1

The evolution and current status of psychotherapy integration

JOHN C. NORCROSS AND HAL ARKOWITZ

Psychotherapy integration has a long history, but it was not until the late 1970s that it crystallized into a strong and coherent force on the psychotherapy scene. While various labels are applied to this movement - eclecticism, integration, convergence, pluralism, rapprochement, unification, prescriptionism - their goals are indeed similar. Psychotherapy integration is characterized by a dissatisfaction with single-school approaches and a concomitant desire to look across and beyond school boundaries to see what can be learned from other ways of thinking about psychotherapy and behaviour change.

Psychotherapy integration has experienced dramatic growth in the past decade, leading some observers (Moultrup 1986; London 1988) to label it a metamorphosis in mental health. Eclecticism, or the increasingly favoured term 'integration' (Norcross and Prochaska 1988), remains the modal theoretical orientation of both American (Norcross *el al.* 1989) and British (Norcross, Dryden and Brust 1992) psychotherapists, and the prevalence may be rising (Jensen *etal.* 1990). Leading counselling textbooks increasingly identify their theoretical persuasion as eclectic (Brabeck and Wellel 1985), and an integrative or eclectic chapter is routinely included in compendia of various treatment approaches. The publication of books which synthesize various therapeutic concepts and methods continues unabated, and the field has matured to a point where entire handbooks, such as this volume and that of Norcross and Goldfried (1992), are deemed necessary. Reflecting and engendering the burgeoning field has been the establishment of interdisciplinary psychotherapy organizations devoted to integration - notably the Society for the Exploration of Psychotherapy Integration (SEPI) - and of internationalpublications, including SEPI's *Journal of Psychotherapy Integration.* The surge of integrative fervour will also apparently persist well into the 1990s: a recent panel of psychotherapy experts portended its increasing popularity throughout this decade (Norcross, Alford and DcMichcle 1992).

A spirit of open enquiry and lively debate pervades the Held, as evidenced by the appearance of several series of articles in different journals. The journals include: *Behavior Therapy* (Garfield 1982; Goldfried 1982b; Kendall 1982; Wachtel 1982a); the *British Journal ofClinical Psychology* (Davis 1983; Messer 1983; Murray 1983; Wachtel 1983; Yates 1983); the *British Journal of Guidance and Counselling* (Beitman 1989; Dryden and Norcross 1989; Lazarus 1989b; Messer 1989; Norcross and Grencavage 1989); and *Psychiatric Annals* (Babcock 1988; Birk 1988; London and Palmer 1988; Powell 1988; Rhoads 1988). A major article on psychotherapy integration appeared in the *American Journal of Psychiatry* (Beitman *el al.* 1989). In addition, theoretical integration was prominently reviewed in the recent *Annual Review of Psychology* chapter on individual psychotherapy (Goldfried *etal.* 1990).

In this introductory chapter, we will begin by considering multiple reasons for the recent growth of psychotherapy integration. The bulk of the chapter will then review the four main contemporary thrusts of integration, and outline what we consider the limitations and obstacles of psychotherapy integration in general. Finally, we will consider the impact integrative thinking has already had - and will likely have - on the field of psychotherapy.

Why integration now?

Integration as a point of view has probably existed as long as philosophy and psychotherapy. In philosophy, the third-century biographer, Diogenes Laertius, referred to an eclectic school which flourished in Alexandria in the second century AD (Lunde 1974). In psychotherapy, Freud consciously struggled with the selection and integration of diverse methods (Frances 1988). More formal ideas on synthesizing the psychotherapies appeared in the literature as early as the 1930s (French 1933).

Although the notion of integrating various therapeutic approaches has intrigued mental health professionals for some time (Goldfried and Newman 1992), it has been only within the past 15 years that integration has developed into a clearly delineated area of interest. The last decade, in particular, has witnessed both a general decline in ideological struggles and the stirrings of rapprochement. The debates across theoretical systems appear to be less polemical, or at least more issue-specific.

A confluence of scientific, professional and socio-economic circumstances has produced the recent preoccupation with psychotherapy integration. Several intertwined, mutually reinforcing factors have fostered the movement in the past decade (see London 1983, 1988; Norcross and Grencavage 1989; Arkowitz 1992).

Psychotherapy integration has, in part, *been a response to the improved quality of psychotherapy outcome research during this period, and to the lack of strong evidence to support differential outcomes among existing therapies.* Prior to the late 1970s, there were few well-designed studies on the outcome of psychotherapy. Since then, the number of such studies has increased dramatically (e.g. see review by Lambert *et al.* 1986), and meta-analytic procedures (e.g. Smith *et al.* 1980) have provided more objective ways to summarize and compare the results of different studies. These studies have revealed surprisingly few differences in outcome among different therapies, and there is little evidence that one empirically evaluated psycho-

therapy is consistently superior to another (e.g. Kikin *et al.* 1989; Beckham 1990; Barkham, Chapter 10, this volume). While we need to be cautious in accepting the null hypothesis, and while there are many possible interpretations of such findings (e.g. Stiles *el at.* 1986), they very likely served as a catalyst for many who began to consider integrative interpretations of these results. Luborsky *ft al.* (1975), borrowing a phrase from the Dodo bird in *Alice in Wonderland,* concluded that 'everybody has won and all must have prizes'. Or in the words of London (1988:7), 'Mela-analytic research shows charity for all treatments and malice towards none.'

A corollary of the equivalence paradox - no differential efficacy despite technical diversity - has been the *growing consensus that no one approach is clinically adequate/or till problems, patients and situations.* Psychotherapy has entered a period of intense self-examination in which the failures of our pet theories are reappraised and their limitations realized. The grand-systems era has been undermined by a wave o! scepticism in which leading figures of each school have criticized their own theories and assumptions. Omer and London (1988) trace scepticism within psychoanalysis (e.g. implausibility of truly 'free associations', doubts about Freud's archaeology metaphor), behaviour therapy (e.g. questions on presumed derivation from learning theory, over-reliance on observed behaviours), and cognitive therapy (e.g. doubts on the precedence of cognition over affect and behaviour, difficulty of dispelling dysfunctional thinking). Obviously, no clinical theory has a monopoly on truth or utility; clinical realities have come to demand a pluralistic, ll not integrative, perspective.

Another contributing factor has been *the proliferation oj the number oj specific therapies.* Paralleling the growth of interest in psychotherapy integration has been a sharp increase in the number of different therapies (Karasu 1986), and in the number of variations within each of the major psychothei apies. This increasing diversity has had two effects. One was to make available a greater range of theories and techniques, from which an integration could be crafted. A second has been to alert therapists to the almost infinite number ol possible variations in technique. The latter may have discouraged the search for further variations and encouraged therapists to seek more creative ways to utilize existing therapies.

The field has been staggered by over-choice and fragmented by future shock. Which ol 400 plus therapies should be studied, taught or bought? No single theory has been able to corner the market on validity or utility. London (1988: 5-6) wryly observed that the hyperinflation of brand name therapies has produced narcissistic fatigue: 'With so many brand names around that no one can recognize, let alone remember, and so many competitors doing psychotherapy, it is becoming too arduous to launch still another new brand.'

Along with the proliferation of 'brand name' therapies has been a trend towards *more specific and operational descriptions oj psychotherapy practice.* There were relatively lew specific and operational descriptions of psychotherapeutic techniques prior to 1970. From the late 1970s onwards, a number ol specific treatment manuals appeared (e.g. Heck *el al.* 1979; Luborsky 1984; Strupp and Binder 1984), often growing out of research on the disparate therapies. In fact, Luborsky and DeRubeis (1984) referred to this manualization of therapy as a 'small revolution'. The availability ol more clearly described therapy procedures has permitted more accurate comparisons and contrasts among them, providing further impetus for various approaches to psychotherapy integration.

Escalating interest in short-term psycholherapies during the past 20 years (Budman 1981) has also contributed to the growing interest in integration. An interest in short-term therapies was accompanied by the development of more problem-focused therapies. A common emphasis on a problem locus (although there is still divergence in how to define the term 'problem') has brought therapies that were formerly very different somewhat closer together, and has created variations of different therapies that were more compatible with each other.

A trend towards increasing interactions among professionals of different therapy orientations in specialized clinics for the treatment of specific disorders, particularly in North America, may also have had an effect on the development of psychotherapy integration (London and Palmer 1988). Since the 1970s, there has been a movement towards such specialized clinics for a variety of problems, including sexual dysfunctions, agoraphobia, obsessive-compulsive disorders, depression and eating disorders, to name just a few. These clinics are often staffed by professionals of diverse theoretical orientations, with greater emphasis on their expertise about the clinical problem than on their theoretical orientation *per se.* This diversity stood in contrast to the earlier emphasis on institutes devoted to specific therapies. At the very least, the exposure to other theories and therapies in such clinics may have stimulated some to consider other orientations more seriously.

An additional reason for integrating the psychotherapies *is a matrix of socioeconomic influences.* The total therapy industry continues to grow: invasion of non-doctoral and non-medical counsellors, the boom in professional practice, the mushrooming of training institutes and the outpouring of third-parly funding in the United States (London 1988).

Meanwhile, pressures for accountability are mounting in the USA from insurance companies, government policy-makers, consumer groups and judicial officials. Third parties and the public are demanding crisp and informative answers regarding the quality, durability and efficiency of psychosocial treatments (Parloif 1979). Until recently the field has had the luxury of functioning within a culture of individual professional freedom. However, the shrinking job market, increased competition and diminishing public support portend a future which is discontinuous with our expansive past (Fishman and Neigher 1982).

Without some change from the field, psychotherapists stand to lose prestige, customers and money. These socio-economic considerations increasingly have psychotherapists pulling together rather than apart. Mental health professionals report that the impact of political and economic changes have led them to work harder, to be more creative and to adjust their treatments to meet the needs of their clients (Brown 1983). Intertheoretical co-operation and a more unified psychotherapy community represent attempts to respond to these socio-political forces.

The development of a professional network has been both a consequence and a cause of the interest in psychotherapy integration. Before 1970 the strands for psychotherapy integration were available, but they did not yet form a connected and unified body of thought. In 1983, the Society for the Exploration of Psychotherapy

Integration (SEPI) was funned (see the description by Goldfried and Newman 1992) to bring together those who were interested in various forms of rapprochement among the psyeliotherapies. Even at the outset, there was strong interest expressed in this group by many professionals from a variety of orientations and backgrounds. The organization has brought together those interested in integration through a newsletter, annual conferences and a journal.

Four directions for integration

There are numerous pathways towards the integration of the psyeliotherapies (Mahrer 1989). The three most popular routes at present are technical eclecticism, theoretical integration and common factors (Arkowitz 1989). In addition, there is a newly emerging fourth direction that integrates psychotherapy theory and practice with theory and research from the broader fields of psychology and psychiatry (Arkowitz 1991a, b; 1992).

All four directions are guided by the general assumption that we have much to learn by looking beyond the confines ol single theories or the techniques tradicionally associated with those theories. However, they do so in rather different ways and at different levels.

Technical eclecticism is the least theoretical of the four. Technical eclectics seek to improve our ability to select the best treatment for the person and problem. This search is guided primarily by data on what has worked best for others in the past with similar problems and similar characteristics. In contrast to the other three directions, technical eclecticism pays significantly less attention to 'why' these techniques work, and instead focuses on predicting for whom they will work. The foundation for technical eclecticism is primarily actuarial rather than theoretical. The work of Beutler (1983; Beutler and Clarkin 1990) and Lazarus (1976, 1981) are illustrations of this form of integration.

The meaning of eclecticism parallels the dictionary definition: 'Choosing what is best from diverse sources, styles, and systems'; 'using techniques and rationales based on more than one orientation to meet the needs of the individual case'; 'the systematic use of a variety of therapeutic interventions in the treatment of a single patient'; and 'the pragmatics of selecting a variety of procedures and wider interventions for specific problems'. The common thread is that technical eclecticism is relatively atheoretical, pragmatic and empirical.

The *common factors* approach attempts to look across diverse therapies to search for elements that they may share in common. This view is based on the belief that these factors may be at least as important in accounting for therapy outcome as the unique factors that differentiate among them. The common factors identified may then become the basis for more parsimonious theory and more efficacious treatment. The work of Frank (1961, 1982) and Goldfried (1980, 1991) has been among the most important contributions to this approach.

One way of determining common therapeutic principles is by focusing on a level of abstraction somewhere between theory and technique. This intermediate level of abstraction, known as a clinical strategy or a change process, may be thought ol as a heuristic dial implicitly guides the efforts of experienced therapists. Goldfrietl (1980:996) argues:

> To the extent that clinicians of varying orientations are able to arrive at a common set of strategies, it is likely that what emerges will consist of robust phenomena, as they have managed to survive the distortions imposed by the therapists' varying theoretical biases.

Common factors may, in fact, be the curative factors.

Renewed interest in common factors has been sparked by well-controlled therapy outcomes which attest to lack of differential outcome. Reviews by Beutler *el al.* (1989a) and Lambert (1989), for example, suggested that techniques accounted for less than 15 per cent of the outcome variance in psychotherapy. This conclusion provides further impetus to look towards common factors and away from the techniques uniquely associated with the different therapies.

In *theoretical integration,* two or more therapies are integrated in the hope that the result will be better than the individual therapies on which they were based. As the name implies, there is an emphasis on integrating the underlying *theories* of psychotherapy (what London (1986) has eloquently labelled 'theory smushing') along with the integration of therapy techniques from each (what London has called 'technique melding'). The various proposals to integrate psychoanalytic and behavioural theories best illustrate this direction, most notably the work of Wachtel (1977, 1987). Other writers have focused on different integrations (e.g. Thoresen 1973; Appelbaurn 1976; Wandersman *el al.* 1976; CJurman 1981; Feldman and Pinsof 1982; Segraves 1982; LeBow 1984; Wachtel and Wachtel 1986).

Theoretical integration refers to a commitment to a conceptual or theoretical creation beyond a technical blend of methods. The goal is to create a conceptual framework that synthesizes the best elements of two or more approaches to therapy. Theoretical integration aspires to more than a simple combination. Instead, it seeks an emergent theory that is more than the sum of its parts, and that leads to new directions for practice and research.

Theoretical integration may be most sharply contrasted with technical eclecticism. The primary distinction is that between empirical pragmatism and theoretical flexibility. Or to take John Davis's culinary metaphor (cited in Norcross and Napolitano 1986: 253): 'The eclectic selects among several dishes to constitute a meal, the integrationist creates new dishes by combining different ingredients.' Despite this sharp contrast, Arkowitz (1989) has suggested that technical eclecticism and theoretical integration are more complementary than antagonistic. (Readers interested in the relative merits of theoretical integration versus technical eclecticism are directed to the debates of Goldlried and Wachtel (1987), Arkowitz (1989), Beitman (1989), Beutler (1989b) and Lazarus (1989b).)

More recently, there has been the emergence of interest in a fourth type of integration in which *psychotherapy theory and practice are integrated with basic theory and research in psychologyjmd psychiatry.* This type of integration aspires to enhance our knowledge of change processes by turning to basic theory and research on cognition, affect, behaviour, biological substrates and interpersonal influences.

This direction is illusdaicd Ijy tlic work ol Alkowitz (1991b), Uuldstein *el at.* (1966), Greenberg and Safran (1987), Horowitz (1988, 1991), Schwartz (1991), Stein (1992) anil Wolfe (1992). It may be considered to be a form of theoretical integration, but the theories to which this approach turns are not psychotherapy theories *per se,* and any empirically supported theory would serve to elucidate aspects of the change process.

In clinical work, the distinctions among these four directions for psychotherapy integration are not so apparent. The distinctions may, in therapy practice, be largely semantic and conceptual, and not particularly functional. Few clients experiencing an 'integrative' therapy would be able to distinguish among them.

Moreover, we hasten to add that the strategies are not so distinct or mutually exclusive. No technical eclectic can totally disregard theory, and no theoretical integrationist can ignore technique. Without some commonalities among different schools ol therapy, theoretical integration would be impossible. And even the most ardent proponent of common factors cannot practise 'non-specifically' or 'commonly'; specific techniques and strategies must be applied.

In the sections which follow, we will briefly trace the early origins of each of these thrusts ol psychotherapy integration, review some American proposals exemplifying each, and present some British contributions to them emanating from this volume. Some more recent developments in each will then be traced. More comprehensive histories of psychotherapy integration can be found in Goldfried and Newman (1992) and Arkowitz (1992).

Technical eclecticim

Eclecticism is an integration strategy that selects what seems best from a variety of alternatives. Eclectic psychotherapists choose from among available therapy techniques on the basis of what they think will work best for the particular person and problem. Different techniques from different therapies may be applied to the same person, or different techniques may be used with different patients and problems.

In eclecticism, the basis for treatment selection is more actuarial than theoretical. The main criterion used by eclectics to select treatments is what has worked best for similar people with similar problems in the past. Theory is notil viewed as a particularly important basis for treatment selection. This relative *y* de-emphasis on theory distinguishes eclecticism from both theoretical integration ' and the common factors approach.

Early stirrings

An eclectic approach was not really feasible until around the 1970s. Prior to that time, the field of psychotherapy was, to a large extent, dominated by monolithic theories that were uniformly applied to all people and all problems. In none of these therapies were there many specific and clearly described techniques from which therapists could choose to form an eclectic approach.

Various surveys since the early 1960s have demonstrated that a large percentage of practising therapists endorsed some form of eclecticism to describe their approach (e.g. Kelly 1961; Garfield and Kurtz 1976). This suggests that the realities of practice were leading clinicians towards some form of eclecticism, and that psychotherapy theories were not reflecting this fact. Nonetheless, prior to 1980, eclecticism was oiten little more than an idiosyncratic mixture of techniques selected on no clearly discernible conceptual basis, The term conveyed little information about how therapists practised and how techniques were selected and combined. This chaotic situation led Eysenck (1970) to describe eclecticism as 'a mish-niash of theories, a hugger-mugger of procedures**,** a gallimaufry of therapies' (p. 145). Eysenck strongly criticized eclectics for lacking an acceptable rationale and empirical evaluation of their approach.

In 1967, Lazarus formally introduced the concept of *technical eclecticism,* using procedures drawn from different sources without necessarily subscribing to their underlying theories. For Lazarus, no necessary connection exists between meta-beliefs and techniques. It is not necessary to build a composite from divergent theories, on the one hand, nor to accept divergent conceptions**,** on the other, in order to utilize their technical procedures:

> To attempt a theoretical rapprochement is as futile as trying to picture the edge of the universe. But to read through the vast amount of literature on psychotherapy, *in search of techniques, can be clinically enriching and therapeutically rewarding.*
>
> (Lazarus 1967:416)

In 1969, Paul posed a question for behaviour therapy that was later to guide psychotherapy research more generally. Paul asked: 'What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances, and how does it come about?' (Paul 1969: 44). This question directed the attention of therapists and researchers to the many variables that could possibly influence the outcome of psychotherapy. It also pointed to the possibility of maximizing treatment outcome by an optimal selection and matching of particular therapies with particular people and problems. Paul's question became the cornerstone of later eclectic approaches to psychotherapy**.**

Lazarus's multimodal therapy

Arnold Lazarus (1967, 1971, 1973, 1976, 1981, 1986b; Lazarus and Messer 1988, 1991) has broadened the potential base of eclecticism from behaviour therapy to techniques associated with other therapy systems. Originally Lazarus referred to his eclectic approach as 'multimodal behaviour therapy' (Lazarus 1973, 1976), and later as 'multimodal therapy' (Lazarus 1981, 1986b). He pointed to the importance of assessment and intervention in the various modalities that characterize human functioning including behaviour, affect, sensation, ; imagery, cognition, interpersonal relationships and biology. Consistent with other modern eclectics, Lazarus emphasizes treatment specificity, the matching of techniques to persons and problems, and selecting treatments based on empirical evidence for their effectiveness.

Despite his relative de-emphasis on theory as a basis for selecting techniques, Lazarus (1986b) acknowledged that every practitioner uses at least some theory to guide his or her choices. Multiinodal therapy rests primarily on social learning theory, drawing also from general systems theory and communications theory. Indeed, an inspection of the techniques that Lazarus (1986b) lists as part of multimodal therapy reveals that it draws heavily from behavioural and cognitive therapies, and minimally from psychodynamic and other therapies. Lazarus's eclectic approach appears to fall somewhere between a broadened version of cognitive-behaviour therapy and an eclectic strategy that can choose from among *any* therapy system. Beutlcr's (1983, 1986) systematic eclecticism takes us closer to a comprehensive eclecticism, and it is to this approach that we turn next.

Beutler's systematic eclecticism

Larry Beutler's systematic eclectic psychotherapy shares several features in common with Lazarus's technical eclecticism: an emphasis on treatment specificity; the matching ol technique to person and problem; an emphasis on empirical data to determine choice of therapy; and a relative de-emphasis on the role of theory to guide the choice ol therapy (Beutler 1983, 1986). Unlike Lazarus's technical eclecticism, which is still strongly rooted in cognitive and behaviour therapies, Beutler's approach draws from the entire range of psychotherapy approaches.

Beutler *et al.* (1991) have argued that there are data to suggest that most of the variance in outcome in psychotherapy is due to variables other than specific techniques. Systematic eclecticism directs attention to the matching of a broad array of patient variables, treatment variables and patient-treatment interactions that are most likely to maximize therapy outcome. Instead of focusing primarily on the match between problem and technique, Beutler also includes such variables as therapist characteristics (e.g. experience, attitudes, beliefs), patient icharacteristics (e.g. symptom complexity, coping style, resistance to influence), I technique variables, and interactions among these variables. According to Beutler, it is only within this broad context that we should seek the best match between problems and techniques.

As Beutler *et al.* (1991) correctly point out, the number of variables potentially involved in such a matrix are limitless. Further, there is little to guide us in the selection of variables that might be most productive or relevant. It is here that Beutler turns to theory to help guide these choices. Beutler (1986) suggests that *a functional* theory must be developed that encourages and dictates the utilization of these approaches. Such a functional approach would be highly actuarial in nature, emphasizing what has worked best in the past in similar matches among variables. In addition, Beutler bases his work on social psychological theories ' of persuasion and influence to understand some of the possible interactions of patient and treatment characteristics.

In a recent extension of the systematic eclectic approach, Beutler and Clarkin (1990) tried to identify empirically the patient qualities that hold most promise for enhancing the fit between specific patients and treatments. These dimensions included level of motivating distress, problem seventy, coping style and the propensity to resist interpersonal influence. Beutler (1989a) found that the average amount of outcome variance accounted for by such variables was substantially higher than the amount of variance that could be accounted for by techniques alone. Beutler *et al.* (1991) reviewed research on patient coping style and reactance levels as predictors of different rates of response to different procedures and present some preliminary data from prospective studies in which some of these variables were used to predict therapy outcome. Thus, Bender's systematic eclecticism continues to evolve and has begun to stimulate empirical research as well.

Emerging directions

Eclecticism in practice and integration in aspiration is an accurate description of what most in the integrative movement do much of the time (Wachtel 1991). The future will bring greater efforts to specify what operations are performed with various clients, and the means by which those operations are selected. As London (1964: 33) observed:

> However interesting, plausible, and appealing a theory may be, it is techniques, not theories, that are actually used on people. Study of the effects of psychotherapy, therefore, is always the study of the effectiveness of techniques.

An emerging direction in eclecticism is that psychological therapies will be increasingly matched to client variables other than diagnosis (Lazarus *etal.* 1992). While there will be a continued movement towards specific treatments for different diagnostic groupings of patients, diagnosis is limited as a basis for developing psychosocial interventions (Beutler 1989a). Diagnostic systems not only change with the shifts of political winds, but their descriptive nature also make them better suited for use as outcome variables than for determiners of different treatments. Psychosocial treatments are seldom so specific (nor would we want them to be) that they can effect a change in major depression but not in anxiety, interpersonal relationships, thought patterns and situational stressors.

This is not to say that the effect of a given psychotherapy procedure is or will be found to be uniform in all cases. Indeed, there are wide variations in outcomes for all interventions and this variation is likely to be demonstrated to be as wide within diagnostic groups as it is between them. The challenge of technical eclecticism is to discover patient characteristics which predispose the effective use of different procedures irrespective of the patient's formal diagnosis.

Furthermore, the meaning of technical eclecticism will be broadened to denote not only specific clinical procedures but also therapist relationship stances (Lazarus *el al.* 1992). Psychotherapy will never be so technical as to overshadow the power of a given therapist's ability to form a therapeutic relationship. Yet the predictors and contributors to these human inlluences are not beyond the scope of psychological science. Regrettably, the historical emphasis of technical eclecticism on systematic synthesis of techniques has led to a relative neglect of tailoring interpersonal stances to fit particular clients' needs. This lacuna is

all the more serious in that, with most disorders, the therapeutic relationship accounts for far more psychotherapy outcome variance than does technical intervention (Lambert and Dejulio 1978). As a result, the scope of technical eclecticism will be enlarged to include the prescriptive use of the therapeutic relationship. One way to conceptualize the issue, paralleling the notion of'treatment of choice' in terms of techniques, is how clinicians determine the 'relationship of choice' in terms of their interpersonal stances for individual clients (Norcross 1991).

The challenge will be to articulate and operationalize the grounds on which eclectics tailor their interpersonal styles and stimulus value to different clients. Beutler's systematic eclecticism, for one, advocates that therapists adjust several interpersonal dimensions to fit various client presentations. The dimensions of therapeutic style that might be influenced by client presentations include (a) the degree to which the therapist engages in a process of confronting the client with feared objects, ideas and images; (b) the degree to which the therapist focuses on altering internal or external experiences and behaviours; (c) the degree to which the therapist draws attention to in-therapy or extra-therapy activities; and (cl) the amount to which the therapist directs therapeutic tasks and initiates topics of discussion. Similarly, noting that even empathy and warmth are not universally indicated psychotherapist behaviours for all clients, Lazarus has adapted Howard *el al.'s* (1987) taxonomy of therapist styles to adjust multimodal therapy in terms of level of support and direction to specific clients.

These and other schemes for relational 'match-making in psychotherapy' (Talley *et al.* 1990) will empirically examine the commonly shared perception among therapists of feeling oneself to be better suited to deal with some patients rather than others. The accumulating empirical literature may then be able to generate prescriptive matching decisions for use of technical as well as interpersonal interventions in specific circumstances.

Common factors

The common factors approach has been a search for the basic ingredients that different therapies may share in common. The common factors approach seeks to abstract *similarities* across different therapies. These similarities may be at the level of theory or clinical practice. Those interested in common factors believe that apparent differences in theoretical constructs or clinical techniques are more superficial than real, and may mask some basic underlying similarities. Implicit in the commonalities search has been the promise that they can not only help us build belter theories of change, but also more effective therapies.

Early stirrings

In many ways, the history of the common factors approach parallels that of theoretical integration. Early proposals appeared as far back as the 1930s.

One of the earliest papers on therapeutic commonalities was by Rosenzweig (1936). In it, he pointed to several factors that he believed might account for the effectiveness of different therapies. These included the therapist's ability to inspire hope, the importance of providing the patient with alternative, and more plausible, ways of viewing the self and the world.

Results from a series of studies by Fiedler (1950a, h) also focused on the relationship as a source of common factors in psychotherapy, and provided a fascinating, although indirect examination of some of these factors. Fiedler (1950a, b) asked therapists of different experience levels and orientations to describe what they considered to be the components of the ideal therapeutic relationship. He found that expert therapists ol'different schools agreed more with each other than they did with novices from their own school. In a companion study using ratings of actual therapy sessions, Fiedler found a similar pattern of findings using actual ratings of the therapy sessions. The experts from different schools were more similar to each other than to novices within their own school in the characteristics of the relationship they actually developed with their clients. Although Fiedler did not examine the outcome of these therapies, his results provide some indirect support for the common factors notion in suggesting that experience may shape therapists to behave in some basically similar ways, at least with respect to (he type of relationship they establish.

Jerome Frank's common factors

One of the most influential early writings on commonalities was a book by Jerome Frank (1961) entitled *Persuasion and Healing.* Frank argued that psychotherapy was an influencing process, and that we may learn about what accounts for change by looking at other influencing processes. He examined basic similarities among psychotherapy, placebo effects in medicine, brainwashing and faith-healing both in our own culture and others. Based upon his review, he suggested that some of the basic ingredients in all psychotherapies include: arousing hope, emotional arousal, encouraging changed activity outside of the session, and encouraging new ways of understanding oneself and one's problems through interpretations and corrective emotional experiences.

Frank posited that all psychotherapeutic methods are elaborations and variations of age-old procedures of psychological healing. The features that distinguish psychotherapies from each other, however, receive special emphasis in our pluralistic and competitive society. Since the prestige and financial security of clinicians hinge on their particular approach being more successful than that of their rivals, little attention has traditionally been accorded to the identification of shared components.

Frank (1973, 1974, 1982) continued to modify and develop his common factors model, and has more recently focused on the restoration of morale as a significant common factor. Frank hypothesized that all therapies address a common problem - a 'demoralization', consisting of a loss of self-esteem, subjective feelings of incompetence, alienation, hopelessness and helplessness. He suggested that all therapies may be equally effective in restoring morale, despite the different ways in which they do so. He has also further suggested the following as therapeutic components shared by different psychotherapies: an emotionally charged confiding relationship with a helping person; a healing setting; a con-

ceptual scheme or myth to explain symptoms; and a ritual to help resolve symptoms (Frank 1982).

Some of the central themes ol common factors thinking were already apparent during this time. There was a strong emphasis on the commonalities in the therapy relationship, and various attempts to conceptualize these relationship factors. Many proposals also included corrective emotional experiences in therapy and the disconfirmation of dysfunctional expectancies, the arousal of hope and positive expectancies, changes in self-perceptions, persuasion and attitude change, and restoration of morale.

Prochaska's trans-theoretical approach

James Prochaska and his associates (Prochaska 1984, 1991; Prochaska and DiClemente 1986) have focused on commonalities in the process of change, across different problems and diflerent methods of change. Prochaska pointed to *stages ofchange* (e.g. precontemplation, contemplation, action and maintenance), *levels of change* (e.g. problematic behaviours, maladaptive cognitions, interpersonal conflicts, family/systems conflicts, intrapersonal conflicts) anil *change processes* (e.g. consciousness-raising, stimulus control, self re-evaluation, environmental reevaluation). The trans-theoretical model is one of the best examples of the common factors approach. It abstracts factors that do indeed appear to be common to various types of psychotherapy. Even more important is the fact that this model is stated in a form that lends itself to hypothesis-testing with empirical research, an area that is sadly lacking in some other forms of integration. The model has already generated considerable research. For example, Prochaska and his associates have demonstrated that it is possible to measure these stages, levels and processes of change, and have published several studies that have demonstrated interesting interactions among them in people trying to change (Prochaska 1984; Prochaska and DiClemente 1986; Prochaska *el al.* 1991). Prochaska's model is one of the few integrative proposals that goes beyond interesting theoretical speculation and moves us towards an empirical basis for integrative common factors models of therapy.

Emerging directions

In the past decade, there has been a sharp increase in interest in the common factors approach, with perhaps more books and papers appearing on the topic during these years than in all previous years combined (e.g. Brady *et al.* 1980; Garfield 1980; Goldfried 1980, 1982a; Beutler 1983; Cornsweet 1983; Prochaska 1984; Haaga 1986; Karasu 1986; Lambert 1986; Orlinsky and Howard 1987; Jones *et al.* 1988; Arkowitz and Hannah 1989; Grencavage and Norcross 1990). The proposals have become more specific and there was more discussion about the locus of the common factors (e.g. in patient, in therapist, in relationship, in techniques, and so on). One of the most promising signs is that empirical studies growing out of a common factors perspective have begun to appear (e.g. Prochaska 1984; Prochaska and DiClemente 1986; Goldfried 1991; Prochaska *et al.* 1991 Such studies attempt to measure common factors, test hypotheses about them, and determine the correlations of diferent possible common factors with therapy outcome.

Empirical work points to the importance of *both* common and unique factors in diverse systems of psychotherapy. In one study, Goldfried (1991) found that both cognitive-behaviour therapists and psychodynaniic-interpersonal therapists tended to focus more on feedback about interpersonal than intrapersonal themes, despite theoretical differences that might lead one to think otherwise. Some differences between the two did emerge. Cognitive-behaviour therapists focused more on patients' actions, while psychodynamic-interpersonal therapists focused more on emotions and expectations. One particularly provocative finding was that, although the two therapies did not differ in their emphasis on interpersonal feedback, this type of feedback was more strongly associated with outcome in the psychodynamic than cognitive-behavioural therapy. In addition, feedback relating to 'transference' themes had a stronger relationship to outcome for psychodynamic than for cognitive-behaviour therapy. Thus, a commonality may have a different impact in the context of different patients, therapies and therapy relationships. This suggests the possibility that our conceptualization of common factors may be too unitary and simplistic, and that we may need to examine contextual factors as well (cf. Jones *et al.* 1988).

In a recent paper, Grencavage and Norcross (1990) took the rather unique approach of looking for the commonalities among common factors suggested in the writings of 50 different authors. They grouped the various proposals into categories and presented the most frequent ones within each. Under *client characteristics,* they found that positive expectations, hope and faith were by far the most frequent. For *therapist qualities,* they found a general category of positive descriptors, followed by cultivation of hope and positive expectancies, as well as factors relating to warmth, positive regard and empathic understanding. The largest number of different factors related to *change processes.* These included catharsis, acquisition and practice of new behaviours, provision of rationale, fostering insight/awareness, and emotional and interpersonal learning. *Treatment structures* that were frequently suggested included use of techniques/rituals, focus on inner world and exploration of emotional issues, adherence to theory, and a healing setting. Under *relationship elements,* there was a rather general factor, endorsed by a large majority of the writers, that they described as the development of the alliance/relationship. In addition to trying to extract what common wisdom there may be among those proposing common factors, this paper also draws our attention to possible locus of the various common factors. Clearly, they are all interrelated (e.g. the relationship and change processes), but there are still questions to be explored about the best places to look for the most potent commonalities.

How can the identification of what is already there create something better than what we started with? The concept of *bootstrapping* may be useful here. The dictionary defines bootstrapping as a procedure that creates something better without external aid. In statistical terms, bootstrapping tries to improve our ability to predict by reducing the bias and measurement error that is associated with each of the individual predictors (see examples by Dawes 1971). In the case of psychotherapy integration, those individual predictors are the different

therapies. The bias and measurement errors relate to those sources of error that are uniquely associated with each therapy that may obscure the 'true' factors that may be the causal agents for change in all therapies.

Crucial to the bootstrapping process is the relationship of the identified factors to some important criterion. One goal of the common factors approach is to discover the profile of factors *that are most strongly associated with positive therapeutic outcome.* Once identified, such factors may be used as starting points for the development of improved theories and therapies. It is even conceivable that such bootstrapping can yield a weighting of different factors for different clinical problems.

Theoretical integration

Early stirrings

The history of theoretical integration is largely the history of attempts to combine psychoanalytic and behavioural approaches to psychotherapy. Several early papers attempted to demonstrate that concepts from psychoanalysis could be translated into the language of learning theory (e.g. Kubie 1934; Sears 1944; Shoben 1949).

In what may represent one of the earliest attempts at theoretical integration, French delivered an address at the 1932 meeting of the American Psychiatric Association in which he drew certain parallels between psychoanalysis and Pavlo-vian conditioning. Acknowledging the wide discrepancy between these two approaches, French discussed the similarities between the psychoanalytic concept of repression and l'avlovian concepts of extinction and inhibition. Trying to tie sublimation to learning principles, he invoked the principle of differentiation, suggesting that some sort of discrimination training had probably taken place to differentiate the unacceptable from the more socially accepted manifestations of certain impulses (Goldfried and Newman 1992).

The following year the text of French's presentation was published, together with comments by members of the original audience (French 1933). As one might expect, French's presentation resulted in mixed audience reaction. As one of the most unabashedly negative responses by a member of the audience, Myerson, acknowledged:

> I was tempted to call for a bell-boy and ask him to page John B. Watson, Ivan Pavlov, and Sigmund Freud, while Dr. French was reading his paper. I think Pavlov would have exploded", and what would have happened to Watson is scandalous to contemplate, since the whole of his behavioristic school is founded on the conditioned reflex . . . Freud . . . would be scandalized by such a rapprochement made by one of his pupils, reading a paper of this kind.
>
> (in French 1933: 1202)

Meyer was not nearly as unsympathetic. Although he stated that the field should encourage separate lines of enquiry and should not attempt to substitute any one for another too prematurely, Meyer nonetheless suggested that one should' enjoy the convergences which show in such discussions as we have had this morning' (French 1933: 1201).

Dollard and Miller's translation and synthesis

A significant event in the history of theoretical integration occurred in 1950 with the publication of Dollard and Miller's book, *Personality and Psychotherapy: An Analysis in Ierms of Learning, '/'/unking, and Culture.* This book went lar beyond its description as a simple attempt to translate psychoanalytic concepts into behavioural language. Rather, it was an attempt to synthesize and integrate ideas about neurosis and psychotherapy from these two perspectives in order to provide a unifying theory for the field. In the opening of their book, Dollard and Miller (1950: 3) wrote:

> The ultimate goal is to combine the vitality of psychoanalysis, the rigor of the natural science laboratory, and the facts of culture. We believe that a psychology of this kind should occupy a fundamental position in the social sciences and humanities - making it unnecessary for each of them to invent its own special assumptions about human nature and personality.

What Dollard and Miller achieved was no less than an integrative theory of neurotic behaviour based on anxiety and conflict, and new suggestions for psychotherapy that grew out of their integration. Granted, some of their work was an attempt to translate the concepts of psychoanalysis into (he language of learning theory (e.g. they attempted to explain the pleasure principle in terms of reinforcement and repression in terms of the inhibition of cue-producing responses that mediate thinking). However, they also presented a rather sophisticated formulation of the dynamics of conflict and anxiety in neurosis, drawing from concepts in both learning theory and psychoanalysis. They also suggested procedures for overcoming repression, and proposed the use of modelling, self-control strategies and homework assignments in therapy. Many of these techniques have since been 'rediscovered' and are now a basic part of several modern-day therapies.

While their theory of anxiety and conflict caught the attention of researchers in learning (see review by Heilizer 1977), their integration did not have much direct influence on the field of psychotherapy. The influence has been more indirect, serving as a reminder of the possibility and potentials of integration during times when integrative thinking was not a part of the *Zeitgeist.* Now that psychotherapy integration is more established as a field, perhaps their work will be rediscovered as it deserves to be.

Wachtel's cyclical psychodynamics

In 1977, Paul Wachtel published his book, *Psychoanalysis and Behavior Therapy: Toward an Integration.* It remains the most comprehensive and successful attempt to integrate behavioural and psychodynamic approaches, and one of the most influential books in the entire field of psychotherapy integration. Wachtel did his graduate work at Yale when both John Dollard and Neal Miller were on

the faculty. In fact, Dollard was one of this first therapy supervisors. Wachtel (1987) notes that lie was ciuite impressed with their attempt to build a theoretical bridge between the concepts of psychoanalysis and learning theory. He noted that any attempt to integrate behavioural and psychoanalytic approaches needs to appreciate the diversity within both and must be specific about the components of such an integration (Wachtel 1977).

Which behaviour therapy and which psychoanalytic therapy shall be integrated? Some may be more compatible than others: for example, orthodox Freudian psychoanalysis and operant behavioural therapies are probably so incompatible that an integration between the two is unlikely. By contrast, Wachtel pursued an integration that incorporated a behaviour therapy emphasizing anxiety reduction and changes in interpersonal behaviour, with interpersonal psychoanalytic approaches (Krikson, Horney and Sullivan) that emphasized the current interpersonal context of the individual and encouraged greater therapist activity than many other psychoanalytic approaches.

The goal of Wachtel's work was to build a framework that could incorporate selected elements of interpersonal psychodynamic approaches and behavioural approaches. It is important to note that his goal was *not* a fixed superordinate theory (or therapy) that would be a hybrid of two sub-approaches. Instead, Wachtel sought to include what he believed were some of the virtues of both in an evolving framework that could incorporate elements ot each in a logical and internally consistent way, benefiting from what he saw as their complementary strengths (Wachtel 1984). This framework, which might change with further developments in each theory, could show how concepts from each of the therapies interacted with each other in ways that might suggest^ new theory for understanding the causes of psychopathology and new clinical strategies for change. From the psychodynamic perspective, he emphasized unconscious processes and conflict, and the importance of meanings and fantasies that inlluenced our interactions with the world. From the behavioural side, the elements included the use of active-intervention techniques, a concern with the environmental context of behaviour, a focus on the patient's goals in therapy, and a respect for empirical evidence (Wachtel 1977, 1987).

In understanding the origins of psychopathology, Wachtel paid considerable attention to the importance of early experience. He adopted the psychoanalytic view that ways of feeling, acting and behaving that reflect unresolved conflicts will persist into our later life, continuing to influence us even outside of our awareness. Had he stopped here, he would have remained a primarily psychodynamic theorist. However, based on learning and interpersonal orientations, he also saw the importance of present interpersonal influences. He wrote (1977:52-3):

> Thus, from this perspective, the early pattern persists, not in spite of changing conditions but because the person's pattern of experiencing and interacting with others tends continually to recreate the old conditions again and again.

In this view, our past experiences skew our present environment, and often lead us to create the very conditions that perpetuate our problems in a kind of vicius encle. For example, the people we choose and the relationships we form may confirm the dysfunctional views that we carry forward from our past and that are at the heart of many of our problems. Wachtel later tailed this approach 'cyclical psychodynamics' (Wachtel 1987). The view of causality in this theory is circular and reciprocal,"rather than the linear causal views of behavioural and psychoanalytic theories.

Wachtel also explored the implications of this integration for the practice of psychotherapy. It follows from cyclical psychodynamic theory that intervening into the factors currently maintaining the problem will be an important aid to change. In addition, active behavioural interventions may also serve as a source of new insights (Wachtel 1975) and insights can promote changes in behaviour (Wachtel 1982a), with the two working synergistically.

Emerging directions

The debate about theoretical integration is now dealing with important and substantive issues in psychotherapy theory and practice. Interest in a psycho-dynamic-behavioural integration has continued to grow and remains a strong force in psychotherapy integration. In the 1980s three books were published that reprinted classic papers relating to theoretical integration (Marnwr and Woods 1980; Goldlried 1982a; Wachtel 1987). There seems to be an interest in reading and rereading earlier contributions, now that they can be understood in the context of a growing body of thought on psychotherapy integration. A number of books and papers continue to develop clinical strategies and to debate issues ! relating to psychodynamic-behavioural integration (Wachtel 1977, 1987, 1991; ^ Papajohn 1982; Segraves 1982; Fensterheim 1983; Rhoads 1984; Arkowitz 1985, 1989; Wachtel and Wachtel 1986; Lazarus and Messer 1988, 1991; Beutler 1989a; Fitzpatrick and Weber 1989; Wolfe 1989).

There has also been an increasing interest in theoretical integration other than the psychodynamic-behavioural. Some papers have discussed the possibility of an integration between humanistic and behavioural therapies (e.g. Thoresen 1973; Wandersrnan *et al.* 1976). In addition, a number of writers from the family therapy area have been exploring various clinical and theoretical integrations between family/systems therapies and others (e.g. Gurman 1981; Feldman and Pinsof 1982; Segraves 1982; Pinsof 1983; Lebow 1984; Wachtel and Wachtel 1986). A small but growing literature on incorporating interpersonal factors into an integrative model has also appeared (e.g. Safran and Segal 1990; Andrews 1991a, b).

Different writers have often referred to theoretical integration at different levels or units of analysis - for example, integrations have been addressed to theories, assumptions about human nature, methods of verification, or combinations of these. Schacht (1984) suggested that some of the conflict and confusion that characterized previous discussions may have resulted from ambiguity about the units and levels that were being discussed. Integration may also take various forms or models. Schacht (1984) sees the most elementary one as a simple *translation* of concepts, as was part of Dollard and Miller's mission. In a *complementary model,* each approach is seen as appropriate for dealing with different problems

in the same patient (e.g. systematic desensilization for a phobia anil psychoanalytic therapy lor identity problems). A third model is *synergistic* one in which the two therapies may be applied to the same problem and are expected to interact in the patient to produce clinical results superior to what might be obtained by either therapy alone. The techniques of each therapy remain unchanged, but the locus of their integration lies in their effects on the patient. In the *emergent* model, the different therapies merge to produce a novel hybrid approach with new characteristics not contained by either therapy alone. This is exemplified by Feather and Khoads's (1972a, b) psychodynamic behaviour therapy involving the application of desensilization to inferred underlying fantasies and conflicts. Finally, according to Schacht, the most challenging level is *theoretical integration* [1] in which there is an integration of theories and metapsychologies, with the hope for an emergent model of human behaviour. Wachtel's work best illustrates this approach.

Recent research demonstrates an emerging preference for both the term 'integration' and the practice of theoretical integration, as opposed to technical eclecticism. Results of studies (Norcross and Prochaska 1982; Norcross and Napolitano 1906) show clinicians preferring the self-identification of integrative over eclectic by almost a two-to-one margin. That is, they like the ring of 'integrative' better than "eclectic[1]. In similar fashion, when instructed to select the type of integration they practise, the majority of eclectics - 61 per cent and 65 per cent - chose theoretical integration.

The preference for integration over eclecticism probably represents a historical shift. In a 1975 investigation (Garfield and Kurtz 1977), most clinicians favoured eclecticism; in a 19ii6 study (Norcross and Prochaska 1988), most favoured integration. This may reflect a theoretical progression analogous to a social progression: one that proceeds from segregation to desegregation to integration. Eclecticism has represented desegregation, in which ideas, methods and people Iroin diverse theoretical backgrounds mix and intermingle. Currently we appear to be in transition from desegregation to integration, with increasing efforts directed at discovering viable integrative principles for assimilating and accommodating the best that different systems have to offer.

Integration with basic psychological theory and research

Recently, there has been increasing interest in a relatively new direction for psychotherapy integration that seeks even broader frameworks than the specific integration of two or more existing theories of psychotherapy. In this form of integration, there is an attempt to look *outside* of (rather than *across)* existing psychotherapy theories for ways to further our understanding of change. In this approach, many are beginning to look to basic theory and research in other areas that may elucidate the processes of change in ways that may improve our ability to help people change. As one example, many have looked for a framework that can potentially incorporate systemic interactions among cognitive, affective, behavioural and interpersonal aspects of human functioning (e.g. Goldfried and Safran 1986; Greenbergand Safran 1987; Horowitz 1988, 1991; Beckham 1990; Safran and Segal 1990; Andrews 1991a and b; Schwartz 1991).

Some are even questioning the existence of sharp distinctions among these response systems, suggesting that such a distinction may be artificial (Schwartz 1984, 1991; Barlow 1988). A recent paper by Beckham (1990) illustrates this trend. After reviewing the outcome research on depression, Beckham (1990: 211) suggested that:

> Depression may be viewed as a horneostatic system to the extent that it involves many different components of a patient's life and consists of feedback loops of reciprocal maintaining processes between these components. According to this model, the effect of psychotherapy in altering one element of the depressive homeostasis quickly spreads to other elements in the depressive system.

Beckham suggested that the elements in this homeostasis are cognitive, affective, interpersonal and biological. Further, he argued that different therapies for depression may be equally effective because they all disturb this horneostatic balance by intervening through one part of the system.

In the area of anxiety, Barlow (1988) has built an impressive theory of anxiety along with implications for treatment based on the construct of anxious apprehension. He defines anxious apprehension as a diffuse cognitive-affective structure.

In addition to these larger-scale systemic integrations, there has also been a growing interest in the cognitive sciences in general, and the construct of schema in particular, as areas for integration with our therapies and theories ol change. Stein (1992) has discussed the increasing interest of many psychotherapies including cognitive-behavioural (e.g. Beck and Weishaar 1989), as well as psycho-dynamic theorists (e.g. Horowitz 1988, 1991) in the construct of schema. Stein also elaborated the utility of the construct for understanding a range of phenomena in psychotherapy and change.

Wolfe (1989, 1992) has developed an integrative theory and therapy for anxiety disorders that draws heavily on schema theory. Wolfe elaborated on some aspects of schema theory and integrates these concepts into some new ways of dealing with anxiety disorders. Arkowitz (1991b) has drawn from schema theory, social psychology and Gestalt psychotherapy to develop an integrative model of resistance to change, along with implications for treatment and some preliminary data to support this model.

Social psychology has been another source of integration with psychotherapy. As early as 1966, Goldstein *el al.* (1966) conceptualized psychotherapy as a process of persuasion and attitude change, and looked to basic research and theory that might enhance our ability to achieve attitude change in psychotherapy. *In* their book, they made some innovative suggestions for psychotherapy that are still worth considering today. A recent book by their students has updated and expanded these earlier proposals (Higginbotham *el al.* 1988).

In the general strategy for integration discussed in this section, the hope is that basic psychological knowledge can inform our understanding of psychopathology and change, and even suggest new ways to approach psychotherapy. In addition, there is also the hope that observations from the 'laboratory' of psychotherapy'can inform basic theory and research. This direction of psychotherapy

integration holds a great deal of promise for theory and practice in psychotherapy, although the clinical implications are still somewhat remote. The greatest potential of this new direction is lor strengthening the empirical base of psychotherapy integration, since links would be made with theory and constructs that are already rooted in supporting research.

British contributions

British interest in psychotherapy integration is not new (Dryden 1984). More than 25 years ago, for example, Marks and Gelder (1966) were among the first to discuss areas of similarity and complementarity between behavioural and psychodynarnic therapies. The chapters in this book reflect the diversity and vitality of the current British interest in psychotherapy integration. We will use our framework of the four directions for psychotherapy integration to place each of these chapters in some perspective. Many of the chapters draw heavily on all four approaches, but in different ways. For ease of communication, we will use the phrase 'combined theoretical integration' to refer to approaches that seem to combine theoretical integration, common factors and integration with other areas. A few chapters may best be described as attempts to develop a combined theoretical framework that to some extent endeavours to integrate two or more theories, to some extent looks at commonalities among therapies, and to some extent looks outside of theories of therapy to other areas of theory. A few chapters then use this framework as a basis lor selecting treatments for people and thus also have elements of technical eclecticism. Examples of this blend can be found in the work of Clarkson (Chapter 2) and Culley (Chapter 5, both in this volume). Clarkson's approach draws from systems, psychoanalytic, behavioural and humanistic thinking, as well as common factors and other theories. This proposed framework is then used to guide the selection of treatment. Clarkson's proposal is one of the few to employ systems theory concepts, an interesting choice since systems theory seems especially well-suited to inlegrative thinking.

The framework proposed by Culley is grounded in the Rogerian client-centred approach and cognitive-behaviour therapy. Within this conceptual framework, it appears to be more of a technically eclectic approach. Culley presents a stage model of counselling in which there are different aims, different strategies to accomplish them ami different skills that are required at different stages of therapy. However, like the stage theory approach of Prochaska and his associates discussed earlier, Culley's is one of the few proposals to address the need for different approaches at different stages of change.

Rowan's proposal (Chapter 9, this volume) may be considered to fit the category of combined theoretical integration, but elements of technical eclecticism are not as clear as they are with Clarkson and Culley. Rowan attempts to blend past approaches, like those of psychoanalytic therapy, with those that are more present-oriented like existential therapies, with those that are more future-oriented like transpersonal therapies. He proposes this integration for group work. Rowan's proposal may be categorized as a combined form of theoretical integration with some hints of a technical eclecticism to match clients to treatments.

The chapters by Ryle and Cowmeadow (Chapter 3), Ridley and Crowe (Chapter 6) and Guirguis (Chapter 7, all in this volume) fit most closely the category of theoretical integration in which two or more theories or therapies are synthesized. Ryle and Cowmeadow describe the former's cognitive-analytic therapy as an attempt to incorporate concepts from both cognitive-behaviour therapy and psychoanalytic therapy. Both Ryle and Cowmeadow, and Barkham (Chapter 10, this volume) discuss recent research that cognitive-analytic therapy has generated. This is particularly noteworthy in view of the relative lack of such research in theoretical integration.

Ridley and Crowe's behavioural-systems couple therapy takes its origins from behavioural marital therapy and family systems work. It is more than a simple combination of these two, but an attempt to integrate these views and come up with new approaches from such an integration. In this way, it has some elements of theoretical integration. Within this general framework, it also has elements of technical eclecticism, emphasizing as it does the alternative levels of intervention (ALI) hierarchy to help choose the particular approach for particular couples at particular points in therapy.

Guirguis describes the need for a comprehensive and integrative model of sexual dysfunction that pays attention to the role of physical as well as psychological factors. The clinical approach and underlying rationale described by Guirguis may best be described as a theoretical integration between behavioural and psychodynamic approaches. The approach begins as a largely behavioural programme to break the cycle of performance anxiety and deficit. However, when resistances, obstacles or lack of progress are encountered, it looks primarily (but not exclusively) to psychodynamic perspectives to help understand and deal with the issues that emerge.

Eskapa (Chapter 4, this volume) presents a summary and update of multi-modal therapy, originally developed by Arnold Lazarus. As discussed earlier, this therapy clearly falls within the category of technical eclecticism. Eskapa notes that British and European students seem less aware of multimodal therapy than their American counterparts, and his chapter is an attempt to bridge that gap.

Treacher's (Chapter 8, this volume) approach may be broadly categorized as eclectic, but not precisely as 'technically eclectic'. Treacher finds something of value in most approaches, but diverges from technical eclectics in his relative de-emphasis on technique. It appears that Treacher is advocating the virtues of experienced clinical judgement as the basis for matching what we do to our clients and their needs, but the specific bases for such judgements are not clearly articulated.

Clarkson (Chapter 11, this volume) discusses some important issues relating to training for psychotherapy integration. The basis for the chapter and the recommended training programme is systemic integrative therapy as described by Clarkson in her other chapter in this Handbook. Clarkson suggests that training in psychotherapy integration can occur either from the beginning of one's psychotherapy training, or after the student has completed training in one or

more pure forms of therapy. She advocates both models for training in psychotherapy integration.

Glarkson presents details of a carefully thought-out training programme in systemic eclectic therapy at a training institute. While the systemic integrative psychotherapy is a rather broadly integrative model, it is still only *one* model of integration. We believe there are real risks to the formation of institutes lor training in particular types of integration, and in the granting of credentials for integrative therapists. While Clarkson seems to be aware of several of these problems, we remain concerned that the exploration of psychotherapy integration may revert to a more narrow training in a fixed 'school' of integration. In closing her chapter, Clarkson cites a paragraph from Norcross. In coming full circle, and in sharing Clarkson's concern, we will cite Clarkson citing Norcross:

> ... it is premature to advance any one integrative system ... I urge students, in the integrative spirit, to take the 'best' from each model and to discern converging themes for themselves.

Barkham (Chapter 10, this volume) presents an overview of research on integrative-eclectic therapy in general, and research on integrative-eclectic therapy in Britain. Me observes that there has been considerably more written on theoretical and clinical issues relating to integration than there has been on research. This is true for Britain as well as other parts of the world. Nonetheless, Barkham reviews some interesting research on a variety of topics relevant to integration. These include: group designs and case-studies on integrative therapies, including cognitive-analytic therapy; studies of common factors as perceived by clients; the Sheffield programme of research on sequencing of contrasting therapeutic orientations; and experience in using the assimilation model to match clients to treatments. Clearly, a number of different research directions are beginning to emerge in psychotherapy integration research in Britain, and we find that a positive and exciting indication.

Obstacles and trade-offs

The accelerated development of eclectic and integrative psychotherapies has not been paralleled by serious consideration of their potential limitations and trade-offs (Arkowitz and Messer 1984; Dryden 1986). If we are to avoid uncritical growth or fleeting interest in psychotherapy integration, then some honest recognition of the barriers we are likely to encounter is sorely needed (Goldfried and Safran 1986). Caught up in the excitement and possibilities of the movement, we have neglected the problems - the 'X-rated topics' of integration. Healthy maturation, be it lor individuals or for movements, requires self awareness and constructive criticism.

What's stopping psychotherapy integration now? Norcross and Thomas (1988) conducted a survey of the SEPI membership to answer this question. Fifty-eight prominent integrationists rated, in terms of severity, twelve potential obstacles using a five-point, Likert-type scale (where 1 = not an obstacle, 3 = moderate

	Severity rating	
Obstacle	*Mean*	*Rank*
Intrinsic investment of individuals in their private perceptions and theories	3.97	1
Inadequate commitment to training in more than one psychotherapy siystem	3.74	2
Approaches divegent assumptions about psychopathology and health	3.67	3
Inadequate empirical research on the integration of psychotherapies	3.58	4
Absence of a 'common' language for psychotherapists	3.47	5

obstacle, and 5 = severe obstacle). The top five obstacles and their mean scores are presented in Table 1.1.

The most severely rated obstruction centred around the partisan zealotry and territorial interests of 'pure'-form psychotherapists. Representative responses were: 'egocentric, self-centred colleagues'; 'the institutionalization of schools'; and 'ideological warfare, factional rivalry'. In examining the history of different therapy methods, Goldfried (1980: 991) notes that, traditionally, therapists have . been guided by a particular theoretical framework, 'often to the point of being completely blind to alternative conceptualizations and potentially effective inter- j vention procedures'.

Unfortunately, professional reputations are made by emphasizing the new and different, not the basic and similar. In the Held of psychotherapy, as well as in i other scientific disciplines, the ownership of ideas secures far too much emphasis. Although the idea of naturally occurring, co-operative efforts among professionals is engaging, their behaviour may realistically be expected to reflect the competition so characteristic of our society at large (Goldfried 1980).

Inadequate training in eclectic/integrative therapy was the second-ranked impediment. The reasons are multiple and explicable. Training students lo competence in multiple theories and interventions is unprecedented in the history ol psychotherapy. Understandable in the light ol its exacting and novel nature, the acquisition of integrative perspectives has occurred quite idiosyncratically and perhaps serendipitously to date.

The critical training question is how to facilitate adequate knowledge ol and competence in the various psychotherapeutic systems. On the one hand, intense concentration on a single theoretical system, though possibly myopic and misleading, is often secure and complete. On the other hand, cursory exposure to multiple therapeutic systems leaves students with a few cliches and disunited techniques, though it does encourage integration (Norcross 1986b; Robertson 1986). Several special sections addressed integrative training and supervision (Norcross *et al.* 1986; Bender *el al.* 1987; Halgin 1988).

The third-ranked obstacle concerned differences in ontologiial and epistem-ological issues. These entail basic and sometimes contradictory assumptions about human nature, determinants of personality development and the origins

of psychopathology. For instance, are people innately good, evil, both, neither? Do phobias represent learned maladaptive habits or intrapsychic conflicts? But it may be precisely these diverse world views that make psychotherapy integration interesting, in that it brings together tiie individual strengths of these complementary orientations (Beitman *et al*. 1988).

We have not conducted sufficient research on psychotherapy integration - the fourth obstacle to be addressed here. Comparative outcome research lias been a limited source of direction with regard to selection of method and articulation of prescriptive guidelines (Lambert 1986; Barkham, Chapter 10, this volume). Hour empirical research has little to say, and if collective clinical experience has divergent things to say, then why should we do A, not B? We may again be guided by selective perception and personal preference, a situation the integrative movement seeks to avoid.

The models of psychotherapy integration are more like general frameworks than formal theories. It is often difficult to cJerive testable hypotheses from them that allow us to accept or reject their ideas. They may be good general ideas, but they are still far from good theory. In addition, those proposals that call for an integration of two existing therapy theories have yet to demonstrate that they can lead to predictions other than those generated by each theory separately. The paucity of good theory in psychotherapy integration may be one of the reasons why it has as yet been so hard to generate much new research. The new direction for integration involving basic psychological research and theory holds some promise for improving theory and stimulating more research.

We are convinced that the largest challenge facing psychotherapy integration is to find ways to generate and test hypotheses from these new points of view. Without such data, integrative theories may become either extinct or a part of a large body of unsubstantiated clinical lore.

Another obstacle to the establishment of clinically sophisticated and consen-sually validated integrative psychotlierapies is the absence of a common language (Norcross 1987). This was rated the fifth most serious impediment to progress. Each psychotherapeutic tradition has its own jargon, a clinical shorthand among its adherents, which widens the precipice across differing orientations.

The 'language problem', as it has become known, confounds understanding of each other's constructs and, in some cases, leads to active avoidance of those constructs. Many a behaviourist's mind has wandered when case discussions turn to 'transference issues' and 'warded-oif conflicts'. Similarly, psychodynamic therapists typically tune out buzz words like 'conditioning procedures' and 'discriminative stimuli'. Isolated language systems encourage clinicians to wrap themselves in semantic cocoons from which they cannot escape and which others cannot penetrate. As Lazarus (1986a: 241) concluded: 'Basically, integration or rapprochement is impossible when a person speaks and understands only Chinese and another converses only in Greek!'

A common language thus offers the promise of increased communication between clinicians and researchers, on the one hand, and among practitioners of diverse persuasions, on the other. Meaningful trans-theoretical dialogue may allow us to enrich each other's clinical practices, access the empirical literature, and discover robust therapeutic phenomena cutting across varying orientations (Norcross 1987).

The purpose of a common language is to facilitate communication, comprehension and research; it is not intended to establish consensus. Before an agreement or disagreement can be reached on a given matter, it is necessary to ensure that the same phenomenon is in fact being discussed. Punitive super-ego, negative self-statements and poor self-image may indeed be similar phenomena, but that cannot be known with certainty until the constructs are defined operationally and consensually (Strieker 1986).

To be sure, this is a demanding task (Messer 1987). In the short run, using the vernacular - descriptive, ordinary, natural language - might suffice (Dris-coll 1987). In the long run, a common language may profit from being linked to a superordinate theory of personality or derived from an empirical data base (e.g. Ryle 1987; Strong 1987).

We would nominate two additional concerns pertaining to the maturation of psychotherapy integration. First, it is disappointing indeed that many eclectic and integrative authors are under-aware of each other's work. In addressing this" surprising and troubling trend, Dryden (1986: 374) writes that,

> It is important that the pioneers of eclectic psychotherapy demonstrate an eclectic attitude (i.e. willingness to draw upon diverse sources) among their own ranks. Otherwise they will act as poor role models and increase the chances that schools of eclectic therapy will proliferate in the future. If this happens, the nettle will not have been grasped!

Integrative compendiums on the order of this volume may serve a corrective function in this respect.

Our second concern relates to a potential contradiction in the synthesis of two or more psychotherapy systems: the integration of today may become the single-school approach of tomorrow (Arkowitz 1992). Integrative therapies may, ironically, become the rigid and institutionalized perspectives which integration has attempted to counter in the first place. As we discussed earlier, the formation of institutes for integrative psychotherapy and the accreditation of integrative clinicians could potentially contribute to such an unfortunate rigidifying of a field that should be characterized by openness and exploration. It is ironic that integration itself must avoid becoming another 'school' of psychotherapy.

Wachtel's original vision can serve as a template. He sought an 'evolving framework' for integration rather than a fixed, static synthesis. What does the concept of evolving framework imply? We may be moving towards what Schwartz (1991) and others have described as an 'open system' model that consists not only of the interaction of its existing components, but one which allows for new elements to be introduced and old ones to be abandoned. There is some internal cohesiveness to the system - not all elements can enter readily into it. Some elements fit more readily into the existing system than others. Other elements, are either unable to enter into the system or must change in order to do so.

Moreover, change in one element potentially changes the entire system. For example, a psychodynamic-behavioural integration may be an overall

framework that encourages attempts to introduce a number of diferent elements from an evolving behaviour therapy, and to introduce them at different times, to see how they interact with elements that are also introduced from an evolving body of psychodynamic theory and therapy. Different elements can be introduced and different resulting systems can be explored. This view of integration is quite different from a fixed synthesis of static entities. The open system framework is one which can generate different models at different times that may lead to new theories, new variations of clinical therapy and new research.

Contributions and promises

At present, psychotherapy integration has probably had its strongest impact in desegregating the field of psychotherapy, rather than in truly integrating it. Integrative perspectives have been catalytic in the search for new ways of conceptualizing and conducting psychotherapy that go beyond the confines of single-school theories. They have encouraged practitioners and researchers to examine what other theories and therapies have to offer. The spirit of integration also encouraged new ways of thinking about psychotherapy and change. The historical 'dogma eat dogma' ambience of psychotherapy is gradually abating.

To date, psychotherapy integration has been most successful in engendering an informed pluralism and nascent convergence. Clinical experience and research findings alike lead us to the conclusion that each therapeutic orientation has its share of failures, and that none is consistently superior to any other. These observations have stimulated many workers in the field to suggest that contributions from orientations other than their own might be fruitfully employed. The weakness of any one perspective might be complemented by another's strength. Pinsol (1983: 20), for example, describes his integrative problem-centred therapy as one that

> rests upon the twin assumptions that each modality and orientation has its particular domain of expertise, and that these domains can be interrelated to maximize their assets and minimize their deficits.

This, then, is the important first step: to view rival systems not as an adversary, hut as a healthy diversity (Landsman 1974); not as contradictory, but as complementary (Norcross 1986b). We have begun to build, rather than burn, the bridges which span chasms separating theories. At long last, we can temper our splitting propensities and reject the puerile claims ol 'We are good - they are bad' (Miller 1985) anil proudly exclaim 'We are good - they are also good' (Norcross 1988).

There is a pernicious misconception in our field that certain processes and outcomes are the exclusive property of particular therapy systems. Norcross (1988) has labelled this fallacy the 'exclusivity myth'. Cases in point are the behaviourist's contention of exclusive ownership of behaviour change, the experi-entialist's presumed monopoly on intense affective expression and the psychoanalyst's assertion of unique genetic insights. The exclusivity myth is part and parcel of the hostile, ideological cold war. Psychotherapy integration has brought many of these warring factions to the negotiation table for peace talks.

Many observers (Karasu 1977; Marmor and Woods 1980; Goklfried 1982a; Messer 198(ib) have noted increasing confluence ol attitudes and practices amongst the psychotherapies. Recent studies of clinical practitioners point to many areas of convergence as well as remaining points of contention. In one study (Mahoney *et al.* 1989), 486 psychologists representing live major theoretical orientations responded to 40 standardized questions about optimal practices in psychotherapy. The results indicated considerable trans-theoretical convergence on the importance of novel exploratory activity, self-examination and self-development in psychotherapy. Behaviourists rated psychological change as significantly less difficult than did their colleagues of other persuasions unless they had been in psychotherapy themselves. In another study (Friedling *et al.* 1984), 85 psychodynamic and 110 behavioural psychologists reported on their use of operationally defined therapy activities. Over a half of these methods were used by both groups, 15 per cent were mutually rejected and only 29 per cent were employed exclusively by members of either orientation.

Furthermore, this convergence and informed pluralism have been accomplished without institutionalizing any one way as *the* way. The exclusive advancement of any one integrative strategy is premature in view of the early stage of development of the field, and is unrealistic in view of fundamental differences in the values, goals and philosophies of clinicians (Norcross 1991). Integration is still an open field in which different ways of thinking and acting are being proposed, explored and debated. This exploration has already been a healthy challenge to more established ways of thinking about psychotherapy.

Integrative perspectives have already opened up several new avenues for theory, research and practice in psychotherapy. One type of theoretical integration suggests new ways of thinking about therapy by integrating existing theories. Another type of theoretical integration, based on systemic interactions among affect, behaviour, cognition and social factors, has also begun to stimulate new thinking in the field. Both theoretical integration and common factors approaches have begun to suggest new research questions and strategies for therapy. Finally, technical eclecticism has been a stimulus for research in psychotherapy in its search lor data on optimal matching strategies to improve therapy outcome. There have also been a number of integrative clinical proposals that suggested new therapy strategies.

In concluding, let us share a thought from Arthur Houts (from Norcross and Thomas 1988): We need to wait for whatever it is that will follow the postmodern era. We are in the post-modern era, but we do not yet know what comes next. There is an old Middle Eastern proverb that applies: 'He who plants dates does not live to eat dates.' We need to be careful to plant dates rather than pumpkins.

While psychotherapy integration has experienced, and will continue to experience, meaningful progress in our lifetimes, the greater legacy of the integrative movement will lie in the future. This legacy, for us, entails the promotion of open enquiry, informed pluralism, empirical research, intellectual relativism and enhanced clinical effectiveness. As with the clinical enterprise itself, the seeds we

sow now may produce enticing flowers quickly, but may not bear the sustaining fruit lor years to come. Our fervent hope is that we all work diligently enough and live long enough to partake of that fruit together.

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