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Integrating Psychodynamic, Cognitive, and Interpersonal Therapies: A Biopsychosocial Role Theory*

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ABSTRACT

A biopsychosocial role theory has been developed to integrate the main findings of psychodynamic, cognitive, and interpersonal therapies. To function in a society, you must achieve a balance between your self-expectations and your performances, and your expectations of others and their performances. These expectations of self and others fall roughly into 16 biopsychosocial areas, or life vectors Imbalance between expectations and performance creates stress. When experiencing stress, you must either modify and negotiate expectations and performances with others, or through defense mechanisms and patterns of reaction, further compound your problems. Interview schedules structured according to this theory have been used to interview patients, parents, and spouses. Social summaries allow the respondents to identify their problems and provide them with a common structure, methodology, and language to resolve their differences of opinion, restructure their roles, and achieve their personal and interpersonal goals.

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Continuity of treatment is a serious problem in the delivery of mental health services, and community mental health facilities have recently been criticized for their failure to provide medical care (Hilts, 1991). When hospitalized, patients are often treated by a multidisciplinary team, but the length of their hospitalization is short—an average of ten days. After discharge, patients are referred to private therapists, hospital outpatient departments, or community centers, depending on their insurance and financial resources. Thus, over a period of time, patients may be treated by therapists with different theoretical orientations. One therapist may focus on their medication, another on their childhood problems, a third on their present personal or interpersonal problems. After discharge, when a new problem occurs patients are often rehospitalized because they and their families are confused by this lack of continuity, and do not know what to do. They often believe that a recurrence of symptoms means that the patient will never get well, and they lack a model by which to evaluate the patient's progress.

This paper presents a theory of alternatives, a biopsychosocial theory of mental health which is based on role theory (Sarbin & Allen, 1968), and which combines the theories of these different theoretical orientations. We have explained in an earlier paper how the theory of alternatives was developed, tested, and operationalized (Ferguson, Ferguson, & Luby, 1991). Our main concern in this paper is to explain how the theory integrates some of the insights of psychodynamic, cognitive, and interpersonal therapies and provides a structure, methodology, and language which can help patients, parents, and spouses resolve their differences of opinion and achieve their personal and common goals.

Karasu (1990a; 1990b) attempted to integrate psychodynamics, cognitive, and interpersonal therapies and explain how these therapies could be used in the treatment of depression, but he did not provide us with a theory that integrates these three therapies.

Psychodynamic therapy is derived from Freudian theory. It focuses on helping patients to become conscious of the effects of past traumatic experiences on their present behavior. (Gabbard, 1990; Ursano, Sonnenberg, & Lazar, 1991). Under this therapy, patients become aware of the defense mechanisms they use "to avoid danger, anxiety, and unpleasantness" (Freud, 1937, p. 235).

Cognitive therapy is based on the underlying theoretical assumption that an individual's affect and behavior are largely determined by the way he interprets his experiences (Beck, 1976). Depression occurs because of maladaptive cognitive schemes. Manuals have been written to explain how cognitive therapy can be used for the treatment of depression (Beck, Rush, Shaw, & Emery, 1979; Burns, 1980), and even recently for the treatment of

schizophrenia (Perris, 1989), and personality disorders (Beck & Freeman, 1990). The techniques used include having patients monitor their own thoughts, identifying the patient's dysfunctional beliefs—such as overgeneralization, personalization, seeing everything in black and white—and cultivating beliefs that are more reality oriented.

Interpersonal therapy helps patients to acquire a sense of mastery, and a sense that they belong to the group instead of living in isolation (Sullivan, 1953; Klerman et al., 1984). The therapy focuses on the patients' assets, and helps them to ventilate painful emotions. Patients learn to solve interpersonal disputes, and deal with loss and role transitions.

Psychodynamic therapy is concerned with the patient's past traumatic experiences while cognitive and interpersonal therapies deal with the here-and-now. The boundaries between these three types of therapies may be artificial, however, because unless you understand the past, you cannot change the present, and to interact successfully with others you must continualy modify and negotiate your own expectations and performances.

A Biopsychosocial Role Theory

Two surveys led to the development of the theory of alternatives. The first study was an attempt to utilize Erikson's theory of the psychosocial development of children to test the repetitive pattern of maternal deprivation (Ferguson, 1962). Erikson (1956) proposed that a person had to go through a series of psychosocial crises to achieve a sense of identity, of knowing who he is and what he wants to do. Two of these psychosocial crises were: trust versus mistrust, and autonomy versus shame and guilt. The study on maternal deprivations showed, however, that children trusted others and acquired autonomy only if their self-expectations and their expectations of others were realized.

The second study was a survey of the adjustment of one hundred young widows (Ferguson, et al., 1981). We found that the widows' problems were biopsychosocial. Although experiencing severe emotional and physiological responses to their loss, they were nonetheless required to solve a wide range of financial, social, and ethical problems. These two studies led to the replacement of Erikson's concept of psychosocial crises by the concept of basic needs, or life vectors, derived from Malinowski's cultural imperatives (1960). Life vectors are defined as the basic biopsychosocial needs that are defined at the individual level and are sanctioned by the institutions of society.

Sense of Attainment

To function in a society you must achieve a sense of attainment which is reached through the knowledge that your self-expectations and your expectations of others are being met in all of your life vectors.

Self-expectations are defined as your expectations for your own actions, rights, and obligations. Expectations of others are defined as your expectations of others' rights and obligations. For example, you feel good because you are ready in time to see your therapist: you have fulfilled your self-expectations. But you are disappointed if your therapist does not appear: your expectations of others have not been met.

Complement of Life Vectors

Interaction with others is not confined to one life vector. As you grow, the demands society makes on you increase in size and scope, and you begin to interact with an increasing number of people. Life vectors are latent in a person, and the period in which they become manifest depends on maturation and the culture in which you live (Table 1).

Survival is a prime concern for the infant and the aged, so that health, nutrition, shelter, and motor development are all crucial to their welfare. Learning to communicate through speech and learning to walk is a concern of the toddler. Acquiring an education is a focus during childhood. In adolescence, social life, love and sex, the choice of an occupation, and finance become increasingly important. Parenthood is of concern to the young adult. A commitment to art, a respect for law and order, an interest in politics, religion, and ethics may develop in youth or become significant later in life.

Life vectors are not stages of development, but rather concurrent dimensions that can occur either simultaneously or sequentially. Life vectors can be conceptualized at different levels of generality. Under law and order, we can classify both how a child is punished by his parents and whether this child adheres to the laws of society. Life vectors are interdependent at a personal level: your financial situation may determine whether you can go back to school. But they are also interdependent at a national level, and must be considered when planning social change. For example, welfare mothers may decide to participate in occupational retraining only if they are assured that they will keep their Medicaid benefits while retraining.

Table 1. Complement of Life Vectors

Health	Occupation
Food	Finance
Shelter (housing)	Parenthood
Motor Development (exercise)	Law
Speech	Politics
Education	Art
Social Life	Religion
Love and Sex	Ethics

Role Theory and Interaction between Two Persons

The basic precepts of role theory are that attached to each of your statuses, or roles, are certain rights and obligations which are defined by you and by society (Sarbin & Allen, 1968). Role enactment occurs when you achieve your expectations, and role complementarity when you and another person agree on your mutual rights and obligations. The theory of alternatives is basically a role theory because it explains that you fulfill your basic needs by functioning in different roles and interacting with others. The human tragedy is that only performances are visible, and you can only infer expectations from performances.

Figure 1 represents the interaction between two persons, you (Ego), and another person (Alter) in one life vector. The circle in the middle of the diagram shows that only performances are visible. The long arrow from Alter to Ego shows that when Alter acts, he or she meets his or her obligations to you and recognizes your rights, and the long arrow from Ego to Alter shows that when you act you recognize Alter's rights.

When there is role complementarity between Ego and Alter there is no problem because you both agree on your mutual rights and obligations. When this is not the case you may experience anger if you believe that Alter did not recognize your rights; you may experience guilt if you believe you have not met your obligations; or you may experience both guilt and anger if you do not know who is to blame.

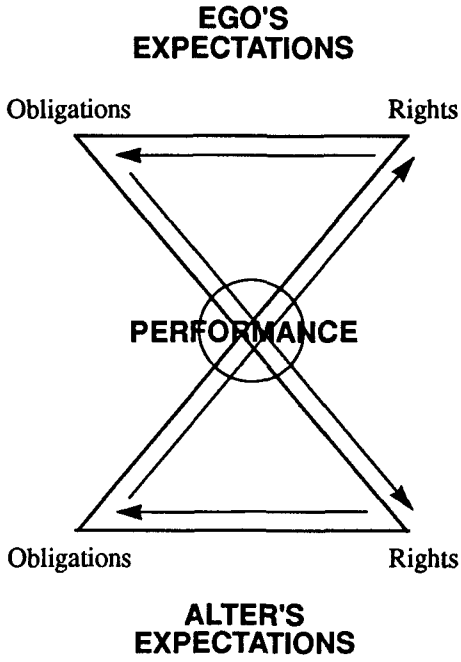

Figure 1. Interaction in Life Vector

Unmet Expectations and Stress

We propose that when you experience an imbalance between expectations and performances, you experience emotional and physiological stress.

There has been a growing body of literature on stress since Cannon (1929) and then Selye (1956) showed that our body has to remain in a state of equilibrium, or homeostasis, and that any factor physiological orsychological can disturb this balance and create stress. Psychosocial measures of stress have first concentrated on the degree of social disruption that a person experiences after a stressful event. Holmes and Rahe (1967) devised a scale of social adjustment where fixed weights were assigned to specific events, such as widowhood or loss of a job. Other factors in adjustment to stress were then identified and surveys were designed to determine whether stress is cumulative through time or specific to one point in time, and whether

stress depends on the importance that you attach to an event, the desirability of the event, your belief that you can solve your problems, or the amount of social support you receive (Paykel, 1973; Pearlin, Lieberman, Menagahan, & Mullen, 1981; Thoits, 1983; Lin, Dean, & Ensel, 1986).

Assessing a Stressful Situation and Selecting Alternatives

W. I. Thomas and D. S. Thomas (1928) said that "when people define situations as real, they are real in their consequences." (p. 572). Your own assessment of a situation is important.

For example, if you are in the hospital and your therapist is late, you may realize that the ward nurse is the person who probably knows why your therapist is late. She may tell you that the therapist had an emergency and will arrive in 20 minutes, and ask you to wait. She may not have told you before because she was busy. So you settle down, read a paper and when the therapist arrives, you proceed with the interviews. You are aware of the therapist's professional obligations, and because of this you have modified and negotiated expectations and performances.

Defense Mechanisms and Patterns of Reaction

But instead of believing that your therapist is late because of professional obligations, you may become unduly anxious: you may believe that the therapist has not come because you are a hopeless case and because she does not like you, or that she is a selfish person who exploits you. But why do you define the situation in those terms?

Defense mechanisms are defined as the rigid and destructive cognitive methods you use when dealing with a stressful situation (Table 2). We have divided defense mechanisms under two headings: escape from reality, and inability to differentiate between self and others. Your assessment of your therapist may become biased when you repress past traumatic memories, such as the anger and guilt you experienced when your mother did not keep her promises, when she did not show up at your birthday parties. You may regress and believe you are still a powerless child and attempt to deny and rationalize your present situation. Or you may displace onto your therapist your repressed feelings of anger and guilt because you do not differentiate between the roles of a mother and a therapist. Because you don't like yourself, you may project these feelings onto your therapist and believe she does not like you.

Table 2. Defense Mechanisms: Rigid and Destructive Cognitive Methods for Dealing with A Stressful Situation

1. Avoidance of Reality

Repression:	Certain painful expectations and performances are suppressed from immediate memory.
Regression:	You retreat to expectations and performances you held at an an earlier stage of development.
Denial:	You refuse to recognize certain expectations or performance.
Rationalization:	You force your expectations to fit your performance.

2. Inability to differentiate between self-expectations and expectations of others

Identification:	You adopt the expectations of another without evaluating whether they are functional for you.
Displacement:	You transfer an expectation that you hold about a person to another or to an object.
Projection:	You attribute to another a derogatory expectation you hold of yourself

But how do you perform when you are angry or feel guilty because your therapist does not show up? Horney (1945) states that a person can move against, toward, or away from people. You may move against people if, when you were a child, you were aware of the hostility around you, and you were blamed if anything went wrong. You may move toward people if you were brought up to feel helpless and preferred to be dependent and lean on others than to be left to your own devices. A third possibility is that you may withdraw from the situation because, as a child, you felt that no one understood you. We have derived the following four patterns of reaction from Horney's comments.

Table 3. Patterns of Reaction: Habitual, Observable, and Unproductive PerformancesWhen Facing a Stressful Situation

Brutalization:	You physically or verbally force a performance on another.
Victimization:	You submit to the performance of another although it is contrary to your expectations.
Self-Brutalization:	You force a pseudo-performance upon yourself: you eat or drink too much, stop eating, or take drugs.
Insulation:	You physically or verbally withdraw from the situation.

We have added a fourth pattern of reaction: self-brutalization. You may feel angry and guilty because, as a child, you did not know who was to blame and so you punished both yourself and others. But your performance is a pseudoperformance because it does not solve your problems.

When your therapist is late and you displace onto her the feelings of anger and guilt you experienced when you were a child and your mother let you down, you respond to her behavior with patterns of reaction. You may brutalize your therapist and insult her when she arrives; you may agree to see her even when she is chronically late; you may seek solace in alcohol, food, or drugs; or you may refuse to see her when she arrives.

Figure 2 sums up the theory. Unmet expectations lead to physiological and emotional stress. You can either assess your situation objectively, modify and negotiate expectations and performances with others and regain your equilibrium, or, because of defense mechanisms and patterns of reaction, you can let your feelings dictate your behavior. In this latter case, not only is your problem not solved, but your stress may actually increase because you worry why you are ineffective.

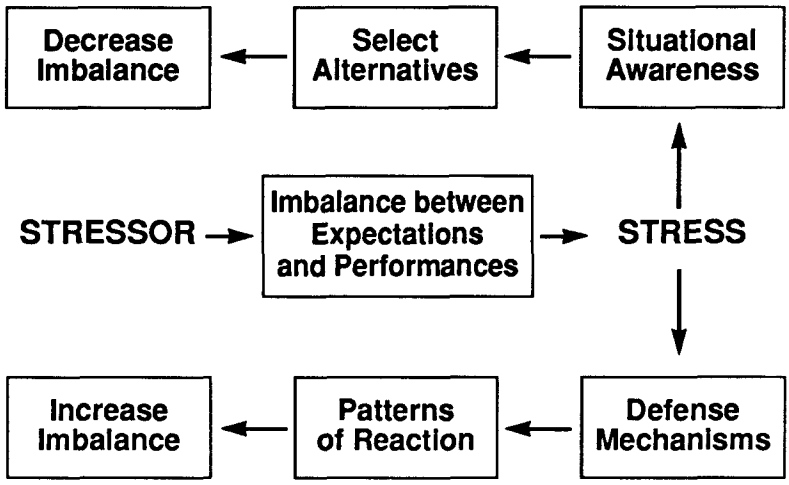

Figure 2. Response to Imbalance in One Life Vector

Methodology and Intervention

The interviews that we developed are therapeutic by themselves because they help the respondents to retrace their life history in a systematic manner. We explain to the patients that we would like to discuss their achievements and not just their problems. We mention that they will be interviewed twice with a structured interview: the first time about their expectations and performances in all life vectors during their last year in high school; the second time about their present situation. In the second interview, we will retrace their behavior from high school to the present in pivotal life vectors such as health, education, occupation and love and sex. We specify that we will discuss with them our theory of alternatives and the results of our interviews.

All the interviews are structured in the same manner. Life vectors are grouped together under the following themes to emphasize their interdependence.

Table 4. Interdependence of Life Vectors

Doing the Work You Like	Taking Care of Your Body
Education	Nutrition
Occupation	Exercise
Speech	Health
Options in Saving and Spending	Be Part of This World
Finance	Art
Housing	Politics
	Law
To Love and Be Loved	At Peace With Yourself
Social Life	Ethics
Love and Sex	Religion
Your Children and Their Future	
Parenthood	

Before they are interviewed for the first time, patients are asked to complete a self-report psychological test, the SCL-90 (Derogatis, Lipman, & Covin, 1976). It consists of 90 questions rated on a five-point scale

Each interview takes about 50 minutes to complete. Patients are asked to describe their behavior in each life vector and evaluate their relationships with significant others. An attitude question guided by the critical incident technique (Flanagan, 1956) is asked for each life vector to determine whether a higher number of life vectors in which patients have an imbalance between expectations and performances results in a higher level of stress, as measured by their SCL-90 test. Attitudes are scored on a 4-point scale ranging from very important to very unimportant. Patients are scored as having an imbalance in one life vector if a critical expectation is not met.

To determine their mode of response to stress and to measure their patterns of reactions, the respondents are asked questions dealing with their relationships with their loved ones, their parents, their boss, and their coworkers

At the beginning of their third interview, the theory of alternatives is explained to the patient, using visual models. Then the social summary of their interviews is discussed with them. This summary lists the life vectors that they consider very important; the life vectors in which they have serious problems according to our cultural criteria and their own evaluation; and the conflicts and priorities that they have indicated are of concern to them. A

quantification of their patterns of reaction and their total score on the SCL-90 test are included in the summary.

Parents or spouses are interviewed with interview schedules based on the same model as the second interview with the patients. During their second interview, their own social summaries and the patient's social summary is discussed with them.

A confrontation between patients and significant others takes place after each respondent has seen the social summaries of the other members of his family. This confrontation helps the respondents to take the role of the other (Mead, 1934). The patient then discusses his goals and priorities with family members. Differences of opinion are resolved and family roles restructured.

We have tested the main propositons of the theory on a sample of 80 schizophrenics and depressed, alcoholic, or anorexic patients and their relatives, a follow-up group of 16 outpatients, and a control group of 347 university students. We have found that the patients' level of stress is related to the number of life vectors in which they have serious problems according to our cultural criteria and their own evaluation (Ferguson, et al., 1991).

Our biopsychosocial role theory allows the patients to integrate the insights of psychodynamic, cognitive, and interpersonal therapies. The concept of life vectors and our interview schedules help the respondents to retrace and identify the traumatic incidents that have biased their appraisal of their present situation. The distinction which we make between expectations, feelings, and performances allows the respondents to become aware of their method of structuring and interpreting their experiences. They learn to monitor their defense mechanisms, and to differentiate them from their patterns of reactions. Instead of mourning their losses forever, they become intent on developing their sense of attainment and solving interpersonal disputes.

We are in the process of writing a book, "Taking Control of Your Life," which explains in detail the development of the theory of alternatives, the construction of our interview schedules, and the therapy based on this model.

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