The Movement Toward Integrating the Psychotherapies: An Overview

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There is a growing tendency among psychotherapists to ignore the ideological barriers dividing schools of psychotherapy and to define what is common among them and what is useful in each of them. After a brief introduction the authors provide a short glossary of terms often associated with psychotherapy integration. They then characterize integrative-eclectic therapists, describe the forces fostering their emergence, and outline recurrent themes of the movement and points of contention within it. The authors hope to encourage clinical thinking about the less ideological approaches to psychotherapy and to advance the integrative movement, which is likely to influence psychotherapeutic practice for decades to come.

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Psychotherapy systems appear and vanish with bewildering rapidity on the diffuse, heterodox scene in the United States. In 1959, Harper (1) identified 36 distinct systems of psychotherapy. In 1976, Parloff (2) discovered more than 130 therapies on the marketplace or the "therapeutic jungleplace." In 1986, Karasu (3) reported a count of more than 400 presumably different "schools" of psychotherapy. The proliferation of therapies has been accompanied by a deafening cacophony of rival claims. The result has been variously characterized as confusion, fragmentation, and discontent (4).

Sibling rivalry among theoretical orientations has a long and undistinguished history in psychotherapy, dating back to Freud. In the infancy of the field, therapy systems, like battling siblings, competed for attention and affection in a "dogma eat dogma" environment (5). Mutual antipathy, profound mistrust, and exchanges of puerile insults between adherents of rival orientations were very much the order of the day.

Amid this strife and bewilderment there slowly emerged a therapeutic "underground" (6). Although not associated with any particular school and not detailed in the literature, the underground reflected a growing openness to contributions from diverse persuasions as well as a nascent awareness that single schools had distinct clinical limitations. Adventuresome clinicians gradually, if unsystematically, began to use strategies that were efficacious without regard to their theoretical origin.

Of course, the notion of integrating various therapeutic approaches had intrigued mental health professionals for some time (7). However, it has been only within the past 10 or 15 years that psychotherapy integration has developed into a clearly delineated area of interest. This movement, by most accounts, has developed more as a cumulating climate of opinion than as an orderly scientific advance (8).

The last decade in particular has witnessed the stirrings of rapprochement and a decline in the ideological cold war. The debates across theoretical systems appear to be less polemical or at least more issue-specific. Clinicians of all persuasions have begun to acknowledge the inadequacies of any one system and the potential value of others.

The concomitant openness to contributions from diverse persuasions has given rise to many publications, organizations, and conferences. Specific systems of in-

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tegrative and eclectic practice (9–13), influential anthologies (4, 14–16), and compilations of prescriptive treatments (17, 18) have flourished. An international journal (*Journal of Integrative and Eclectic Psychotherapy*) and several series of articles devoted to psychotherapy integration have appeared in the last decade. Two interdisciplinary and nonideological organizations—the Society for the Exploration of Psychotherapy Integration and the International Academy of Eclectic Psychotherapists—also exemplify the spirit of open inquiry and growing collaboration.

This article is designed to provide an overview of the movement toward the integration of the psychotherapies. It will not address the combination of psychotherapy and psychopharmacology (19, 20) nor the synthesis of such therapeutic formats as individual, family, or group therapy. We will begin with a short glossary of terms often associated with integrative movements. We will then characterize integrative-eclectic therapists and outline the forces fostering their emergence. Several recurrent themes and points of contention follow.

A SHORT GLOSSARY

The terminology relating to the psychotherapy integration movement has been applied inconsistently and indiscriminately. This semantic disarray has fostered conceptual confusion. In this section, we briefly review the definitions of and distinctions among these terms in an effort to clarify our thinking and to enhance the consistency of our vocabulary.

Rapprochement. According to *Webster's Ninth New Collegiate Dictionary*, "rapprochement" refers to the "establishment of or state of having cordial relations." This term denotes an earlier developmental stage than mature theoretical integration in that cordial relations typically precede incorporation.

Convergence. This is the tendency to grow alike, to develop similarities in form. Many observers (15, 21–24) have noted increasing confluence of attitudes and practices among the psychotherapies. Behavior therapy, for instance, has largely regained its "mind" and has become far friendlier to the cognitive concepts of psychoanalysis and to the affective experiences of humanistic-expressive therapies (24). "Convergence" refers, however, to emerging similarities of distinct orientations rather than to their integration per se.

Eclecticism. This is a vague and nebulous term, with connotations ranging from "a worn-out synonym for theoretical laziness" to the "only means to a comprehensive psychotherapy" (25). In some corners eclecticism is prized as complex, relativistic thinking by people united in their respect for the evidence. In other corners, it connotes undisciplined subjectivity and muddle-headedness (26). Indeed, it is surprising that so many clinicians admit to being eclectic in their work, given the negative valence the term has acquired (27).

Apart from its connotation, the use of "eclecticism" has increasingly been restricted to the technical, atheoretical synthesis of clinical methods. Lazarus (12, 28, 29), the most eloquent proponent of technical eclecticism, emphasized the distinction between the theoretical eclectic and the technical eclectic. The theoretical eclectic draws from diverse systems that may be epistemologically and ontologically incompatible, whereas the technical eclectic uses procedures drawn from different sources without necessarily subscribing to the theories that spawned them. We will employ "eclecticism" in the technical, atheoretical sense advanced by Lazarus.

Integration. Although "eclecticism" is certainly one component of the integration of psychotherapy in that it integrates clinical methods from diverse sources, the term "integration" has come to acquire a more theoretical meaning (30, 31). "Integration" commonly denotes the conceptual synthesis of diverse theoretical systems. "Eclecticism," by contrast, is atheoretical but empirical in pragmatically applying what already exists. "Integration" is more theoretical than empirical in creating something "new": a superordinate umbrella, coherent theoretical gestalt, metatheoretical framework, or conceptually superior therapy (32).

Other descriptive terms have been proposed as alternatives or replacements for the foregoing. These include "creative synthesis," "metamodeling," "comprehensive therapy," "prescriptive counseling," and "differential therapeutics." Each term has a slightly altered emphasis, but all generally denote a trend toward a more consensual and comprehensive framework.

INTEGRATIVE-ECLECTIC PSYCHOTHERAPISTS

Eclecticism has emerged as the modal theoretical orientation of contemporary mental health professionals. Across all disciplines, between one-third and one-half of American psychotherapists disavow an affiliation with a single therapeutic tradition, preferring instead the label of eclectic. This holds true for psychiatrists (33, 34), psychologists (35, 36; unpublished 1988 manuscript of J.C. Norcross et al.), and clinical social workers (34, 37). Interestingly, even surveys of clinicians belonging to behavioral and humanistic organizations reveal sizable percentages of respondents who align themselves with eclecticism: 42% of behavioral clinicians (38) and 31% of humanistic clinicians (39).

The existing research has not delineated any consistent differences between those psychotherapists who identify themselves as eclectic and those who identify themselves as noneclectic, with the exception of clinical experience (39–41). This research has indicated that clinicians ascribing to eclecticism tend to be older and more experienced. Conversely, inexperienced therapists are more likely to endorse exclusive theoretical orientations. Reliance on one theory and a few techniques may be the product of inexperience; put another way, with experience comes diversity and flexibility.

Eclecticism is approached from a multitude of pathways. Garfield and Kurtz (42) found that approximately 40% of eclectic respondents had not previously adhered to a particular theoretical perspective, whereas 50%–60% indicated that they had. Of those with previous theoretical allegiances, the largest shift occurred from psychodynamicism and psychoanalysis to eclecticism. Norcross and Prochaska (31) found that one-half of eclectic psychologists with a previous alliance were formerly in the analytic tradition, and Jayaratne (43) found that one-half of eclectic social workers with a previous alliance were also formerly in the analytic tradition. Next most common for both groups were the behavioral and client-centered orientations.

There appears to be an emerging preference for theoretical synthesis (integration) as opposed to technical synthesis (eclecticism). In the 1970s, 47% of eclectic therapists characterized their clinical practice as pragmatic-technical eclecticism (42), whereas 34% did so in a 1980s sample (31). Concomitantly, 27% of the respondents in the 1970s combined two theories or amalgamated aspects of multiple theories (42), whereas 39% indicated that they did so in the 1980s (31).

WHY INTEGRATION NOW?

A historical perspective of psychotherapy integration (7) has persuasively demonstrated that the stirrings of rapprochement have always been with us but have been actualized and organized into a coherent movement only recently. The unprecedented growth in integrative psychotherapies over the past decade leads one to inquire, Why now? What is there in our socioeconomic environment or the field's maturation that has intensified the spirit of open inquiry?

At least six interacting, mutually reinforcing factors have fostered the advancement of psychotherapy integration in the past decade (4, 7, 44).

1. Proliferation of therapies. In describing the genesis of scientific revolutions, Thomas Kuhn (45) indicated that the abandonment of any given paradigm is ordinarily preceded by a period of crisis. This crisis is characterized by the open expression of discontent about the current state of affairs and by the proliferation of different orientations. The field of psychotherapy, it would appear, is currently experiencing such a crisis (46).

The field has been staggered by too many choices and fragmented by future shock. Which of the more than 400 therapies should be studied, taught, or bought? No single theory has been able to corner the market on validity or utility. The search for a more unified and comprehensive paradigm has thus become a prime motivation for both eclectic and integrative psychotherapists.

2. Inadequacy of single theories. A related factor is the growing consensus that no one approach is clinically adequate for all problems, patients, and situations. Clinical realities have come to demand a more flexible, if not integrative, perspective. Psychotherapy, as a result, has entered a period of intense self-examination in which the failures of our pet theories are reappraised and their limitations realized. The integration movement, to some extent, reflects dissatisfaction with single approaches. A survey of self-designated eclectic and integrative clinicians (42) revealed that their alignment is motivated in part by disillusionment with single-therapy systems.

3. Equality of outcomes among therapies. A third reason for the recent surge toward integration is the general inability to show that one therapeutic approach is clearly superior to any other in manifest outcome (47–49). Despite a notable increase in both the quantity and quality of psychotherapy research, there are few conditions in which a given therapy system leads to differential effectiveness. With few exceptions, there is little compelling evidence to recommend the use of one form of psychotherapy over another in the treatment of specific problems. Borrowing a phrase from the Dodo bird in *Alice in Wonderland*, Luborsky et al. (50) wryly concluded that "everybody has won and all must have prizes."

A paradox has emerged from the equivalence conclusion: there is no differential effectiveness despite technical diversity (51). A number of reasons for this paradox have been advanced, notably the lack of specificity of outcome measurement, the poor integrity of treatments, and the elucidation of common core factors in the therapist, client, or alliance. The two most common suggestions for resolving the paradox seem to be a specification of factors common to successful treatments (52) and a synthesis of useful concepts and methods from disparate therapeutic traditions (53).

4. Resultant search for common components. The identification of common change processes or therapeutic factors has been called the most important psychotherapy trend in the 1980s (54). Strupp (55) has noted that the important advances in psychotherapy research have resulted from better conceptual analyses of basic processes operating in all forms of therapy rather than from premature comparisons of techniques. This observation stems from the emerging view that the commonalities in all forms of therapy are far more impressive than their apparent differences.

A transtheoretical analysis of prominent psychotherapy systems (56) demonstrated how much therapeutic systems agree on the processes producing change while disagreeing on the content to be changed.

Frank (57) 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 psychotherapists hinge on their particular approaches being more successful than those of their rivals, little attention has been traditionally accorded the identification of shared components (4).

Frank (47, 57, 58), among others, has argued that therapeutic change is predominantly a function of factors common to all approaches. For Frank, these include an emotionally charged and confiding relationship, a healing setting, a rationale or conceptual scheme, and a therapeutic ritual. For Garfield (11), these common factors entail the relationship, catharsis, explanation, reinforcement, desensitization, information, and time. Similarly, Karasu (3) identified three nonspecific change agents that all therapy schools share: affective experiencing, cognitive mastery, and behavioral regulation. These authors have noted that features shared by all therapies account for an appreciable proportion of clinical improvement, and psychotherapy outcome research (59) has generally substantiated this claim.

5. *Emphasis on patient characteristics and the therapeutic relationship.* Psychotherapy researchers have come to recognize that the powerful determinants of therapeutic success lie in the personal qualities of the patient and the therapist and in the interaction between them. The particular clinical method appears to have little differential effect. Meta-analytic studies (49, 60, 61), for example, indicate that only 10%–12% of outcome variance is generally accounted for by technique variables. In substantial concurrence, a panel of psychotherapy experts (62) estimated that one-third of treatment outcome is due to the psychotherapist but two-thirds is attributable to the patient. Echoing the consensus on the issue, Bergin and Lambert (63) concluded, "We believe . . . that the largest variation in therapy outcome is accounted for by preexisting client factors, such as motivation for change, and the like. Therapist personal factors account for the second largest proportion of change, with technique variables coming in a distant third" (p. 180).

Consequently, it would appear that singular attempts to improve techniques within one orientation would have a negligible effect on therapeutic outcome. Beutler (64) has noted the irony of devoting 80% of the psychotherapy literature to specific technologies and procedures, which account for about 10% of the change.

Instead, our efforts might be more profitably expended in tailoring the therapeutic relationship and clinical method to the patient. To the extent that there are some specific technique effects (and refined research may discern still more), treatment success can be maximized by altering the therapist's stance and operations to the patient's presenting problem, interpersonal style, personality configuration, readiness to change, and related variables. To the degree that clinicians are able to modify and enlarge their practices to fit the patient's needs, the benefits are potentiated. This is one of the distinguishing characteristics of the integration movement: prescriptive treatment based primarily on patient need and empirical evidence rather than on theoretical predisposition (17).

6. *Sociopolitical contingencies.* The movement toward integrating the psychotherapies is one adaptive response to social, political, and economic influences. There are at present mounting pressures from insurance companies, government policy makers, consumer groups, and judicial officials for accountability. Third parties and the public are demanding crisp and informative answers regarding the quality, durability, and efficiency of psychosocial treatments (65). Until recently the field has had the luxury of functioning within a culture of individual professional freedom. Clinical services had been in steady demand in the marketplace, generally oblivious to economic forces and sociopolitical realities. However, the shrinking job market, increased competition, and diminishing public support portend a future discontinuous with our expansive past (66).

Without some change from the field, psychotherapists stand to lose prestige, customers, and money. These sociopolitical considerations have us increasingly pulling together rather than apart. Mental health professionals report that 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 (67). Intertheoretical cooperation and the search for a unified psychotherapy paradigm represent attempts to respond to these sociopolitical forces. As the external demands escalate, so too will the spirit of open inquiry and psychotherapy integration.

RECURRENT THEMES

In a historical analysis of previous attempts to integrate the psychotherapies, Goldfried and Newman (7) identified issues that have repeatedly emerged over the past half century. Such recurrent themes include the complementary nature of different therapeutic approaches; the advantages of identifying interactions among cognition, affect, and behavior in patients; the importance of an empirical foundation on which therapies may be based; the need for a common language with which to engage in dialogue across different orientations; the need to arrive at a set of therapeutic principles that can account for commonalities across different orientations; and the view of therapy as involving certain common phases or stages. As the topic of therapeutic integration has moved from being a latent concern to a more clearly defined area of interest, clinicians and researchers have started to devote increasingly more attention to each of these themes. The sections that follow describe some of these considerations.

Complementary Nature of Different Orientations

Clinical experience and research findings alike lead us to the conclusion that each therapeutic orientation has its share of clinical failures and that none is consistently superior to any other (51). Such findings have stimulated many workers in the field to consider the possibility that contributions from orientations other than their own might be fruitfully employed. In es-

sence, the weakness of any one orientation might be complemented by another's strength. This notion has been articulated by Pinsof (68), who described an integrative problem-centered 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" (p. 20).

In considering the potential benefits and liabilities of an integrative approach, Messer and Winokur (69) indicated that patient variables may play a particularly important part in determining the most appropriate therapeutic intervention. Thus, a verbally limited patient with little skill at introspection may be less likely to benefit from psychodynamic treatment but may, instead, show greater gains with an action-oriented, behavioral intervention. Like Wachtel (6, 70), Messer and Winokur further argued that both action and insight might be effectively used in any given case, particularly when insights are translated into action, which can in turn further enhance awareness.

Consistent with this thesis, Fensterheim (71) suggested that a psychoanalytic style may be used to develop hypotheses about ways patients organize their perceptions of the world and to select the most relevant behavior patterns that are in need of change. Having done so, however, a behavioral approach may then be more appropriate in helping to actually facilitate behavior change.

Another way in which the complementarity between psychodynamic and behavior therapies may be implemented has been noted by Messer (72), Rhoads (73), and Salzman (74). It has been suggested that there will be times when a behavioral approach may be called for to help a patient cope with some debilitating symptom at the outset of therapy. Having gained the patient's trust and cooperation, the therapist may more readily be able to use a psychodynamic approach to explore long-standing problems that have contributed to the initial complaint. By achieving insight through this second phase of treatment, the therapist may then return to a behavioral orientation to help patients develop more adaptive behavior patterns.

Interaction of Cognition, Affect, and Behavior

In the most general sense, different therapeutic orientations have tended to focus on different aspects of a patient's functioning. Thus, psychodynamic therapy has tended to deal with awareness, experiential therapy with emotionality, and behavior therapy with the patient's action patterns. The emphasis of such therapists as Lazarus (75) on "multimodal" therapy has underscored the importance of dealing with the interaction among these different components of a patient's functioning. Integrative therapists, such as Driscoll (76), have raised the question, Shouldn't the choice to concentrate on one component more than others be a function of patient characteristics instead of the therapist's training background?

In an article that draws a parallel between interpersonal therapy and cognitive-behavioral approaches, Safran (77) suggested that Sullivanian concepts can supplement the cognitive-behavioral approach by providing a framework within which "hot" information processing occurs in an emotional and interpersonal context. Based on experimental data and models of information processing, Greenberg and Safran (78) proposed a way of conceptualizing the integration of emotion and cognitive processes within a single approach to therapy.

An Empirically Based Therapy

Clinicians and researchers alike have long called for the development of a theory of therapy that would have a strong empirical base. Strupp (79) has emphasized that therapies must be testable, so that independent observers can specify what is going on clinically, communicate to others about such phenomena, and ultimately reach some consensus as to whether therapeutic change has in fact occurred. Although many modern workers in the field have reaffirmed this position and it is generally agreed that psychotherapy is effective in producing change (48), little empirical work has been done to specify the actual principles that underlie the change process. There has been considerable speculation about such principles on the basis of what different therapists say they do, but much less is available that is based on direct observations of what therapists actually do (46). It has been suggested (80) that a workable methodology is needed in order to study the common principles of therapeutic change and that such research efforts may best be found in the area of psychotherapy process research.

Need for a Common Language

It should come as a surprise to no one that each of our therapeutic orientations has its own unique set of jargon which, although facilitating communication within a school, prevents dialogue across orientations. Such problems in communication are reflected not only in the difficulty one has in understanding concepts from another orientation but also in the emotional barriers to listening that occur when one hears certain terms associated with another orientation (e.g., "extinction," "self-actualization," and "transference").

At an NIMH workshop on research in psychotherapy integration (81), it was noted that the language of psychotherapy may be used for four different purposes: 1) to enhance communication within a particular school, 2) to retrieve basic research findings from the literature, 3) to engage in dialogue with colleagues of different orientations, and 4) to carry out comparative psychotherapy process research. To communicate with colleagues that subscribe to our own orientation, the use of jargon typically affords us a relatively convenient and efficient method of communication—either with each other or with the psychotherapy lit-

erature that is derived from a particular school of thought. However, basic research on human functioning and the change process is rarely couched in the jargon of any of our therapeutic orientations. Consequently, a translation is needed between the jargon of our particular therapeutic school and the language systems used in basic research on human functioning (cognitive psychology and social psychology, for example). The NIMH workshop participants suggested that in engaging in dialogue across orientations, ordinary or natural language (everyday English) would stand the best chance of allowing for cross-theoretical conversation. Finally, a psychotherapy research language was suggested, which would allow the incorporation and translation of the concepts from various theoretical orientations into an operationalized system that was neutral with regard to each of the separate schools. Creating such a language for psychotherapy process research would enable us to identify points of convergence and points of contention as they occur within different therapy interventions.

The Search for Common Therapeutic Principles

Goldfried (53) has suggested that a particularly fruitful way of determining common therapeutic principles is by focusing on a level of abstraction somewhere between theory and clinical technique. This intermediate level of abstraction, referred to as a clinical strategy, may be thought of as a heuristic tool that implicitly guides the efforts of experienced therapists. Goldfried (53) argued,

> *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.* (p. 996; author's italics)

Although there have been no empirical studies of common clinical strategies based on direct observations of therapy sessions, a review of the available literature (13, 46) reveals a number of potential similarities. Among these are the initial expectations that therapy may be helpful, the patient's participation in a therapeutic relationship, the opportunity to obtain an external and/or objective perspective on one's problems, the encouragement of corrective experiences, and the opportunity to engage in repeated reality testing. Even though the specific clinical procedures used to implement each of these strategies may conceivably vary from orientation to orientation, the strategies themselves nonetheless represent common threads.

Stages of Psychotherapy

One of the common heuristic tools used by therapists across orientations is the notion that psychotherapy proceeds in stages. Patients must be engaged in therapy; patterns of dysfunction must be elucidated; these patterns must then be altered in some beneficial way; termination then follows (9, 10, 13). These stages may be defined by their objectives: engagement, pattern search, change, and termination (9). Some evidence suggests that change may be divided into three substages: giving up the old pattern (or patterns), initiating the new pattern, and maintaining the new pattern (9). Several investigators have examined the critical elements of the engagement process, including the patient's and therapist's perceptions of each other, the therapist's techniques, and the patient's motivation (82). Future research is likely to elucidate the optimal approach to dysfunctional patterns and the management of the substages of change.

POINTS OF CONTENTION

At the 1932 annual meeting of the American Psychiatric Association, Thomas French (83) stood before his audience and presented his thoughts on the relationship between psychoanalysis and Pavlovian conditioning. Horrified by French's attempt at rapprochement, Myerson (84) confessed,

> 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 an approchement made by one of his pupils, reading a paper of this kind. (p. 1201)

The latent theme of psychotherapy integration has continued over the past half decade or so, and staunch supporters of specific schools of thought have voiced their strong opposition to such trends. These arguments have typically been presented in passing and have usually been of the "my-school-is-better-than-yours" variety. As this latent theme has developed into a clearly articulated area of interest—indeed, movement—reservations about integration have become more explicit (85–87). Supporters and critics of the integration movement have begun to engage in open dialogue (14, 88), and certain points of contention have been debated, including the conflicting perspectives on reality held by differing schools, the role of the unconscious, the importance of transference, and the goals of psychotherapy itself.

Conflicting Perspectives on Reality

Messer and Winokur (69) and Yates (87) have argued that in the light of the differing world views taken by psychodynamic and behavior therapists, little hope exists for rapprochement between these orientations. Messer and Winokur (69) described a behavioral approach as being consistent with a "comic" view of human functioning, reflected in the belief that happi-

ness can be obtained in one's life by identifying and removing environmental barriers. By contrast, psychoanalytic therapists assume a "tragic" view, which recognizes and accepts some of the limitations inherent in the human condition. Similarly, Yates (87) characterized the behavioral approach as emphasizing realism, objectivity, and "extraspection," in marked contrast to the psychoanalytic perspective of idealism, subjectivity, and introspection. In acknowledging that such differing world views do indeed exist, however, several theorists (89–91) have suggested that these differences in philosophy are precisely what makes psychotherapy integration interesting, in that it brings together the strengths of the different orientations.

The Role of the Unconscious

One of the basic differences that has existed between psychodynamic and behavioral approaches to therapy has been that of "the unconscious." Indeed, the essence of therapeutic change from a psychodynamic point of view has traditionally focused on underlying conflicts and needs of which the patient had little or no awareness, whereas a behavioral approach has typically emphasized the development of alternative behavior patterns and alteration of interfering environmental factors.

Although the concept of the unconscious appears to represent an irreconcilable point of incompatibility between psychodynamic and behavior therapy, this is the case only if one compares classical psychoanalysis and radical behavior therapy. As emphasized by many writers (6, 11, 77, 92–94), today's psychodynamic therapists have begun to recognize the importance of conscious thoughts, action, and environmental factors, and behavior therapists' recognition of cognitive factors has led them to accept the importance of "implicit" thoughts.

Meichenbaum and Gilmore (94) suggested that all therapies deal either directly or indirectly with the patient's hypothesized cognitive structures. These authors maintain that the psychodynamic goal of making the unconscious conscious parallels the cognitive-behavioral therapist's attempt to have patients identify automatic assumptions about themselves and others. To be sure, there are theoretical differences between these two views of unconscious processes. For example, the psychodynamic view maintains that the unconscious reflects a basic motivational system within the individual, whereas the cognitive-behavioral view adopts a more nonmotivational, information-processing conceptualization. Nonetheless, we seem to be witnessing a most important convergence between what have traditionally been opposing views of this clinical phenomenon.

The Importance of Transference

Another key concept that has served as a barrier for the integration of psychodynamic and behavior therapy is that of the existence and function of transference. In addressing this issue, Gill (95) expressed doubts that classical psychoanalysis, which requires a uniquely ambiguous and restrained analytic stance, could ever be integrated with any intervention approach in which the therapist is more directive. Gill acknowledged, however, that this basic incompatibility does not necessarily exist between psychoanalytically oriented therapy and other approaches.

In conceptualizing the therapeutic interaction from a more Sullivanian point of view, Wachtel (6) maintained that the therapist can never really be the total "blank screen" presumably required for the development of a transference reaction. As participant and observer, the therapist "is as much a part of the context if he is silent and invisible as if he is face to face with the patient and overtly discernibly responding to him" (p. 69). Such a broad conceptualization of the therapeutic context, Wachtel argued, allows one greater freedom to intervene with procedures that might be more directive in nature.

Viewing transference from a cognitive-behavioral vantage point, Arnkoff (96) noted that certain similarities exist between psychodynamic and cognitive-behavioral approaches in the use of the therapeutic relationship. She suggested that there may be instances in cognitive-behavioral therapy when it is most relevant to focus on the relationship as it is occurring within the session itself. This observation has also been made by Goldfried and Davison (97) and Goldfried (98), whose depictions of cognitive-behavioral therapy allow for the possibility that the therapeutic relationship offers a sample of the patient's relevant thoughts, emotions, and behavior, thereby affording the opportunity for an "in vivo" intervention. The primary difference between the use of the therapeutic relationship in these two therapeutic approaches appears to be more the relative emphasis placed on this therapeutic change procedure rather than its existence.

Goals of Therapy

Beutler (10) has suggested that different therapeutic orientations probably do not dictate the specific interventions used so much as they determine the therapeutic goals to pursue. In arguing for the incompatibility of different therapeutic approaches, Yates (87) maintained that the differences in goals are a function of basic philosophical differences across therapeutic viewpoints. Thus, a behavioral therapist might emphasize the need to change specific behaviors and perceive a patient's sorrow as a negative emotion to be eliminated. A psychoanalytically oriented therapist, on the other hand, might choose to focus more directly on the sorrow and, construing it as a natural reaction to an unfortunate life circumstance, would pursue the goal of helping patients to experience, work through, and finally accept certain losses.

Wachtel (6) related potential differences in therapeutic goals set by behavioral and psychodynamic thera-

pists as a function of their conceptualizations of the patient's problem. From a behavioral point of view, problems are more likely to be construed as reflecting the individual's difficulty in attaining certain socially acceptable aims in life. Psychodynamic therapists, by contrast, view a patient's problem as reflecting conflicting needs and wants, some of which may be socially unacceptable. Consequently, the behavioral therapist's goal would be to assist patients in making changes in either themselves or their environment that might more readily allow them to obtain their objectives, whereas a psychodynamic therapist would primarily work with helping patients to develop an understanding of the internal conflicting factors. Neither is necessarily more correct, Wachtel pointed out, and there is nothing to prevent either the behavioral therapist or the psychodynamic therapist from pursuing both goals.

Messer (24) has dealt at length with the complementary nature of therapeutic objectives outlined within psychodynamic and behavioral points of view. Noting that the visions of reality have begun to change among practicing psychodynamic and behavioral therapists, he outlined how each therapeutic orientation might fruitfully expand its range of therapeutic goals in actual clinical practice. Messer (24) fully acknowledged that not all therapists would be willing to engage in this integrative effort, but that

> there are many therapists of both orientations who undoubtedly will welcome the kind of change occurring in each therapy. For them, the mutual influence of one therapy on the other, the convergence of certain perspectives, and the particular shift of visions and values that this entails constitute a creative challenge both to the theory of each therapy and to its practice. (p. 1270)

FUTURE DIRECTIONS

The integrative movement appears to be gaining momentum and is likely to be the *Zeitgeist* of the next several decades of psychotherapy research and practice. Unsubstantiated theories about the psychotherapeutic process will grudgingly give way to solidly grounded concepts to which the different approaches will make their various contributions. The great charismatic leader proclaiming the right and true path is likely to gain fewer constituents as psychotherapy becomes increasingly more pragmatic. New ideas will be welcomed as contributions rather than quantum leaps into new and startling territory. Trainees, we hope, will be less ideologically programmed and will be taught to recognize the value of each of the many approaches as well as the inevitable influence of their own personalities on the process (99). Ideally, consumers of psychotherapeutic services will be shown clearly just what it is they are receiving and thereby be able to make better judgments about their reasons for choosing this form of assistance.

A number of formidable obstacles confront this movement as it grows to represent a substantial number of practicing and research psychotherapies (100). For example, can comprehensive frameworks and/or a common language be developed that are acceptable to diverse audiences? Can we overcome the interprofessional bickering and partisan zealotry that continue to restrain psychotherapeutic evolution? Will integrative therapists be able to effectively train neophyte clinicians in multiple approaches and integrative perspectives? Will future research demonstrate the utility of integrative concepts and strategies? Will the movement generate information for the practicing clinician that will improve his or her ability to decide what to do, when, and with which patient? Will it be necessary to develop not only a superordinate clinical theory but also integrative theories of personality and psychopathology? We are witnessing an exciting development in the history of psychotherapy. The future holds the answers to its durability and significance.

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