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Circumstances to integrate acceptance and commitment therapy with short-term psychodynamic psychotherapies

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Abstract: How therapists integrate short-term psychodynamic psychotherapy (STPP) and Acceptance and Commitment Therapy (ACT) is not well understood. This study focused on the circumstances used to guide the integration of ACT and STPP as a therapeutic strategy from therapists' perspectives and experiences. Thirteen participants from the United States, Australia, and Canada who integrate ACT and STPP as a therapeutic strategy were interviewed by video call or video conference. Grounded theory method was utilized to collect and analyze qualitative data generated from the interviews. *Findings and conclusions*: To the best of the author's knowledge, this is the first study to use grounded theory methodology to describe the circumstances to integrate ACT and STPP. Seven response markers were identified to consider ACT and STPP integration with matched patient characteristics in the context of the patient's current functioning and the therapeutic alliance. The theoretical framework used for this study was Gold and Stricker and Stricker and Gold's three-tiered model of assimilative integration. The framework offered the possibility of relieving symptom distress and building new intra-psychic representations and effective interpersonal skills. The results indicated that while the seven response markers can serve as useful guidelines for implementation of STPP and ACT integration, the therapist's intuition is and may always be a determining factor in the decision to integrate these two modalities. The combination of ACT and STPP provides an opportunity to improve methodologies, strategies, and treatment outcomes.

ABOUT THE AUTHORS

Michele Matoff, PsyD, LCSW is an experienced psychotherapist and licensed clinical social worker with over 20 years of clinical private practice specializing in the treatment of anxiety disorders, post bariatric emotionally supportive psychotherapy, and finding meaning in the second half of life. Michelle is a published author and an adjunct professor at Brandman University, School of Psychology. Her research interest is in psychotherapy integration for improved treatment outcomes.

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PUBLIC INTEREST STATEMENT

Mental health conditions affect millions of people in the United States. Costs for treatment can be astronomical. Furthermore, using one type of psychotherapy is not always effective. This research examined how combining two types of psychotherapy can lead to effective outcomes. Linking Acceptance and Commitment Therapy and short-term psychodynamic therapy, can not only improve treatment outcomes, but also may be more cost effective than using only one type of therapy for the treatment of mental health conditions. The researcher asked 13 psychotherapists what the circumstances are for combining these 2 types of therapies. The research indicated that psychological integration can move mental and physical health forward by deepening understanding of best practices.

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1. Introduction

Mental health concerns are the primary cause of disability and affect 10 million adults in the United States (Insel, 2015; Substance Abuse & Mental Health Services Administration, National Survey on Drug Use & Health, 2014; World Health Organization, 2004). Untreated mental health issues effect economics. As Vecchio (2016) stated, a combined decline in mental health-related productivity and deficit income account for an estimate of 305 billion dollars of losses per year in the United States. Therapeutic interventions can reduce these numbers substantially (Abbass, Kisley, et al., 2014; Hayes, Pistorello, & Levin, 2012; Hooper & Larsson, 2015; Insel, 2015; Substance Abuse & Mental Health Services Administration, National Survey on Drug Use & Health, 2014). However, the cost and length of therapy are economic and time-consuming considerations (Abbass, Kisley, et al., 2014; Abbass, Kisely, Rasic, Town, & Johansson, 2015; Abbass & Town, 2013). Further research is needed to identify efficient and cost-effective health care for treatment of mental illness (Abbass et al., 2015).

Research using ACT and STPP has shown these methodologies are effective for treating mental health issues (Abbass, Nowoweiski, et al., 2014; Ambresin, Despland, Preisig, & de Roten, 2012; Dekker et al., 2014; Hayes et al., 2012). However, single orientations are limited in views and explanations for human behavior and can leave many patients unimproved (Goldman, Hilsenroth, Owen, & Gold, 2013; Govrin, 2014). An example of this phenomenon is when a patient in psychoanalysis struggles with the inability to experience rather than defend against feelings. Contemporary researchers urge the development of multiple strategies for addressing treatment resistance (Nani, Uher, & Danese, 2012; Ziv-Beiman, 2015). Furthermore, patients who experience chronic mental health problems and high relapse rates may respond better to psychotherapy integration (Luyten & Blatt, 2012; Vocisano et al., 2004).

The psychology literature affirms the benefits of integrating behavioral and psychodynamic therapy (Castonguay, Eubanks, Goldfried, Muran, & Lutz, 2015; Goldman et al., 2013; Vocisano et al., 2004). It is therefore possible that combining ACT with STPP provides a solution to developing improved efficacious treatment and a cost-effective therapeutic strategy for mental health concerns. There are no studies from the current literature that provide empirical and theoretical explanations for the integration of ACT and STPP. This journal article seeks to (1) explore the *circumstances to implement the synthesis of STPP and ACT,* (2) present theoretical implications of ACT and STPP synthesis using Stricker and Gold's (1996) three-tiered assimilated integration model, and (3) discuss recommendations for future research and clinical practice.

1.1. Theoretical foundation of ACT and STPP

ACT is a contemporary form of behavioral analysis, which views behaviors as historically defined in a contextualized framework (Hayes, Luoma, Bond, Masuda, & Lillis, 2006). Founded by Hayes (2004), ACT is rooted in Relational Frame Theory that hypothesizes four philosophies: (1) stimuli interact in a bidirectional manner, leading to reinforced behavior (responses); (2) arbitrary relationships form because of interactions between stimuli; (3) language is pivotal in generating relationships between stimuli without actual experience; and (4) responses are contextually controlled (Moran, 2015). Application of this framework to psychological phenomena implies that avoidance occurs from paired stimuli that result in learned behaviors that are then reinforced through repetition. Because language is linked to thinking, stimuli are avoided (and fears are maintained) using language (Moran, 2015). Thus, language becomes the mediating factor that transforms internal representation to external behaviors.

A first goal of treatment is to teach the client not to accept thoughts as literal truths to thwart avoided behaviors (Hoffmann, Contreras, Clay, & Twohig, 2016). Not believing everything the mind declares helps to establish space for adaptive behavior change directed by values (Hoffmann et al., 2016). A second goal of treatment is to increase psychological flexibility by enabling the choice of choosing behaviors reflective of values and allowing challenging and uncomfortable personal thoughts and feelings to coexist (Hayes, 2004). Thus, change occurs with increased psychological flexibility (Hayes, 2004; Westrup, 2014).

The main aspects of the theory are as follows. *Defusion* is defined as creating space to experience thoughts as behavioral processes separate from truisms (Westrup, 2014). *Acceptance* of thoughts, feelings, urges, and sensations despite discomfort is another theoretical factor (Luoma, Hayes, & Walser, 2007). Westrup (2014) suggested *self as context* to mean viewing experiences from a constant position of "the one who experiences" rather than the experience itself. *Present moment awareness* is described as bringing attention and curiosity to the here and now to facilitate recognition of how the mind fuses thoughts to inflexible beliefs (Westrup, 2014). According to Hayes et al. (2006), *values* denote a personal philosophy of how to engage in life. Finally, *commitment* is taking actions that are in agreement with acknowledged values (Hayes et al., 2006; Westrup, 2014). ACT proposes utilizing defusion and acceptance strategies to increase willingness to face anxiety (Hayes et al., 2012). When avoidance is no longer practiced, it is possible to function by following one's values rather than anxiety-laden cognitions (Hayes et al., 2012).
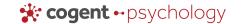
Short-term psychodynamic psychotherapies are derived from a psychodynamic psychoanalytical model and have a time-limited feature, a delineated therapeutic focus obtained from the therapist and client agreement, and the use of transference (Abbass, Kisley, et al., 2014) with (Davanloo, 1978) and without interpretation (De Jonghe et al., 2013).

Furthermore, STPP involves a high degree of therapist interaction with the intention of fostering the therapeutic alliance to discover and address interpersonal and intrapersonal present-day conflicts (Abbass, Kisley, et al., 2014; Driessen et al., 2010; Messer, 2015; Wells & Giannetti, 2013). A central STPP assumption is that unconscious affect, behaviors, and cognitions shape current relationship patterns (Abbass, Kisley, et al., 2014; Driessen et al., 2010; Messer, 2015). STPP's focus remains on the content (e.g. intra-psychic and interpersonal cognitions; Abbass, Kisley, et al., 2014; Shedler, 2012) and context (e.g. the therapeutic alliance being the milieu for relationship change; Abbass, Kisley, et al., 2014).

Goals of STPPs are more robust interpersonal relationships resulting from therapist–patient interactions, cognitive and emotional changes, and working through painful past experiences (Abbass, Kisley, et al., 2014). New interactive patterns take the place of previous problematic relational patterns (Abbass, Kisley, et al., 2014). A person's corrective experiences, coupled with greater self-awareness, can be generalized to new interactional experiences (Abbass, Kisley, et al., 2014). Goals are accomplished in fewer therapy sessions than long-term psychodynamic psychotherapy (Messer & Warren, 1995). Having a therapeutic focal point acknowledges that not all characterological factors need addressing in a patient's current life, and this narrowed, and less open-ended focus distinguishes short-term psychodynamic psychotherapy from long-term psychodynamic psychotherapy (Messer & Warren, 1995).

2. Underlying theory and integrative framework

Gold and Stricker (2013) and Stricker and Gold's (1996) three-tiered assimilated integration model provides an ideal set of guidelines for integrating ACT and STPP based on theoretical foundations. An assimilative integration model incorporates strategies of one psychological approach, which are then purposefully synthesized with another approach to create treatment that is based on the conceptualization of a single theory (Stricker, 2010). Each modality maintains its respective philosophical viewpoint. The goal is to achieve effective outcomes in a shorter time than the treatment provided by an approach that utilizes a single orientation. I used Gold and Stricker's (2010) and

Stricker and Gold's (1996) suggested three-tiered model of assimilative integration to explain the integration process in this study. Tier 1 of this model focuses on overt behavior and relationship patterns; tier 2 focuses on thinking, feeling, sensory, and perceptual interoceptive awareness; and tier 3 focuses on unconscious relationships between variables in different tiers (Stricker & Gold, 1996, 2013).

This framework offers the possibility of relieving symptom distress and building new intrapsychic representations and effective interpersonal skills. In addition, Stricker and Gold's (1996) three-tiered model purports flexibility by considering a person's current functioning level (e.g. robust/fragile), the category of intervention (behavioral or exploratory), and tri-directionality (Gold, 2014; Stricker & Gold, 1996). Lastly, the model reflects both ACT and STPP by focusing on antecedents and relational contexts of presenting problems, whereby dynamic understanding and experiential change is possible.
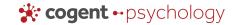
3. Method

3.1. Participants

I interviewed 13 participants from the United States, Australia, and Canada who possess a master's and/or a doctoral degree with a minimum of one year of professional experience integrating STPP and ACT. I recruited these participants through targeted emails to the following professional associations: (1) The Society for the Exploration of Psychotherapy Integration (SEPI); (2) International Integrative Psychotherapy Association (IIPA); (3) Association for Contextual Behavioral Science (ACBS); (4) Institute for Integrative Psychotherapy; and (5) agencies where integrative approaches are utilized.

Eleven women and two men participated in the study. Eight therapists held master's degrees, and five therapists held doctoral degrees. Eleven therapists identified their race as Caucasian; one therapist described herself as a white Anglo-Saxon Protestant, and another stated that she was European-Australian with Scottish heritage. The therapists' ages varied from 33 to 58. The participants' experience practicing psychotherapy varied from 3 years to 29 years. Experience practicing ACT and STPP began at one year, with the most experienced therapist practicing ACT for 10 years and STPP for 29 years. Years of experience integrating ACT and STPP varied from one year to ten years (see Table 1).

Table 1. Participant demographic data										
No	Name	Gender	Ethnicity	Age	Degree	License	Psych exp	ACT exp	STPP exp	Integration exp
1	Marley	F	Caucasian	33	Masters	LMFT	1.5	1	1.5	1
2	Rita	F	Caucasian	42	Masters	LMFT	3	2	7	2
3	Emma	F	Caucasian	41	Masters	LMFT	15	3.5	12	3.5
4	Susie	F	WASP	50	Doctorate	Psy.D	12	7	9	2 to 3
5	Kara	F	Caucasian	32	Doctorate	Ph.D.	9.5	2.5	5	2.5
6	Tito	M	Caucasian	50	Doctorate	Ph.D.	27	10	25	10
7	Molly	F	Caucasian	54	Masters	LMFT	10.5	2.5	7	2.5
8	Sydney	F	Caucasian	55	Masters	LMFT	22	4	12	3
9	Frank	M	Caucasian	37	Doctorate	Psy.D	15	2.5	7	2.5
10	Maureen	F	Caucasian	33	Doctorate	Psy.D	9	2	2	2
11	Jenny	F	Caucasian	54	Masters	RClinP	29	10	29	10
12	Bonnie	F	EASH	47	Masters	RN/RClinP	4	4	4	4
13	Mary	F	Caucasian	58	Masters	LMFT	20	7	1	1

Note: All names have been changed to protect confidentiality; exp = experience in years; WASP = White Anglo-Saxon Protestant; RClinPsy = Registered clinical psychologist; LMFT = Licensed Marriage and Family therapist: EASH = European Australian with Scottish heritage; RN = Registered Nurse.

3.2. Data collection

The Institutional Review Board (IRB) of California Southern University approved this study on 25 April 2016. Data collection occurred in Australia from 24 July–2 September 2016. Skype or Face Time® was used to conduct face-to-face interviews. Interviews were tape recorded and documented participants' verbal consent to take part in the study before interviews occurred. Pseudonyms ensured confidentiality of the participants' identities and personal information. Scheduled Skype or Face Time® interviews lasted between 45 and 60 min with the possibility of a second interview by email was completed for the purposes of further clarification to aide in analysis. Second interviews with three participants assisted in supplying missing information to verify or substantiate categories for emerging analysis (Charmaz, 2014). I audiotaped and transcribed all interviews verbatim, and each participant was given a $25 gift certificate for completed interviews to compensate them for their time, regardless of the length of time or the number of interviews.

3.3. Materials and procedures

The semi-structured, in-depth interviews began with general open-ended questions designed to identify and understand how therapists integrated STPP with ACT. The questions were formulated by identifying preexisting assumptions through the process of memoing—a part of the qualitative research process which helps the researcher in drawing conceptual conclusions between the data and the concepts that help illuminate the research phenomena (Birks, Chapman, & Francis, 2008). I used a heightened awareness of my preconceptions to guide in the development of the interview questions. I included the data from these participants in the analysis. Interview questions can be found in Appendix A.

I used four criteria to decide when to end data collection and mark theoretical saturation, which refers to the stage of qualitative data analysis wherein no new data emerge and concepts in the theory are well rounded (Lewis-Beck, Bryman, & Liao, 2003). First, each category had ample rich description of its contents. Rich descriptions can be characterized as narrative reports of the major events that conceptualize the emerging relationships among the variables involved (Becker, 1993). Second, new data ceased to produce new categories. Third, the relationship among categories was clearly ascertained. These three criteria are in accordance with Strauss and Corbin's (1990) definition of theoretical saturation. I added Mack, Woodsong, MacQueen, Guest, and Namey's (2005) criterion that no new data emerged that provided any additional insight to the research questions.

3.4. Research design

I applied grounded theory method to analyze interview transcripts. Grounded theory uses inductive strategies to develop analytic categories (Charmaz, 2014). The design supports a shift from descriptive to a conceptualized and explanatory understanding which can lead to a theoretical model and a further the knowledge of a social phenomenon (Charmaz, 2014; Glaser & Strauss, 1967). This study involved exploring and understanding how a therapist's action-oriented interventions of integration can lead to an explanation and theoretical understanding of a phenomenon. Theoretical understanding of the phenomenon under investigation included my interpretation of how participants constructed ACT and STPP integration.

I completed data collection and analysis using interpretive and constructivist principles, which posit that humans construct knowledge and meaning from their experiences. This lens was used to understand the circumstances when psychotherapists choose to integrate STPP and ACT as a therapeutic strategy, how the process unfolds, and the potential benefits and challenges they face (Charmaz, 2014; Strauss & Corbin, 1990). Therapists' perceptions are pivotal to understanding how STPP and ACT are synthesized, as multiple views can illuminate an abstract understanding of interactions between therapist, client, and the context—all of which can influence whether the therapist chooses psychological integration as a strategy.

In accordance with Charmaz (2014), constructivist grounded theory analysis begins with a constant sequential comparison method applied to the collected and coded data. The first level of

coding is initial coding. Initial coding serves as a transition from data collection to the first step in analysis. The specific steps that the researcher uses to analyze the data began with line-by-line coding to sort and organize data into preliminary categories. The researcher then uses these provisional codes in a constant comparison core process, where newer codes are compared to determine whether the original codes still fit or require change to reflect emergent data (Charmaz, 2014; Saldaña, 2015).

The second stage of coding is focused coding, which refers to identifying and selecting the most frequent and noteworthy codes to analyze large amounts of data (Charmaz, 2014). Charmaz suggested that this type of coding brings to the researcher's attention, the most prominent and more precise categories that best describe the emerging analysis. This focused coding process helps to conceptualize the theoretical direction of the research (Charmaz, 2014). The researcher keeps memos simultaneously with data collection and theory development. Memos are written notes about the researcher's ideas regarding codes and interview reflections that are intended to assist in analysis of data (Charmaz, 2014). Examples of an interview reflection memo might include pauses in a participant's response to a question, emotional intensity when answering a question, or nonverbal communication such as body language. When the researcher analyzed the data, memos were included in the theoretical interpretation.

Subsequently, theoretical sampling was used to sharpen ambiguous or insufficient categories and to establish connections among categories. Theoretical sampling is used to explain linked categories of focused coding and can add detail to the analysis when the codes represent the collective data and the analysis (Charmaz, 2014). The findings of these features were then compared and integrated with extant literature and presented in a final analysis.
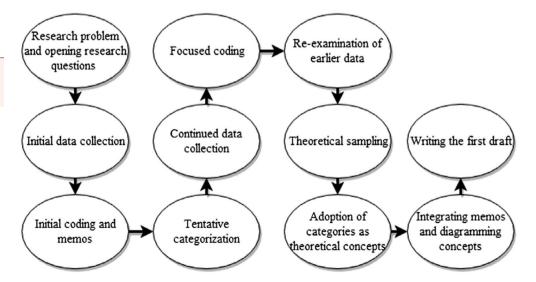
In this method, the researcher "simultaneously codes and analyzes the data in order to develop concepts; by continually comparing specific incidents in the data, the researcher refines these concepts, identifies their properties, explores their relationships to one another, and integrates them into a coherent explanatory model" (Taylor & Bogdan, 1984, p. 126). For a flow chart that depicts constructivist grounded theory process, see Figure 1.

3.5. Credibility

Credibility determines how well the data reflects the multiple realities of the phenomena being studied (Morrow, 2005). To account for threats to internal validity, a methodological journal was kept of how I ascertained participant knowledge to ensure their contributions were represented accurately and avoided preconceiving data. I provided "thick descriptions" of the context of when and how

Figure 1. Flow chart following constructivist grounded theory process.

Source: Adapted from *Constructing Grounded Theory* by Charmaz (2014).

therapists chose integration as a strategy, with the thickness referring to multi-layers of the data (Sikola, Biros, Mason, & Weiser, 2013). Lastly, I offered participants in this study the opportunity to verify the accuracy of their transcribed interviews. To ensure that the research findings reflected the focus of the study, I used an iterative process with emerging data, memoing, and increasing levels of abstraction to manage subjectivity and provide a well-documented path of the evolution of inquiry.

3.6. Dependability
Dependability refers to how well the variables in the research can be repeated and lead to consistent outcomes (Brown, 2015). To check for coding errors, I used the constant comparison method to compare provisional codes to newer codes to determine whether the original codes fit or require change to reflect emergent data. To account for theoretical development, the researcher's chair reviewed and examined the process for coherence and confirmation of the findings. Having another examiner review the data collection process helped to establish an audit trail. An audit trail is a technique to help ensure three outcomes: those outcomes are dependability, iteration, and confirmability. Dependability is accomplished through keeping an organized and chronological account of data collection and theoretical development (Morrow, 2005). Through constant comparison of the analysis, the iteration process helps direct future studies (Bowen, 2009). Researchers utilize confirmability to evaluate the objectivity of the grounded theory to confirm the findings (Brown, 2015).
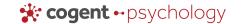
4. Data analysis
Data were coded using Gold and Stricker (2013) and Stricker and Gold's (1996) three-tiered assimilative integration model. Per Charmaz (2014), initial coding serves as a transition from data collection to the first step in analysis. I used line-by-line coding to sort data into preliminary categories to identify how diverse therapists integrate ACT with STPP and under what circumstances they feel integration is clinically indicated. Line-by-line coding established 12 initial categories: ACT; STPP; integration of ACT and STPP; use circumstances; patient benefits and outcomes; components of integrated therapy (IGT); skills; client–therapist relationship; session practices; strategies of IGT; challenges; managing responses to challenges; and self–evaluation and work evaluation.

Following the initial coding process, I used an amalgamation of codes to identify core categories and potential themes. I used the constant comparison method defined by Charmaz (2014) as an inductive process that culminates in increased levels of abstract concepts achieved by the comparison of categories to data and categories to codes. Direct quotes from participants helped support my interpretation of the data, provided deeper significance to participants' experiences, and provided a means to trace systematic theme development (Saini & Shlonsky, 2012). I interwove memos, written notes about my ideas regarding codes, and interview reflections into the data analysis to ensure researcher credibility and facilitate theoretical interpretation (Charmaz, 2014). Properties emerged which described features of concepts (Corbin & Strauss, 2014). For purposes of this research, properties provided dimensions for subthemes. The final stage, theoretical coding, leads to a framework and depiction of a social practice developed from previous stages of data collection, emergent categories, and theoretical sampling (Saldaña, 2015).

5. Results
Based on the practices and opinions of the participants, results indicated that the integration of STPP and ACT therapy is effective. Seven response markers were identified to match interventions to patient characteristics in the present context of the patient's current functioning and the therapeutic alliance. For purposes of this study, response markers were defined as clinical junctions where a therapist can make decisions to integrate STPP and ACT or implement therapy from one of these single orientations.

The circumstances under which the integrated therapeutic model was implemented constituted one theme that contributed to the construction of a narrative explaining how, when and why participants chose to integrate STPP and ACT. The following seven sub-themes were identified as response markers in this category:

(1) Therapist intuition, defined as an organic or spontaneous decision made on a case-by-case basis and on contextual factors. Contextual factors include, but are not limited to, whether the integrated approach was a clinically appropriate means of addressing the problem with which the patient presented, the level of functioning during sessions, and patient characteristics;

(2) Patient acuity, described as degree of distress coupled with pathology. Four mental illnesses were mentioned as conditions whereby integration of STPP and ACT would be considered. These four properties were trauma, obsessive compulsive disorder (OCD), eating disorders, and personality disorders. Based on patient characteristics such as personality disorders, the property, *duration of therapy,* became evident in the analysis and is described as the length of time for treatment based on patient circumstances;

(3) *Stuck-ness*, described by participants as their patients being stagnant in momentum toward change;

(4) Relationship and attachments, identified as a patient characteristic likely to influence the integration model of STPP and ACT;

(5) Patient readiness in terms of being inflexible or stuck in their process;

(6) The need for an approach that is versatile, while giving structure to the therapy; and

(7) Contraindications to what is clinically indicated.

5.1. Therapist's intuition

In describing the decision to implement the integrated model, each of the participants used the word intuitive or identified properties of the sub-theme with similar wording, such as, organic, going with the flow, and natural; all indicating that the determination of IGT application was made on a case-by-case basis. On her approach to using IGT, Marlee responded:

The decision to integrate therapeutic models is intuitive and spontaneous:

> I think in a sense; the integration is more of an organic process. Maybe not always. I do not want to say unintentional, because I feel the decision does need to be intentional, but the moment often depends on the client, the situation, and what is happening organically in the context of the session.

For Sydney, trusting her intuition was linked to training. The more training she acquired, the more intuitive and receptive she became.

Although less specific in her wording, Bonnie reported that the decision to use IGT was an intuitive one and not reducible to a rule or principle. She stated, "I wouldn't say, if someone comes to me with this particular diagnosis, I definitely would or would not use STPP. It is on a case-by-case basis."

5.2. Patient acuity

Patient acuity is a second subtheme under the category of circumstances in which to implement the model. Participants who use a psychodynamic foundation for treatment reported that they integrated ACT when the patient presented with an acute condition. Emma confirmed that the formal and explicit application of the ACT model was most beneficial to clients who were in acute distress, whereas with other patients, though they might benefit from certain elements of ACT, they were not as needful of the structure that model provided:

> I don't think there's any place that I wouldn't integrate ACT, it's more that I wouldn't feel the need to elucidate it and make it more formalized with a patient who was not in acute distress. With somebody who's experiencing more acute distress, I would probably want to give them the structure of an actual ACT experience; with a less acute patient, I would sprinkle in tidbits here and there and encourage them to experiment.

Like Emma, Frank stated that he integrated ACT with an STPP process when treating an acute condition:

> Psychodynamic or STPP are my default positions. However, there are situations when a patient needs more structure. Sometimes patients need a model in some settings and in some context, which helps when anxiety and apprehension feels intolerable. ACT helps look at anxiety as an opening to roll with, rather than to fight against. At some point, resistance comes into sessions with enactments where it is best to understand this from a STPP perspective.

Trauma was a property within the category of patient acuity. Several participants felt that the integrated model was useful in treating patients who presented with trauma, with or without PTSD. Molly also recommended the integrated model for treating trauma but added a qualifier: "The patients that benefit the most would be people that are struggling with some past trauma but are relatively well-functioning." Rita likewise recommended the integrated model for "people that have developmental trauma or complex trauma." Susie said, "I'll merge ACT and STPP with trauma patients—even in developmental trauma where the parents had not been emotionally accessible for some reason." Jenny cited PTSD specifically, saying "I think the integrated model is imperative with complex PTSD."

Obsessive Compulsive Disorder was a second property of this the subtheme patient acuity. In regard to applying the integrated model for patients with OCD, Kara stated, "I work a lot with OCD and the role of using ACT with OCD is different because you're working with irrational obsessive thoughts, so you're going to hold those differently than you might hold realistic thoughts and fears." She elaborated as follows: "you might give a little bit of reassurance for someone because that's the attachment need, whereas you would not give every assurance to someone who has OCD who might use it in a compulsive way." Frank stated that he integrated ACT into his psychodynamic process when the patient presented with OCD. "If somebody says I can't go to sleep without checking to make sure the stove is turned off twenty times, then I'm thinking, Oh, okay. Let's start with the OCD. If that is the case, then I'll default to ACT."

Maureen, however, stated that the integration of STPP might not be appropriate for patients suffering from OCD:

> I would say maybe for a client who has clear-cut OCD, where it is more about exposure work and resisting compulsions, I don't think it's necessarily so important for them to understand where it's all coming from, i.e. the history behind it.

A third property of the patient acuity subtheme was *eating disorders*. Susie stated, "I'm just thinking, a lot of the patients where I seem to use an integrated approach quite heavily is with my patients who have eating disorders. Mary feels the synergy of integration of STPP and ACT to shorten the duration of treatment is particularly true with eating disorders. Kara stated people with eating disorders, in my mind, well, it's not a quick fix." Kara listed patients with eating disorders as an example of people who were likely to benefit from the integrated model. She stated:

> In terms of being more likely to use an integration model of STPP and ACT, when patients are in a place where they are using a lot of avoidance, e.g. attempting to control their thoughts and feelings and using a lot of unhealthy coping skills that are not functioning well for them, such as what I find with eating disordered patients.

Personality disorders was a fourth property under the patient acuity category. Participants differed in their opinions of whether the integrated model was appropriate for patients with personality disorders. Frank stated, "When I work with character disorders or personality disorders, mindfulness is an invaluable tool for folks who exist in the traditional borderline space." Frank uses the tool of mindfulness combined with an STPP stance of "examining unconscious conflicts that are self-defeating and

self-destructive: both in their life and in the therapy." Rita, who integrates STPP with her standard ACT process under circumstances when longer term treatment seems warranted, mentioned clients with personality disorders among those who could benefit. Sydney stated, "I think that most of the personality disorders, whether it's narcissistic or borderline or histrionic or dependent, could benefit once there's a stable attachment with the therapist." Molly, on the other hand, said, "I think personality disorder clients do not benefit as much from the integrated process as those without personality disorders."

Duration of therapy was a fifth property of patient acuity. Whereas the participants quoted in the previous section began courses of treatment with a psychodynamic orientation and added elements of ACT in cases in which the distress was circumscribed or acute, participants who began with an ACT orientation would add STPP when the duration of treatment seemed warranted. Rita noted that the integrated model made the course of treatment longer than it would be with pure ACT and stated that "with people that have personality disorders, developmental trauma, or complex trauma; the treatment becomes longer-term."

Sydney stated that the integrated method worked best with long-term clients who were more focused on personal growth than on crisis management:

> I would integrate the two approaches with my longer-term clients who are specifically oriented toward personal growth and self-knowledge. They are likely to be looking at how they show up with others, the impact that they have on other people, and the kinds of feelings, urges, and responses that they have with other people.

5.3. Stuck-ness

One prominent subtheme under the category of circumstances of use is the concept of "stuck." Kara felt that the integrated model was helpful, not only for patients with PTSD, but also for patients who were, in general, stuck. "This is the case with a lot of anxiety disorders, eating disorders, and PTSD clients." Elaborating on her statements about patients who were stuck, Kara added:

> Other than the anxiety, eating disorders and PTSD, I treat people who have trouble making decisions, who have some self-esteem issues influencing indecisiveness, and choosing direction for career issues. The anxiety is about what they want to be doing that's meaningful in their life; so, people who are feeling maybe a lack of purpose? This is where ACT brings in the focus on values.

Mary stated she sees behavior ruminations as the patient being "stuck." Ruminations are "interpersonal dynamics that have been developed and perpetuated often from childhood where the rumination serves as a form of self-punishment." Under these circumstances, Mary would switch from using STPP to ACT. Other participants also used the term *stuck*. Bonnie stated that the integrated model was particularly beneficial to "middle-aged women who are stuck in their lives. They want to know why they are stuck and want to move on. They do not necessarily meet diagnostic criteria. Progress can happen in a very short period."

5.4. Relationships and attachment

Relationships and attachment is the fourth subtheme within the category of circumstances in which to implement STPP and ACT integration model. Maureen felt that IGT was appropriate for patients who are struggling with relational issues. "I think it's helpful for people who struggle with attachment issues to figure out ways to cope by having some coping and insight around some of those patterns and the role that they play in them."

Jenny stated, "I think IGT is imperative for people whose relationships haven't been great."

Kara furthered the category of relationships and attachment by saying, "I feel like sometimes people get stuck in relationship patterns and understanding the root of some of those things can be

helpful combined with noticing and skill-building." Lastly, Tito commented that "patients have better interpersonal relationships and family members also benefit from the ACT tools and from patient ability to have better interpersonal relationships.

5.5. Patient readiness
Patient readiness was the fifth subtheme**.** Marlee stated, "Clinical appropriateness is necessary in choosing to integrate ACT and STPP. She added that a patient should be 'open to look at themselves.' Sydney stated that integration was most appropriate for patients who were "willing to look at themselves on a deeper level and be interested in insight." She added that she would not integrate the models until the client had begun to form a stable attachment with her. Susie confirmed that she preferred to start treatment with a psychoanalytic model and add pieces of ACT over time, but that she steered away from a psychoanalytic course of treatment when the patient lacked insight or was otherwise unprepared. She supported this statement with the following:

> If I think that once we go there, what is brought up will land on deaf ears; if I don't think our relationship is solid enough; and if I don't think the patient is solid enough to walk out the door at the end of a session and sew themselves back together, as someone once said to me, then I won't go there.

Emma stated:

> The decision to use IGT depends on how far the client wants to go. Some clients do not want to go further than just getting some set of tools they can use and a way of maintaining, while other clients very much want to get to that place where they feel like they actually understand; and therefore, probably move beyond maintenance of their symptoms to having a different internalization of what is possible.

One property of patient readiness is *well functioning*. Two participants noted that a patient should be well functioning before undertaking an integrated course of treatment. Molly stated, "The patients who benefit the most would be people that are maybe struggling with some past trauma but are relatively well functioning." She further explained:

> Well-functioning means, not so deep in their depression that they're struggling to get out of bed. So, people that can get up in the morning, have moderate depression, but still are able to meet their daily needs.
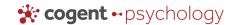
Tito agreed, stating that the client had to be able to tolerate a certain amount of stress for the integrated model to work, and that the patient needed to be stable. "I think a patient has to be able to tolerate some discomfort and distress without becoming too dysregulated."

The necessity for an adolescent patient to be ready for IGT influenced the opinions of several participants about whether the model is inappropriate for younger patients. Asked for whom the integration of STPP into the treatment model was inappropriate, Susie stated, "With teens actually, that would be another place where I would more likely start right from an ACT model and stay there, unless I thought something like CCRT would be helpful." [1] Marlee also had reservations about integrating the psychodynamic model into treatment processes for younger patients:

> I worked in crisis situations where kids are living in the family. With kids, I think they need to come back later in life and look more under the surface of what's been happening. They're just not at the place either developmentally, or in their current life situation to successfully be able to do this.

5.6. Versatility and structure
Versatility and structure is the sixth subtheme within the category of circumstances in which to implement ACT and STPP. Sydney, Kara, and Maureen expressed a preference for using IGT because it offered both versatility and structure: a unique combination. Emma, Jenny, and Susie voiced the

opinion that the integrated model was versatile enough for an almost universal application. Emma cited the versatility of an integrated model that brought ACT into a STPP process:

> I do not think there's any reason that I wouldn't pull in certain elements of ACT. Like I said, who cannot benefit from mindfulness? Even your most inaccessible kind of client can benefit from mindfulness. It helps them build that observing ego, which you are hoping for.

Susie stated that she combines the two models naturally in her practice: "I think there's elements of STPP in all of my ACT work, and probably there's elements of ACT in the STPP model because when we're talking about experiential avoidance, we are really getting into what analysis would call defenses."

 Participants also noted that adding ACT to STPP was sometimes a useful means of introducing more structure into the course of treatment. Emma said:

> Intuitively, ACT and STPP seem to work well together with people who are more anxious and with avoidant attachments. The integration of ACT and STPP provides a way to approach their feelings, which I think ACT does a really good job of providing some of the structure in doing that in a more concrete way than psychodynamic therapy does.

Emma added that introducing the structure of ACT could be particularly helpful when STPP reached a dead end:

> The way I practice the integration of ACT and STPP is to first explore and then if I have the sense that it's a dead-end process, i.e. that the exploration is more of a defensive process or it's an anxiety process, then I won't keep going through that loop. Then it will be more like let's accept; let's defuse. We already understand the underpinnings and work on different areas where we can get insight which is not necessarily in that same process. Why would you keep asking somebody why they're anxious? They are just anxious, but there are many other doors into understanding the anxiety.

Frank cited another way in which the structure provided by ACT could promote the goals of STPP:

> I think part of the treatment process in STPP is in the person internalizing gradually, my openness to their internal experience. I think that can be helped along by talking more explicitly about defusing, having a mindful stance, acceptance, and that sort of thing. I do not think we need to confine ourselves to that quintessential analytic stance "Say more." I think sometimes people need a structure. Sometimes they need a model. Sometimes they need the whiteboard and the matrix.

Susie had found the integrated model particularly useful in her practice when the psychoanalytic approach did not provide enough structure for the therapist:

> I think I tend to look for ACT for a bit of structure when I'm feeling a bit lost. If I am feeling quite mired down and I'm not sure where I am going, coming back to something that has some structure like CCRT or even ACT will help pull me in a little bit.

She qualified this statement, however, by adding that the structure associated with ACT would occasionally become obtrusive: "There are moments when applying that structure feels very artificial and would just feel kind of jarring and I do not want it there."

5.7. Contraindication

The last subtheme for this category is contraindications. The participant responses were elicited from the question, "What are some particular circumstances you would choose not to integrate ACT and STPP?" Sydney and Tito stated they would not use it with clients who were clearly having any kind of psychotic break. Kara stated that she avoided adding the ACT pieces in certain cases: "I really

try to stay away from skill-building when a person, really just needs their experience heard and validated and to not minimize those experiences such as with patients of color who have suffered from discrimination." Mary avoids the synthesis of ACT and STPP when implementing exposure work; that is "when the exposure is happening as it can be 'too distracting.' One situation where Mary feels ACT and STPP integration would be a contradiction is "when a person is struggling with an impulsive situation ... in this case, I believe problem solving and values focus is clinically indicated."
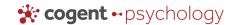
6. Discussion of findings

This study provides insight into how an integrative STPP and ACT strategy works for patients from a provider perspective. Seven response markers were identified as circumstances for IGT integration. What constitutes this study's specific contributions to the extant literature is twofold: (1) the identification of circumstances for which these two modalities are integrated and then implemented into therapy, and (2) the finding that therapists' intuition is and may always be the decisive factor in the synthesis of ACT and STPP application.

6.1. Therapist's intuition as a marker

Therapist intuition appeared in the findings as an organic or spontaneous decision to integrate STPP and ACT, made on a case-by-case basis according to contextual factors. Contextual factors mentioned by participants included, but were not limited to, whether the integrated approach was a clinically appropriate means of addressing the problem with which the patient presented, the patient's level of functioning during and between sessions, and patient characteristics. While therapists' intuitive decisions to integrate may be informed by training and experience, the criteria on which the determination is ultimately made may not be reducible to a formula or a set of rules. Welling (2005) defined intuition as a possible common factor in psychotherapy that is influenced by the integration of client functioning and therapist perception. Intuition is knowledge not fully formed, yet this initial knowledge coupled with a theoretical framework can help the therapist to recognize patterns from experiences that can be used in choosing strategies to guide treatment (Welling, 2005).

Therapist intuition as a response marker for STPP and ACT integration is an unexpected finding and the social practice depicted from theoretical coding from this study. Over half of the participants in this study admitted to relying on their professional intuition to guide them at times in the process of psychotherapy. However, therapists may not be willing to admit the degree to which they rely on intuitive thinking when they make clinical decisions that are not informed by evidence-based research (Dodge Rea, 2001; Eells, 2013; Marks-Tarlow, 2014; Welling, 2005). Grasping the imprecision of how intuition is quantified, measured and applied in clinical decision-making has been an endeavor by researchers (Dodge Rea, 2001; Eells, 2013; Marks-Tarlow, 2014; Oddli, Halvorsen, & Rønnestad, 2014; Welling, 2005). Nonetheless, intuition exists in the intersubjective space between the patient and the therapist. Evidence-based research is imperative for credibility, for harm prevention, and for measuring treatment efficacy. Still, controlling every aspect of what contributes to therapeutic change is challenging and has its limitations. This could be a valuable resource for augmenting the therapeutic alliance. Of note, novice psychotherapists may have not internalized conceptual knowledge to the degree that they can work from intuitive knowledge which can be gained from acumen of more experienced practitioners (Chi, Glaser, & Farr, 1988).

In reality, the practice of mental health treatment contains a degree of subjectivity and involves some degree of speculation. To represent evidence-based knowledge, constructs are created by researchers and scientists to measure outcomes. This process begs the question of whether we as psychotherapists negate the uniqueness out of people when we form constructs and attempt to treat the constructs while forgetting that a history comes with a patient. If we treat the construct, is that the same as treating the person? Perhaps intuitive thinking by clinicians has value in co-creating a process with evidence-based research that is associated with a direction that works best for the patient. This researcher concurs with Dodge Rea (2001), who states that intuition can not only be complementary to a theoretical framework but can also be a tool that is possibly undervalued and

devalued by the community of therapists in general due to the lack of understanding for implementation in clinical practice.

6.2. Patient acuity as a marker

As suggested by the participants, patients in acute distress, with or without acute conditions, needed more structure and a tool-based focal point, which is possible through ACT concepts. Results from this study support previous research findings indicating that when patient arousal is high, exploration and reflection of emotions may produce excessive psychological fragmentation (Cohen, 2016; Gold, 2014). Participants who utilize STPP as a primary therapy reported they would integrate ACT tools into treatment when anxiety and fear felt intolerable. Supportive techniques such as skill building, and psychoeducation can enable the patient to tolerate challenges associated with anxiety, resistance, or temporary incapacitation due to trauma (Leichsenring, Leweke, Klein, & Steinert, 2015). ACT offers concrete behavioral training in defusion and self as context. This modality may be more immediate in reducing the intensity of stimulation. When a person is in a less fragmented state, adding STPP therapy to ACT may provide insights into once unconscious obstructive patterns and their impact on present-day functioning.

In addition to patient acuity as a subtheme, the findings of this research suggest trauma of variable causation, including complex and developmental, with and without PTSD, to be phenomena amenable to a treatment approach that utilizes an integrated theory of STPP and ACT. In general, participants believed this integrated approach helps to address coping skills and insight into maladaptive patterns and the role the patient plays in them. The participants suggested patient dysregulation as one reason not to apply an integrative approach. The degree of patient functionality matters if an integrated theory is selected as a strategy.

Extant research supports these research findings. For trauma victims and some patients with certain personality characteristics, establishing personal meaning through psychodynamic techniques may arguably be necessary before acceptance of feelings can occur (Stewart, 2014). After meaning-making has been developed, the practice of acceptance can then be integrated into the therapy. Also, it is possible in situations that reflect a delayed expression of the trauma, for acute symptoms to be treated with an ACT protocol. Should the original trauma triggers reoccur later, then perhaps this would be the context in which integration would be implemented so that antecedents or unconscious conflicts linked to the trauma could be addressed. Alternatively, for some trauma patients, integration of different paradigms can occur immediately. As Messer (2015) theorized, an assimilative integration approach using a psychodynamic model blended with the experiential technique of expressive writing can assist a trauma victim with interoceptive awareness of bodily held affect linked to present moment awareness. Self-disclosure becomes possible within the safety of the therapeutic alliance.

Applied to Gold's (2014) three-tiered assimilative model, the opportunity to identify, connect, and express thoughts with feelings on tier 2 could help trauma victims with prevention of reenactment behaviors categorized on tier 1. A tier 3 strategy would be to examine unconscious maladaptive resolutions to the trauma. Diminished vulnerability coupled with new interpersonal and relational skills can result from interactions among all three tiers.

Regarding specific diagnosis, participants had varied responses to whether a diagnosis of OCD would benefit from IGT, although they would generally default to ACT. One participant indicated that STPP was inappropriate for this presenting problem because investigating the roots of the behaviors is less important than resisting compulsions. Another participant always used ACT and STPP integration with OCD. An explanation for this discrepancy is that although most individuals with OCD commonly experience a comorbid diagnosis, as in the case of depressive or anxiety disorders (American Psychiatric Association, 2013), a smaller percentage may benefit from a focus exclusively on exposure work and learning how to resist compulsions associated with the obsessions. In contrast to this position, one participant believed adding STPP to an ACT based therapy "holds the depth and a fuller

story or what is happening in their life," while another participant touched on the benefits of mindfulness for an OCD patient in helping them to develop an observing ego. There is research that supports behavioral interventions blended into a psychodynamic interpretative framework, which focuses on areas of developmental arrest such as in the treatment of trichotillomania (Ziv-Beiman, 2015) and eating disorders (Rance, Moller, & Clarke, 2015). It is possible that patient characteristics in the case of OCD influence the decision to choose STPP and ACT integration as a treatment strategy.
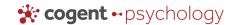
Like OCD, developmental arrests can be part of a person's characteristics if they struggle with an eating disorder (Rance et al., 2015). Patients with eating disorders, a property of patient acuity, benefit from the replacement of unhealthy coping skills such as avoidance with ACT tools and the insights gained through STPP. Four participants affirmed merging STPP with ACT when treating eating disorders to examine unhealthy coping skills that function in the service of avoidance not only of food, but also of living life. The therapists provide a focus on identifying interpersonal relationship patterns which influence and maintain the eating disorder behaviors combined with exposure response prevention, mindful eating homework, and education about relapse. The overarching goal is not to avoid life, but rather to craft a workable one that is lived well.

The results of the current study are consistent with the extant literature on integrative treatment for eating disorders. Previously, McDonald (2012) identified treatment interventions based on the perceptions of the psychotherapist who work from an integrative approach to the treatment of eating disorders. A behavioral framework added skill training in mindfulness, relapse prevention, and trigger identification. Psychotherapists implemented psychodynamic theory to examine the role of unconscious dynamics in maintaining unhealthy attachments to food and people. Also utilized was a psychodynamic framework of building the therapeutic alliance to support the working through of enactments in the transference. McDonald (2012) study supports earlier research with the theoretical underpinnings of a multi-integrative approach to the treatment of eating disorders (Zerbe, 2008). An individualized integrated treatment plan reflects the developmental needs of the eating disorder patient.

Not all participants agreed that STPP and ACT integration is clinically appropriate for personality disorders; a property of patient acuity. Those participants who found IGT beneficial for the treatment of personality disorders indicated that ACT tools such as mindfulness could be beneficially combined with STPP's examination of unconscious conflicts. Mindfulness is particularly useful for patients with borderline, histrionic, and narcissistic personality disorders. One participant stated she would choose an assimilative integration strategy of STPP and ACT if the patient exhibited characterological defenses but not necessarily a personality disorder. This participant believed that psychodynamic psychotherapy is a better choice for the treatment of personality disorders in general. Another participant expressed concern about integrating STPP into ACT; some patients get stuck in the *why* their life unfolded the way it has. This participant provided an example of a patient diagnosed with narcissistic personality disorder. The patient intellectualized ACT concepts but was unwilling to apply them in behavioral ways; thus, forward progression in treatment was stagnant.

Some researchers have supported that STPP is too brief and possibly not appropriate for complex and chronic conditions such as personality disorders (Leichsenring, Abbass, Luyten, Hilsenroth, & Rabung, 2013). Contrarily, other researchers have indicated that an integrative approach may be preferred for the treatment of personality disorders because of the flexibility to treat co-occurring diagnoses and functioning levels that vary according to the patient's traits and current state (Nelson, Beutler, & Castonguay, 2012). Furthermore, Gold's three-tiered integrative model was originally designed as a suggested framework to treat personality disorders (Strieker & Gold, 1988).

It is possible that if integrative therapists participated in discussions with other like-minded therapists and shared ideas about integration, then nascent ways of working with different patient populations in an STPP and ACT integration theory may become more evident.

6.3. Stuck-ness as a marker

For purposes of this research, the participants referred to being stuck as the patient's inability to move forward or make changes toward patient-identified goals. The findings of this current study indicate the state of being *stuck* happens for patients during times when they are immobile or unresponsive to the process of psychotherapy. Participants reported that this is especially true with the common mental disorders of anxiety, eating disorders, PTSD, and in situations where a person was feeling they lacked purpose in life.

When a patient is stuck, a different method to influence progress may be needed (Gold, 2014; Messer & Warren, 1995; Westra, Constantino, & Antony, 2016). During times when a patient lacks a sense of meaning or purpose, the focus on the ACT feature of values may help to identify a direction formed by following a personalized way of interacting with life. It is plausible that the desire to change according to values may be present; however, if the pace of therapy is too fast, the patient may become stuck. In these situations, being stuck may require more self-exploration and understanding by the patient of fears associated with moving toward identified goals. STPP can explore these fears from a less structured viewpoint and at a slower pace for purposes of discovering the patient's personal meaning attached to change by paying attention to developmental history when other circumstances of stuckness were part of their life. This likely once-unconscious information can then be integrated and implemented into strategies that are more active and structured in nature; hence, a therapeutic paradigm shift reverts to ACT.

6.4. Relationship and attachments as markers

The participants perceived that integration is appropriate for patients who are suffering from relationship issues, particularly attachment issues. While ACT provided the client with tools that were useful in coping with the problematic issue, STPP facilitated insight into unhealthy relationship patterns. According to Davanloo (1978), using STPP helps to recognize a focal unconscious problematic relational pattern in a relatively short time period. ACT principles encourage the formation of an alternative context, such as through acceptance, within which to consider how a person relates to the discomfort, while STPP offers clarification, interpretation and, depending on the type of therapy, confrontation of resistance. Given the finding that motivation for behaviors is the foundational component of interpersonal as well as intrapersonal functioning (Lemma et al., 2011; Luborsky, 1984; Stricker, 2010; Strupp & Binder, 1984); STPP may be a means of gaining insight into the unconscious motivations for problematic interpersonal behaviors, whereas ACT may be used to relieve immediate distress through alternative-context formation.

Interpersonal and intrapersonal growth are outcomes of STPP and ACT integration. Patients gain intrapersonal and interpersonal clarity, insight, and understanding of what contributed to their being unable to move forward, while ACT provides direction on how to activate and use this information in a practical manner to move forward in life in a meaningful and self-defined way. The benefits that patients gain from this exploration include fewer unconscious conflicts that are acted out in self-destructive ways in therapy and life.

To tolerate the distress, they may experience as a result of the STPP process, patients should be well functioning; that is, they should not be incapacitated by the presenting problem, have a stable attachment to the therapist, and exhibit readiness to undergo extensive self-examination. Kuutmann and Hilsenroth (2012) advocated that to achieve improved therapy outcomes, therapists should pay early attention to the therapeutic alliance when integrating techniques with people who have severe personality disorganization. Past researchers have found that the quality of the therapeutic alliance is a common change factor associated with various psychotherapy orientations (Hilsenroth, Cromer, & Ackerman, 2002).

Several participants mentioned that when working with individuals with personality disorders, choosing an integrative strategy should be delayed until after the formation of a stable attachment between themselves and the patient. Additionally, IGT may be contraindicated for adolescent

patients who may be developmentally unprepared to examine formative conditions under which they may still be living. Although there are no current studies in which practitioners have combined STPP and ACT for younger patients, some scholars have suggested that young patients have better success in integrated therapies (Murrell & Scherbarth, 2006). As Murrell and Scherbarth (2006) discussed, play therapy, group therapy, and ACT are often chosen therapies to use in an integrative format with younger patients, and these integrated therapy modalities produced better outcomes than single-oriented therapies.

6.5. Patient readiness as a marker

Several participants mentioned that when working with individuals with personality disorders, choosing an integrative strategy should be delayed until after the formation of a stable attachment between themselves and the patient. Each of these participants further explained that patients would not be ready for an integrative approach until after a therapeutic alliance has been established. Readiness refers to a patient's capacity for mastering developmental stages, level of insight, and the establishment of a stable therapeutic alliance. Ultimately, patient readiness for a change may dictate when and how a problem is addressed. Furthermore, different treatment approaches may be more suitable, depending on the patient's current level of functioning (Nelson et al., 2012).

6.6. Versatility and structure as markers

Participants emphasized the unique combination of versatility and structure in an integrative theory of STPP and ACT. IGT allows therapists to choose techniques and tools at their discretion from these two models. An illustrative conceptual example of a versatile application of clinical integration that considers client characteristics would be to combine Davanloo's (1978) Intensive Short-Term Dynamic Psychotherapy (ISTDP) with ACT. ISTDP relies on graded exposures to unconscious emotion, dependent on the level of the resistance, in the context of a person's psychic structure (Johansson, Town, & Abbass, 2014). Although conceptually different, ACT also relies on a hierarchically based graded level of interoceptive, *in vivo*, and imaginal exposures related to behaviors. ISTDP's emphasis on retrieval of repressed emotional content for psychoneurotic patients found large effect sizes accompanied by symptom relief (Johansson et al., 2014). Coupled with ACT's acceptance component, the resistance associated with interpersonal and intrapersonal conflict could conceivably move in the direction of resolution, an STPP goal, with exposure to discomfort in service of a value-driven life, which is an ongoing goal of ACT. The versatility of an integrative STPP and ACT theory can allow for flexible responding to the fluctuating contextual demands that occur within the therapy process.

6.7. Contraindications as a marker

As mentioned by one participant, ACT techniques of defusion and acceptance may be invalidating for patients whose primary need is to be heard, as with persons of color who have experienced discrimination. According to participants, another contraindication for STPP and ACT integration is with psychotic patients. Currently, there are no extant studies that examine STPP and ACT integration in the treatment of psychotic disorders. However, each theory has separately been implemented to treat psychotic patients. Butler et al. (2015) applied ACT for psychotic patients in a group therapy format with the focus on being willing to make choices that follow values. Preliminary results suggest promise for relapse prevention and a shorter recovery time (Butler et al., 2015). A modified version of ISTDP for psychosis targets emotional awareness, emotional self-regulation, and perceptual ability to notice frequent commonplace social interactions (Abbass & Town, 2013) using more supportive techniques. Outcomes revealed improvement on pre-to-post treatment symptom severity, interpersonal problems, and social inhibition (Abbass, Nowoweiski, Bernier, Tarzwell, & Beutel, 2014). It is possible that ACT and STPP combined could progress treatment outcomes by working on a willingness to follow values coupled with greater success in improved interpersonal and intrapersonal problems. By synthesizing ACT and STPP, the progression of therapy could be more rapid when skills are reinforced.

7. Theoretical application to study

Using a psychodynamic framework, Gold (2014) assimilated ACT interventions into a three-tiered model that affords interactional exchanges between conscious and unconscious behaviors and emotions and cognitions. The interactional exchanges bring about changes that are noted to be integral to a psychodynamic model, including insight, change in perception of self, and corrective emotional experience due to transference in the therapist–client relationship. Although all participants in this study practiced assimilative integration, eight participants stated that they implement STPP as the primary theoretical paradigm adding ACT strategies, while five participants apply ACT as the primary therapy and add STPP techniques. Participants blended ACT behavioral interventions with STPP focus on unconscious psychological dynamic influences based on context, patient observations, and client characteristics. Specific to context as applied by participants in this study and Gold's three-tiered model of integration are the observable (tier 1 and tier 2) and non-observable (tier 3). Contextual interactions between tier 1 and tier 2 offer observation of internal context features combined with external observations. Process of integration of STPP and ACT using Stricker and Gold (1996) three-tiered model can be found in the supplementary material.

7.1. Theoretical implications

The research findings provide a foundation for the implementation of Gold and Stricker's (2013) three-tiered model of assimilative integration with ACT and STPP. In tier 1, the practitioner investigates relationship patterns and avoidant behaviors. In tier 2, the practitioner concentrates on ACT core processes of present moment awareness such as mindful eating, body awareness, and emotion expression. In tier 3, the practitioner addresses the defenses associated with an identified focal issue and unconscious relationships between variables in different tiers. STPP adaptations of a specific unconscious psychodynamic maladaptive relationship pattern on tier 3 of Gold's-three-tiered model theoretically may reduce the amount of time in therapy.

Results from this study espouse that assimilative integration can offer a multi-perspective and comprehensive understanding of a person's intrapsychic and inter-psychic functioning as the conceptualization of intervention choice based on different collective combinations, e.g. context, client characteristics, current functioning level, that are synthesized into a primary therapeutic foundation. Depending on the primary therapy, the chosen technique may be in the service of creating a different outcome. For example, if ACT is the primary therapy, changing the context in which symptoms are experienced would depend upon focusing on affect and sensations in the present moment, skill building deficits, and systematic desensitization in service of the issue(s) being treated. Psychodynamic approach as a secondary theory would focus on rapport building, transference, and counter-transference issues, and resistance and defenses with the goal of living a more authentic self.

For fragile patients, (client characteristics), the ACT process of *defusion* could be prominent for purposes of building the capacity to allow for the experience of patient-defined distressing emotions before trying to understand how these emotions contribute to current interpersonal problems. One possible outcome could be more flexible responses to adverse context-dependent states, an ACT conceptualization, achieved by working through affect associated with unyielding unconscious pain, an STPP conceptualization.

Regarding current functioning level, when a patient is stuck, a different method of influencing progress may be needed (Gold, 2014; Messer & Warren, 1995; Westra et al., 2016). During times when a patient lacks a sense of meaning or purpose, the focus on the ACT feature of values may help to identify a direction formed by following a personalized way of interacting with life. It is plausible that the desire to change according to values may be present; however, if the pace of therapy is too fast, the patient may become stuck. In these situations, being stuck may require more self-exploration and understanding by the patient of fears associated with moving toward identified goals. STPP can explore these fears from a less structured viewpoint and at a slower pace for purposes of discovering the patient's personal meaning attached to change by paying attention to developmental

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times when other circumstances of stuckness were part of their life. This likely once-unconscious information can then be integrated and implemented into strategies that are more active and structured in nature; hence, a therapeutic paradigm shift reverts to ACT.

8. Limitations

Although this study advanced the understanding of the integration of ACT and STPP, there were some practical limitations. One of these limitations was the number of participants. It is possible that despite reaching data saturation, more findings would have emerged with additional participants. The generalizability of the findings is limited based on small sample size and therefore not considered exhaustive. Treatment settings were limited to outpatient private practice and intensive outpatient programs. Psychotherapists who integrate ACT and STPP in public or hospital settings may utilize different strategies based on agency protocol such as allocated number of sessions, patient acuity, clinical training, and professional competencies. There is a possibility that sample selection bias would explain why most of the participants practice STPP not only before ACT, but also for a longer period of time. The years of accumulated experience of the psychotherapists who implement STPP and ACT varied from 1 year to 10 years, with 3.8 years being the average. It is possible that providers with more STPP and ACT integration experience would yield different results.

Another limitation of this study was the use of semi-structured interview questions as a means of acquiring data. Reviewing audiovisual data with the therapist's and the patient's permission may have been helpful as a supplement to textual information and as an illustrative example of how the synthesis of ACT and STPP occurs. Using Skype or Face Time® permitted contact between the interviewer and the participant, however the same space was not shared. Thus, it is possible that the connection is less robust than had the interview occurred in the identical environment (Iacono, Symonds, & Brown, 2016). Also, technical faults in video sound and transmission can result in additional time spent with second interviews for clarification of participant contributions. Full range of bodily posture is often not evident using Skype or Face Time®. Some researchers (Seitz, 2015; Strauss & Corbin, 1990) state that listening to the voice and observing facial and upper body expressions conveys an adequate amount of sentiment to comprehend social cues to guide conversations and to detect perceptions of interactions.

9. Future research

ACT theory purports that new learning occurs via changing the context of the response to previously trained stimuli. Therefore, it is conceivable that attending to unconscious conflict, an STPP philosophy, when paired with exposure therapy, an ACT technique, may help to prevent spontaneous recovery or reinstatement of the originally derived relationship. Future research exploring this hypothesis might discover ways to extinguish unwanted behaviors in a variety of contexts sooner than the implementation of traditional exposure therapy.

Given both the novelty of this research, and the concomitant limitations of the study, there are other avenues for further research. While this study explored the perceptions of therapists using integrative therapy, the reasons for the specific development of these processes were not investigated. Future research could explore why most of the participants practice STPP not only before ACT, but also for a longer period of time. This line of research would explore whether bringing into awareness a person's connection between a focal pattern of maladaptive past and current intrapsychic and interpersonal experiences eventually elicit a need for more focused work, or, alternatively, whether therapists who are committed to an integrationist approach eventually feel the need broaden in their treatment plan.

While this study found that some therapists believed integrative therapy was contraindicated for psychosis, there was no exploration of why this was so. Further research could address if the integration of ACT and STPP would be a viable and clinically indicated approach to treat psychosis, and if so, at what junctures in the therapy process. To the best of my knowledge, there are no current studies that examine this phenomenon.

Finally, additional research could focus more exclusively on the specific types of STPP used in integrative therapy. Because of the limitations of sampling, this study engaged participants who integrated STPP with ACT in a broad and generalized way; as the use of integrative therapy grows, studies can focus on how specific typologies of STPPs are used, and comparatively function within the integrative therapy framework.

10. Conclusion

Integration has undergone decades of evolution, with emphasis varying on conceptualization, the process of change, technique selection, and outcomes in the service of furthering understanding about how internally motivated aspects and externally motivated behaviors influence one another. By adding strategies to a primary theory, conceptualization and framework change by broadening the scope in which human behavior is examined. As a result of this process, the extant literature has been expanded and pragmatic application of tested theories added to the evolution of integration in psychology. Studying a theory's conceptualization and its accompanying components through testing and observing advances the understanding of human nature. Flexibility on the part of the scientific community in developing, testing, and letting go of ideologies which no longer hold relevance moves psychology in the direction of global intervention. Researchers have indicated that psychological integration can move mental and physical health forward by deepening understanding of best practices. The seven response markers to consider ACT and STPP integration has added more detail to the framework regarding conceptualization and reasons why certain techniques were implemented (assimilated) into a primary therapy.

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Note
1. Core Conflictual Relationship Theme (CCRT; Luborsky, 1984). CCRT uses a psychodynamic and cognitive blended approach to predict and identify relational patterns leading to maladaptive behaviors (Critchfield, 2012). For more information on CCRT see Luborsky (1984).

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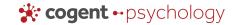Hilsenroth, M. J., Cromer, J., & Ackerman, S. (2002). How to make practical use of therapeutic alliance research in your clinical work. In R. A. Levy, J. S. Alblon, & H. Kaechele (Eds.), *Psychodynamic research: Evidence-based practice and practice-based evidence* (pp. 361–380). New York, NY: Springer. doi:10.1007/978-1-60767-792-1_22

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Appendix A

Interview questions

1. Why were you interested in integrating ACT and brief psychodynamic theory?

   a. What aspects of your professional background played a role in your integration of ACT and brief psychodynamic theory?

2. What are your thoughts about using ACT and STPP as a combined strategy?

3. What is the process you use when combining ACT and STPP?

4. What strategies do you use when combining ACT and STPP?

   a. What are the theoretical challenges in integration?

   b. What are the solutions to theoretical problems of integrating ACT and STPP?

5. How does integrating ACT and STPP in your clinical practice differ from other therapeutic approaches?

6. What patient benefits do you identify through integrating these two approaches?

7. What are some particular circumstances when you would choose to integrate ACT and STPP?

   a. When would you choose not to integrate ACT and STPP?

   b. Are there particular patients you feel particularly benefit from integrating ACT and STPP?

8. Describe a typical session where you would integrate ACT and STPP.

9. What are the outcomes of integrating ACT with STPP?

10. What are the potential problems and challenges for a therapist who integrates ACT with STPP?

11. How do you manage the potential problems and challenges to ensure success with the integration process?

12. Is there anything else I have not asked about or anything you would like to add to previous questions/responses regarding integrating ACT and STPP that you would like to add?

13. Do you know of anyone else who might be interested and eligible to participate in my study? Would it be OK to either pass information about the study to them, or could I have their email address to contact them?

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