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The Struggle to Find Things Therapists Can Agree On

The Compleat Therapist

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Table of Contents

The Struggle to Find Things Therapists Can Agree On

When Less Is More

The Advantages of Integration

Eclecticism, Pragmatism, Pluralism

The History of Therapeutic Integration

Current Efforts at Integration

References

The Struggle to Find Things Therapists Can Agree On

One would think that the fellowship of professional therapists would be a fairly cohesive group, unified in the promotion of services and mutually supportive of one another's efforts. But this could not be further from the truth. It is the nature of our species to be territorial, to stake out our boundaries of private space with fences and other demarcations of ownership. This is true not only with our land, but with our ideas. Since the beginning of recorded history, we have evidence that wars over competing ideologies, religions, or life-styles are a "natural" way of life for human beings. And these bat les go way beyond racial, ethnic, or national boundaries.

The tribal wars between competing schools of therapy are vicious, but rather than throwing spears at one another, we seek to discredit our adversaries through more subtle means. Sit in on the staff meeting of a large clinic and watch everyone go at it — the psychiatrists versus the psychologists versus the social workers versus the counselors versus the psychiatric nurses, each group believing they are truly just and do things the way they are intended to be done. Then, the ideological armies come into play, all fighting for dominance and control: The psychoanalysts ridicule the others for their lack of depth; the behaviorists mount their attack, accusing the rest of ignoring the most salient features of client change. The humanistic

group sits patiently, planning their own ambush by reflecting the feelings of anger and superiority among their brethren, all the while feeling smug that *they* really know what is going on. And these “global powers” are all attacked by the upstart groups, the other 100 tribes who believe they have found what everyone else has missed.

In a cynical and humorous parody of therapists’ tendencies to be “groupies” of a particular theoretician in vogue, Chamberlain (1989) offers a step-by-step blueprint for how to be the perfect disciple of Milton Erickson. She provides this advice because Erickson represents one of the few schools of thought that still has openings for apostles (this is explained by the fact that he did not write much himself, and that his work is so complex that nobody really understands what he did). In order to be a good Ericksonian, it is suggested that a disciple do the following:

1. Wear lots of purple (that was Milton’s favorite color).

2. Know at least one basic metaphor (it does not have to make sense — sometimes it is better if it does not).

3. Take vacations in Phoenix (visit all the places Milton used to hang out; wear lots of purple).

4. Report a significant life-changing experience as a result of your contact with Erickson (since he died in 1980, you are all owed to include the impact of his videotape).

5. Get the jargon down pat (especially useful are *induction, trance,* and *intercontextural cues*) so as to sound as much like Erickson as possible.

This satire could, of course, be applied to any orthodox approach currently in practice. Psychoanalysis, behavior therapy, gestalt, humanistic, rational-emotive, ego psychology, or strategic family therapy all have their own disciples who pay homage to their creators, honor their memories, and flock together for mutual support. While providing a degree of comfort to us in affiliating with a particular tribe, the result of this "theory worship" is the proliferation of competing schools all vying for power, control, and a chance to be anointed the true heir to truth.

When Less Is More

In Kuhn's (1962) classic work on the evolution of scientific disciplines, he describes a state of existence in which there is no single generally accepted view about the nature of a phenomenon. For example, before Newton and his colleagues in the seventeenth century, there were dozens of competing theories about the nature of light, each of which made sense to experts at the time. It was Newton who was able to pull together these diverse schools of thought into a single organized paradigm with a set of established rules, standards, and directions for future research.

Pentony (1981) suggests that the preparadigmatic stage psychotherapy is currently in is remarkably similar to the chaos of competing schools of physics before the seventeenth century. He endorses Kuhn's observations on the development of science in general to the evolution of psychotherapy in particular — that is, that in the absence of a unifying paradigm, efforts should be directed toward developing one that will help to increase cooperation and decrease competition among scientists and practitioners. Continuing to gather more facts, generating more data, and proliferating more theories to explain the nature of human dysfunction and change only exacerbates the problem of having more concepts than we could ever deal with. As Pentony (1981, p. xiii) explains: "What is called for seems to involve a special kind of theorizing. 'Breakthroughs' in science seem to come from a way of thinking that penetrates into theory, reveals something of the assumptions that are involved in it, and in doing so opens alternative ways of contemplating the phenomena — ways which at first glance seem strange and unreal but which, when their implications are reached, seem obvious."

We do not need more theories of psychotherapy; we need fewer of them. We need unifying principles of helping that simplify the confusion of competing concepts, that describe the essence of effective psychotherapy and provide generally accepted principles that most clinicians could subscribe to. In fact, this movement has begun in the past decades, most notably by those such as Gregory Bateson and company, who sought to discover the

underlying basis for human communication; by Carl Rogers, Robert Carkhuff, and colleagues, who have tried to describe the core conditions of helping; and finally, through the most recent efforts by dozens of writers and theoreticians who have been attempting to reduce the existing chaos.

There have been a number of systematic attempts to integrate diverse elements of effective psychotherapy into a unified system of helping. Some of these efforts are summed up here:

1. *Eclectic models.* Eclectic models are presented or critiqued by Woody (1971), Thorne (1973), Dyer and Vriend (1977), Garfield (1980), Palmer (1980), Goldfried (1982b), Beutler (1983), Hart (1983), Driscol (1984), Held (1984), Prochaska and DiClemente (1984a), Fuhriman, Paul, and Burlingame (1986), Howard, Nance, and Myers (1986), Kanfer and Schefft (1988) and Egan (1990).

2. *Single theories that have synthesized attributes from a few other models.* For synthesizing theories, see French (1933), Kubie (1934), Dollard and Miller (1950), London (1964), Birk and Brinkley-Birk (1974), Kaplan (1974), Watzlawick, Weakland, and Fisch (1974), Bandler and Grinder (1975), Bandura (1977), Wachtel (1977), Lazarus (1981), Fensterheim and Glazer (1983), Murgatroyd and Apter (1986), Erskine and Moursand (1988), Kahn (1989), and Duncan, Parks, and Rusk (1990).

3. *Collections of research on what makes therapy effective.* Studies

include Gurman and Razin (1977), Marmor and Woods (1980), Rice and Greenberg (1984), Garfield and Bergin (1986), Greenberg and Pinsof (1986), Kanfer and Goldstein (1986) and Norcross (1986).

4. *The non-specific major factor approach that seeks variables common to most methodologies.* On this approach, see Rosenzweig (1936), Hobbs (1962), Truax and Carkhuff (1967), Frank (1973), Strupp (1973), Marmor (1976), Cornsweet (1983), Karasu (1986), Omer (1987), Decker (1988), Mahrer (1989), and Patterson (1989).

5. *Recent integrative approaches to the treatment of specific problems.* To cite only a few examples, integrative approaches have been applied to *anorexia nervosa* (Steinlin and Weber, 1989), *bulimia nervosa* (Johnson and Connors, 1989), *the child molester* (Barnard, Fuller, Robbins, and Shaw, 1989), *self-mutilation* (Walsh and Rosen, 1988), *cocaine addiction* (Washton, 1989), *phobias* (Wolfe, 1989), *suicidal clients* (Bongar, Peterson, Harris, and Aissis, 1989), *borderline clients* (Kroll, 1988), *autistic children (Konstantareas, 1990), and narcissistic disorders* (Gold, 1990).

It is in this tradition of unification, cooperation, simplification, and synthesis that the present work was undertaken. I am attempting to answer the question, What can we be reasonably sure makes an effective therapist?

The Advantages of Integration

The search for what makes therapists universally effective is growing. The majority of practitioners, in fact, are undertaking such a task independently — trying to sort out for themselves what colleagues are doing and why, and how new learnings from readings, workshops, conventions, informal discussions can be integrated into one's existing practice. Most clinicians are becoming more and more uncomfortable with the labels that identify them as disciples of any particular school, preferring instead the term *eclectic* to mean only that they are somewhat flexible.

In a survey of mental health practitioners representing four different professions, Jensen, Bergin, and Greaves (1990) confirmed previous studies that the vast majority of practitioners (68 percent) describe themselves as eclectic in their orientation. They also noted that among the 423 therapists in the national sample the trend seems to be moving toward integrative attempts between four divergent theories (psychodynamic-humanistic-cognitive-behavioral combinations, for example) rather than just combining those that are already closely aligned (cognitive and behavioral, for example).

It would appear, then, that one of the most significant challenges for contemporary clinicians is neither the mastery of therapeutic skills nor the learning of new interventions; it is the blending of what they know, understand, and can do into an integrated model of practice. Certainly, we are not very well prepared for such a task. Most of us were indoctrinated into

particular schools of thought when we were young and impressionable. Our professors and mentors tried hard to influence our theoretical allegiances along lines compatible with their own — and they were largely successful (Sammons and Gravitz, 1990). We were not adequately instructed in the methods by which to pull together diverse points of view and conflicting ideas. Instead, we were after simplicity; things were complicated quite enough as they were — trying to stay in the good graces of our teachers, maintaining the approval of our supervisors, and not losing too many clients. Adventurism, creativity, bucking the system with too much flexibility might jeopardize our already vulnerable positions in the professional hierarchy. It was easier to follow the party line, that is, until we got out into the field and discovered that our clients did not care what theory we were using; they just wanted results.

In spite of the difficulties inherent in trying to reconcile conflicting opinions, divergent philosophies, sometimes even radically different assumptions regarding treatment goals, there are several reasons why the movement toward integration will only continue to flourish:

1. If we know what aspects of a therapist's behavior and being are most powerful and influential in promoting successful treatment outcomes, we can concentrate our efforts on refining skills and sorting out the specific ways in which they can be more optimally helpful. This can take place along the usual lines of trying to substantiate these assumptions

through empirical research, as well as through the efforts of practitioners who can monitor their methods and those of their colleagues to observe common denominators.

2. There is increasing frustration and impatience with the bickering that has existed among theoreticians in the field for the past decades. Each proponent of a particular approach seeks to convince the world that his or her methods work better than any other. Too much energy has been invested in disputing the wrongness of what other professionals do, rather than in figuring out the rightness of what everyone seems to be doing.

3. It is somewhat embarrassing, when one thinks about it, to consider that the state of affairs in the therapy profession is such that there is so little agreement (at least publicly) as to what constitutes effective therapy. The prospective client is faced with the task of choosing a helper among those who say it is best to address symptoms in a direct way, those who claim it is better still to examine unresolved conflicts in the past, those who favor attention to thinking processes or to affective states, those who say talking things out is most important, while others believe that being retrained, reconditioned, or reindoctrinated into new ways of behaving is most appropriate. The sum total of this chaos is that it does not seem like we really know why and how therapy works.

4. There are mounting pressures from third-party reimbursement organizations to produce changes within certain time

parameters. This has forced clinicians to be more adaptive in their approaches, doing some things with clients who have the inclination and resources to work in long-term treatment and doing other things with clients who are interested in different goals (Norcross, 1986).

5. Integration means, for Mahrer (1989), reducing the number of theories in the field to a more manageable number in order to establish a common marketplace of specific operations and a shared vocabulary of terms with common meanings.

6. It would be so much more useful in our teaching and supervising of beginning therapists to focus less on indoctrinating them into a specific system, and to concentrate more on the generic skills (such as empathic resonance) and attitudes (such as multicultural sensitivity) that most often make a difference. There are, however, many distinct advantages to affiliating with a particular theoretical approach, the most important of which is that it narrows the scope of our work to manageable limits; it is just too overwhelming to keep up with advances in all the different approaches and it is too impractical to maintain competency in all the various interventions. In other words, I am urging greater flexibility in our thinking and a greater willingness to adopt aspects of competing schools that we might find useful.

As convincing as these rationales are for creating a more integrative profession, there is also tremendous resistance, especially from those theoreticians who are vested in keeping their own approaches “pure” and

undiluted by others' influence. In a volume devoted to the presentation of the dozen major systems of eclectic therapy, Dryden (1986) was stunned to discover that the contributors, who advocated so strongly a cross-fertilization of ideas, did not refer to, or draw on, each other's work! Even these eclectic theoreticians, who are committed to the integration of research, finding commonalities among diverse approaches, and following a pluralistic, flexible approach, did not particularly acknowledge the work of colleagues working along parallel courses.

Eclecticism, Pragmatism, Pluralism

The reduced influence of individual systems is due not only to the burgeoning number of new additions each year, or to the fierce debates that are waged between competing schools, but to skeptics within the ranks. Omer and London (1988) review three of the main approaches that are being slowly modified by their own proponents. Within psychoanalysis, for example, many clinicians no longer accept Freud's notions that it is possible to unearth "truth" from the client's memory or that the analyst should be a completely neutral figure. Among behavior therapists there is skepticism regarding the value of learning theory in explaining all behavioral phenomena or the appropriateness of dealing with only observed behaviors. And many cognitive therapists question the value of denying affective dimensions in favor of exclusively concentrating on cognitive processes.

The application of specific approaches has evolved into a new series of schools with different names and broader scopes: technical eclecticism, pluralism, pragmatism, nonspecific factors, microinvestigations, and treatment manuals are representative of the new diversity and synthesis. As Omer and London (1988, p. 178) explain: “Different responses to the systems’ collapse chiefly reflect different assumptions of the systems’ era: Eclecticism does away with technical purity; the nonspecific approach denies the importance of conceptual differences between systems; pluralism waives exclusivism in favor of relativism; microinvestigators dismiss the systems’ units of analysis in favor of smaller and more common units; and the advocates of therapy manuals renounce therapy training by total commitment and lengthy immersion. The resulting changes, while profound, are *evolutionary,* not *revolutionary.* The new clinical and research psychotherapy enterprise which may arise from the present diversity seems likely, if anything, to be that of a maturing scientifically based art rather than of an ideologically based secretarian mission.”

We have a number of labels describing methodologies of integration that are similar and yet quite different. The general term *eclectic* denotes the “process of selecting concepts, methods, and strategies from a variety of current theories which work” (Brammer and Shostrum, 1982, p. 35). Eclecticism has been further demarcated to allow for variations on this theme. For example, *theoretical eclecticism,* or the integration of diverse

philosophies, is often distinguished from *technical eclecticism.* Eysenck (1970, p. 145) called the former "a mishmash of theories, a huggermugger of procedures, a gallimaufry of therapies, and a charivari of activities having no proper rationale, and incapable of being tested or evaluated," while Lazarus (1986) believes the later is truly a systematic, empirically based methodology that employs a variety of techniques within a theoretical structure. Thus, Lazarus (1986, p. 67) says, "technical eclecticism sidesteps the syncretistic muddles that arise when attempting to blend divergent models into a super-organizing theory."

Unfortunately, the inconsistent labels and language among those interested in reconciling diverse therapeutic systems contributes even more to the confusion. Norcross and Napolitano (1986) tried to pin down the label that nonaffiliated practitioners prefer in describing themselves. According to their survey, roughly half like *integrative,* one-third prefer *eclectic,* and the rest cannot decide. The authors then attempted to add more precision to the meanings of the two most common terms. Whereas *eclecticism* implies an emphasis on the technical, the divergent, and the practical, as well as selective application of interventions to particular situations, *integration* is more often associated with the theoretical, the convergent, and the blending and synthesis of various parts into a unified whole.

Whatever we are calling it — eclecticism (theoretical, atheoretical, or

technical), pragmatism, or pluralism — we are referring to the therapist's personal integration of all he or she knows, understands, and can do into a unified theory that is adaptable to change and evolution through experience. Prochaska (1984), for example, finds an erroneous dualism between the search for common factors *versus* prescriptive eclecticism. He points out that therapists can operationalize the factors common to all systems and *also* adapt their interventions to specific clients and situations.

Millon (1988) has observed that psychotherapists, like the ancient Hebrews, have wandered for forty years searching for a common homeland and an integrated god. Yet it was only after being offered the guidance of the Ten Commandments that the wandering Jews were successful. It is in this spirit of integration that Millon assumed the mantle of Moses to offer those commandments he feels are necessary so that a unified reconciliation between approaches can occur.

True integration is more than eclecticism, pluralism, pragmatism, or any other buzzword; it is the sincere effort to synthesize all that is known into a body of knowledge that is inclusive, empirically and intuitively derived, and in which the whole is greater than the collection of its parts. Integrative therapy is much more than an accumulation of techniques or a merging of a few theories: it is nothing less than the synthesis of philosophy and science, empiricism and phenomenology, research and practice. Millon (1988, p. 211)

believes that the conceptual basis for treatments should be no less complex than the concerns of our clients:

> The personality problems our patients bring to us are an inextricably linked nexus of behaviors, cognitions, intrapsychic processes, and so on. They flow through a tangle of feedback loops and serially unfolding concatenations that emerge at different times in dynamic and changing configurations. And each component of these configurations has its role and significance altered by virtue of its place in these continually evolving constellations.
>
> In parallel form, so should integrative psychotherapy be conceived as a configuration of strategies and tactics in which each intervention technique is selected not only for its efficacy in resolving particular pathological features but also for its contribution to the overall constellation of treatment procedures of which it is but one.

This is an ambitious goal, but one that is well on its way to being reached in a discipline such as medicine, which has existed a hundred times longer. In such an organized world, therapists — like physicians — would agree philosophically on basic assumptions of practice. Most doctors concur, for example, on diagnostic thinking, surgical procedures, standard of ice practices, and even the mechanisms by which most diseases occur and are cured. That is not to say that they do not have tremendous arguments, but these occur within a completely different context from our own debates. While we are still concerned with the meaning and causes of symptomatology, medicine has turned its attention to the structure and mechanisms of the body’s immune system. Yet, we too are moving in that

direction of looking at the underlying processes of personal growth and behavioral change.

The History of Therapeutic Integration

Trying to find the essence of what cures emotional suffering is not just a recent trend. Over 2,000 years ago the first written accounts of an integrative system of treating mental illness were recorded. Hippocrates initiated the field of psychiatry by attempting to classify the various emotional disorders he observed and suggested treating them with a unified mind-body approach. He believed practitioners should be guided by reason and by inductive methods of diagnosis, and he recognized the value of dream interpretation.

In one representative example, Hippocrates treated King Perdiccas II using an integrative form of psychotherapy we would recognize even today. The king sought the services of the renowned physician after all the court's doctors had been unable to relieve his suffering. Hippocrates interviewed him for some time, gaining his trust. Eventually the king confessed that he was secretly in love with a concubine who belonged to his recently deceased father. Hippocrates believed that this intense longing was creating his patient's suffering and so diagnosed reactive melancholy. He treated the problem partly through dream interpretation and also by urging the king to acknowledge his feelings and to overcome the malaise of helplessness by

acting on his convictions.

There was not much advance beyond Hippocrates' techniques until the last century or two. Until recently, a systematic treatise on healing was not considered a matter of great priority. However, some trends in earlier centuries paved the way for this development. The Renaissance brought with it many attempts to unify understandings in the search for solutions to human problems. Leonardo da Vinci combined science with art to understand human reality. Shakespeare created a literature of complex characters who manifested conflict and suffering. In the seventeenth century, Descartes attempted to resolve the dualism between body and mind. Other integrative attempts that followed — especially by Spinoza, Locke, Kierkegaard, and Darwin — set the stage for the birth of the mental health specialties. At the beginning of the twentieth century, Sigmund Freud, William James, and Emil Krapelin all worked independently to create a universal conception of human behavior.

When Freud and his collaborator Breuer stumbled onto the phenomenon that people feel better after talking out their problems, the profession of psychotherapy was born. A lifetime of experimentation and further refinement by Freud created the first comprehensive system of helping people with their emotional problems. Freud was drawn to the past, and this became the guiding force that led him to invent a method for

excavating relics of the individual soul. Just as the archaeologist collects bits of pottery representing a past life, and then attempts to piece them together in an effort to reconstruct and understand a prior culture that evolved into our own, Freud sought to unearth the hidden secrets of the unconscious. His many pilgrimages to Athens and Rome were undertaken to satisfy his insatiable curiosity about the historical heritage of culture. And in his lifetime Freud spent a lot more time and energy studying archeology than he did neurology or psychiatry.

Yet Freud was only the first to integrate the diverse disciplines of medicine, history, archeology, literature, philosophy, and art to forge the new discipline of psychotherapy. And at approximately the same time he was fighting his bat les in Vienna to gain respectability for his new "talking cure," William James was waging his own fight at Harvard for psychology as an independent discipline that would combine both science and philosophy.

Dozens of practitioners who originally followed the tenets of psychoanalysis — among them Fritz Peris, Eric Berne, Albert Ellis, Carl Jung, Alfred Adler, and Carl Rogers — broke from this camp to create their own schools. Of this group, Rogers was probably the most successful at distilling the essence of what empowers all therapy — the therapeutic alliance. He postulated that the presence of qualities like genuineness, unconditional positive regard, and empathy would lead to greater success in sessions and

improvement in clients.

Things, however, are not quite that simple. The search for truth is an elusive enterprise, one in which we can never be sure if we have the full picture. As the Russian novelist Turgenev once explained to his compatriot Tolstoy: “The people who bind themselves to systems are those who are unable to encompass the whole truth and try to catch it by the tail; a system is like the tail of truth, but truth is like a lizard; it leaves its tail in your fingers and runs away knowing full well that it will grow a new one in a twinkling” (Boorstin, 1983, p. 81).

In the 1960s many practitioners were convinced they had discovered the most effective way to do therapy by reflecting client feelings and facilitating growth in the context of a nurturing environment. They were only to find that while their relatively benign interventions did not hurt anybody, neither were they tremendously helpful for those clients who required more active involvement in their sessions or attention to issues other than their feelings. Also, many therapists abandoned the Rogerian method, or at least augmented it with something else, for the same reason so many disciples of Freud abandoned psychoanalysis decades earlier: to satisfy the need to imprint their own influence on the therapy they were practicing. Thus Adler, Jung, Reich, and latter-day analysts developed their systems not only because they felt there was something else out there that could work better than what

they were doing, but because they felt a personal need to follow their own path to the truth.

Is it narcissism and inflated ego that prevents us from following someone else's formulation of truth for very long and urges us to build our own monuments? Or rather is it that relentless human drive to never be satisfied with what we have, but to always strive for improved functioning and efficiency?

The ancient Egyptians were perfectly satisfied with their sun dial for measuring time, before the Greeks introduced their water clocks as a way to tell time even on cloudy days. And they too were content with their devices, although the English preferred their sandglasses, since water freezes in their colder climate. But it was the invention of the mechanical timepiece during the Middle Ages that made other instruments obsolete. The fifteenth-century monk must certainly have felt smug, now that his appointed prayer intervals could be clearly announced, yet several centuries later these primitive machines were in turn made obsolete by the invention of the pendulum. This brought portable clocks into being. And when the gear in these clocks was first created, people laughed at the primitive nature of swinging weights.

It is simply amazing to consider that until the last two decades we had assumed that the closest we would ever get to accurately measuring time is

with a $2,000 chronometer. Now, for less than $10 we can find a digital watch that is accurate to within a few seconds a month. The lesson here is that each succeeding generation has been convinced they have finally found the ultimate truth. And just as we or our parents would have been truly astonished at the prospect that people would someday have video recorders and computers in their homes, what awaits the next generation?

Actually, the evolution of psychotherapy has been quite slow, relative to the changes in medicine during the past century. Many clinicians are essentially doing the same thing that Freud was doing a hundred years ago, with certain minor refinements. It was not until after the Second World War that writers such as Thorne (1950) attempted to integrate the concepts and methods of therapy then in practice. He was intrigued by the fact that so many different treatments could produce satisfying results and surmised only two possible explanations: either similar factors are operating in different approaches or there is more than one way to accomplish the same thing.

It is hardly an either/or proposition, since both hypotheses can be true. This was, in fact, the approach Truax and Carkhuff (1967) took in ferreting out what they believed were the variables common to all therapeutic systems. By examining the core elements originally proposed by Rogers (1942), Truax, Carkhuff, and their colleagues sought to identify those variables that are consistently effective in helping relationships. Accurate empathy,

nonpossessive warmth, and genuineness became the watchwords for a generation of counselors and therapists who were trained according to a skill-development model. Thus microcounseling (Ivey, 1971), interpersonal process recall (Kagan and Schauble, 1969), and other skill-oriented programs became relatively atheoretical training approaches that stressed learning-specific behaviors practiced by all clinicians.

Current Efforts at Integration

Whereas the early twentieth century was devoted to the development of the first unified helping system, and the decades thereafter became a period of experimentation, the 1980s have been a period of rapprochement, convergence, and integration (Norcross, 1986). We have now reached a point where roughly half of all practicing therapists describe themselves as eclectic in orientation (Norcross and Prochaska, 1982). Never before has there been such flexibility and willingness on the part of clinicians to go to any lengths in order to increase their effectiveness. If that means abandoning exclusive allegiance to a single school of thought, so be it. Yet even those who function quite well within the parameters of a single helping model remain open to the contributions of competing approaches.

The International Academy of Eclectic Psychotherapists and the Society for the Exploration of Psychotherapy Integration were established to create a

forum for the exchange of ideas regarding how divergent methods of treatment could best be reconciled. London (1986) has characterized himself and other members of these organizations as having several beliefs in common (although as feisty and independent a lot as they are, I suspect a number of them would object strongly to being classified with *anyone* else). These tendencies include a resentment of orthodoxy in any form, an attitude that is often seen by the major schools as antiscientific and uncivilized; a commitment to the scientific method of subjecting any methodology to public scrutiny; and the conviction that the nature of clinical work is so complex that it defies description in any simple language or single theory.

One of the most comprehensive attempts to integrate the best of all possible worlds is found in the work of Lazarus (1976, 1981, 1985), who merged the theory of behavior therapy and cognitive therapy as well as giving some attention to the affective, sensory, and interpersonal dimensions of human experience. This approach also recognizes that human beings are extraordinarily complex and multidimensional, requiring interventions that are adaptable enough to allow for vast individual differences.

Representative of the most recent attempts at theoretical integration is the work of Beitman, Goldfried, and Norcross (1989) and Norcross and Grencavage (1989). They undertake retrospective analyses of various approaches to create a framework that permits greatest flexibility. They

attempt to reconcile the discrepant language used by various theorists *(catharsis* versus *self-disclosure* versus *presentation of data)',* they also try to blend processes that are usually expressed as polarities — cognitive *or* affective, conscious *or* unconscious, insight *or* action, symptoms *or* causes, individual *or* family treatment. Further, they search for commonalities in clinical practice that are of pragmatic use and emphasize “goodness of fit” — that is, the match between certain client characteristics and presenting complaints on the one hand and specific approaches that are optimally effective on the other.

Current integrative efforts are therefore targeted more toward a prescriptive eclecticism for practitioners rather than a philosophical melding for theoreticians. London (1988, p. 4) contends that we are bumbling along into the same archaic metamorphosis that is usual for a relatively young discipline: “We are entering, I believe, an era o f‘sloppy integration’ in which psychotherapists will lack broad theories of personality for elegant systems of treatment, but will compensate for them with good *general* practice done by true eclectics and good *specialist* practice by specialists in problem-by-treatment interactions.”

The voices of clinicians are finally being heard! London and colleagues such as James Prochaska, John Norcross, Arnold Lazarus, Larry Beutler, and others — are concentrating more on developing a framework for applying

systematic application of therapeutic technology than on reconciling contradictory theoretical orientations. It is now recognized by many integrationist theorists and eclectic practitioners that even if we cannot identify common factors in all therapists, we can at least acknowledge that there are many different ways to be helpful to clients.

A typical argument for the pragmatic integration that now takes place in the thinking and practice of many therapists is presented by Corey (1990) who extracts aspects from each of seven different models to create his own unique approach. From psychoanalytic theory, Corey encourages his clients to talk about their earliest memories, interprets client reactions to him as manifestations of other significant relationships, connects present difficulties to events from the past, and recognizes unconscious motives. From existential theory, he helps clients to assume more responsibility for their lives, deals with issues related to fear of death, and interprets anxiety as a message to face one's freedom and choices. From client-centered theory, he uses himself and the therapeutic relationship as the major force for change, works on trust issues as a core area, and listens really intently, in a thoughtful, accepting, nonjudgmental manner. From gestalt theory, he challenges clients to deal with unfinished business, asks them to act out their polarities, and stays with his clients by focusing on the immediacy of their feelings. From transactional analysis theory, he explores early injunctions that led to scripted internal messages, identifies early decisions clients make about their conduct that are

still operating, and accesses parent, adult, and child elements of client functioning. From behavioral theory, he uses rehearsal strategies to role-play behaviors, helps clients to set specific goals, and believes in the use of homework assignments between sessions as a way to facilitate change. Finally, from rational-emotive theory, he teaches clients they can change the way they feel by changing the way they think, challenges clients' irrational thought patterns, and encourages them to talk to themselves differently.

I would suspect that Corey's integration of these various elements into a personal eclectic style is not much different from the ways most of us operate. We are the sum total of all the teachers and mentors we have worked with, all the classes and workshops we have at ended, and all the books we have read, movies we have watched, and experiences we have lived through.

In a review of the literature related to process and outcome variables in therapy, surveying over 1,100 studies, Orlinsky and Howard (1986) reiterate the conclusion that has by now become familiar: there is no consistent evidence that one treatment modality or approach produces better results than any other. This means that it makes little difference whether we are doing group versus individual versus family therapy, whether we are doing daily or weekly sessions, whether the treatment is time-limited or ongoing, or which one of the hundreds of theoretical models we are using.

If these are the things that are *not* important, then what *is?*

1. The therapist should feel comfortable with and have confidence in what he or she is doing.

2. A collaborative relationship should be established in which there is mutual respect, sharing, and bonding between the participants.

3. It is important to allow the client to talk, explore ideas and feelings, and experience emotional discharge.

4. The therapist needs to have an adequate level of competence in applying various skills and interventions that are believed to be helpful.

5. Mutual understanding and empathic resonance between participants that allows for risk taking and confrontation is essential.

Almost every effective therapist has integrated these factors into a personal theory of operations — whether it is a single mainstream approach or an eclectic model. Even those pragmatic clinicians who claim to follow no single theory or no fixed methodology nevertheless have organized their knowledge into some synthesizing structure that allows them to retrieve information, replicate interventions, and think through problems and conflicts (Decker, 1988). Most of these individually designed pragmatic models of practice, as well as the most orthodox systems, share several

common variables that can be identified in the chapter that follows.

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