasies and anxieties are clarified, confronted and interpreted.

Liaison psychiatry

Psychiatric intervention with medically ill patients or those with conversion disorders is inherently integrative. For example patients with chronic

fatigue syndrome respond to a combination of cognitive therapy, graded exercise and, where indicated, antidepressants. Chronic pain requires relaxation training, reattribution cognitive therapy and sometimes a dynamic approach. Similarly, sex therapy usually combines specific behavioural interventions (sensate focus, squeeze technique, etc) with dynamic and systemic approaches when indicated.

Conclusions

There is no clear relationship between psychother-apeutic theory and practice. Good theory can lead to bad therapy, and vice versa. For this reason there is a strong argument against premature theoretical integration, as opposed to the observation of interesting similarities. Creative conflict between different models will lead to new integrative syntheses, further differentiation, and so on. As Fonagy (1995) argues:

> "Ultimately, theoretical orientations will have to be integrated since they are all approximate models of the same phenomenon: the human mind in distress. For the moment, however, integration may be counter-productive, as theoretical coherence is the primary criterion for distinguishing false and true assertions in many psychotherapeutic domains. However, this objection does not apply to the desirability of integration at the level of technique. In everyday clinical practice there is much that is 'borrowed' from different orientations by all practioners." (Fonagy, 1995)

In summary, psychotherapy needs to cultivate both purity and integration. At the level of theory, dialogue between different camps is urgently needed, but should not lead to the dismantling of complex and carefully constructed theories. At the level of psychiatric practice, flexibility and adherence are both important and need to be the focus of supervision. At an organisational level there needs to be sharing and academic contact between different psychotherapeutic disciplines.

Clinical implications

- Many effective psychotherapeutic treatments in psychiatry depend on integration.
- Effective therapists stick to one model but apply it in a flexible and integrative way.
- Integrated psychotherapy departments are likely to lead to better matching between patient need and type of therapy

Limitations

- Integration is a vague concept and has many different meanings.
- Integration can lead to blurring of real differences between theories.
- Promiscuous mix and match' of therapies produces poor outcomes.

We end with a psychoanalytical analogy. From a Kleinian perspective 'integration' might be seen as a metaphor for parental intercourse, tolerable once the maturation associated with 'depressive position' functioning is achieved; the French psychoanalyst Chasseguet-Smirgel, however, argued that denial of real differences - between the sexes and between the generations - is the basis of perversity, both at an individual and a social level (Bateman & Holmes, 1995). The balance between integration and purity should be seen as part of a developmental process that encompasses understanding, coherence, tolerance, flexibility and communication - goals no less ambitious than psychotherapists strive for with their patients.

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