1. *Introduction*

A graduate student in psychology was struggling through his oral examinations. The head of his committee recognized that his strengths lay in clinical work and shifted the questioning to clinical decision making.

PROFESSOR: If you had a choice between two therapeutic techniques, positive reinforcement or shock, how would you decide which to use?
STUDENT: I'd look at the data.
PROFESSOR: What if the data don't exist for this situation?
STUDENT: I'd read well-respected therapists on the subject to get their opinion.
PROFESSOR: What if these authorities were contradictory and unclear?
STUDENT: I'd check to see if I had a shock generator or candy pellets available.
PROFESSOR: Let's say you have both in your desk.
STUDENT: Then I could use either one.
PROFESSOR: How could you decide?
STUDENT: I'm not sure what you are getting at, Sir.
PROFESSOR: What would keep you from using the aversive condition?
STUDENT: If I didn't think it would help.
PROFESSOR: Is there any other reason you wouldn't?
STUDENT: I don't know. I really don't know.
PROFESSOR: C'mon! Shock hurts!

Therapeutic choices are forced by multiple factors beyond scientific data and advice from authority. Clinicians must often make decisions in the absence of sufficient predictive information. Knowingly and unknowingly we fall back on values, experience, and expediency to select the range of alternatives.

Dogmatic declarations about the correct way to perform psychotherapy have provided therapists with guidelines by which to judge their actions. Freud's insistence upon the pure gold of transference interpre-

tation and Wolpe's insistence upon relaxation for systematic desensitization, once generally accepted, have given way to other concepts. Transference may be interpreted for many years without change and psychoanalytic change may take place without attention to transference (Horwitz, 1974). Relaxation is unnecessary for in-imagination exposure to feared situations (Yates, 1975). Techniques have not yet been shown to have a consistently powerful effect on the outcome of psychotherapy (Orlinsky & Howard, 1978). Some technique is necessary to establish therapeutic alliances, to gather information, and to promote change. That no single clinical approach is clearly superior has created a paradigm strain among many psychotherapy theorists and practitioners.

The search has begun for a better conceptualization, an integration, a systematic eclecticism. Many authors are rushing to fill the breach with their notions about how to solve this increasingly evident problem (Beutler, 1983; Driscoll, 1984; Garfield, 1980; Hart, 1983; Prochaska & DiClemente, 1984). The problem, however, appears to be beyond the competence of one person to solve. To redefine psychotherapy in terms more compatible with clinical and research experience requires the efforts of large groups of therapists working together to determine its nature. No one person is capable of defining the "true" form of psychotherapeutic practice because it is being defined daily through the activities of hundreds of thousands of therapists. Models of psychotherapy must therefore begin with general descriptions of what psychotherapists do every day rather than with the theories and experience of one persuasive writer and speaker.

In constructing this book, I have tried to stay close to what happens and what can happen. "What happens" is that patient* and therapist meet, decide to work together, attempt to find psychological patterns to change, to change them, and to stop seeing each other. "What can happen" refers to the numerous alternatives available to therapists at these recurrent choice points. Consequently, theory is replaced by description of fundamental elements of the psychotherapeutic process. The "glue" holding this description together is the human relationship proceeding through time. Theory in psychotherapy has become closely aligned with ideology, and ideology obscures many practical considerations.

*A note on word choice: Among the problems in writing a psychotherapy book are whether to use "client" or "patient" and whether to use "he/she." I have opted to use client in some places and patient in others. Rather than use the masculine pronoun (or the feminine pronoun) I have opted to use *he or she* and *him or her*.

THEORIES OF PSYCHOPATHOLOGY AS IDEOLOGICAL DISTORTIONS

The schools of psychotherapy have provided great impetus to the growth and proliferation of psychotherapy in the United States. Their theories of psychopathology have provided individual therapists with prescriptions about the correct way to practice psychotherapy and strong beliefs to justify these practices. In addition, the schools have provided professional organizations through which members can seek out like-minded colleagues to gain support for their shared theories. The rigid doctrines that compose the school walls provide protection from hostile forces but also limit the range of perceptions of those cloistered inside.

The greatest controversies among psychotherapy schools concern theories of human psychological functioning and dysfunctioning. Each has taken a slice through the complicated tangle that is the human psyche and declared its version superior. Theorists have divided the unconscious into many competing sections, drawn boundaries in preconscious activity, and placed varying maps upon behavior in the interpersonal environment. Humans are all these psychological territories and psychotherapy directly or indirectly touches each area. If these ideological illusions are stripped away, the actual daily interaction between therapists of different schools and their patients show considerable overlap. In this book, I offer a general model of psychopathology that does specify certain techniques and is subordinate to the requirements of the psychotherapeutic process.

The names and purported purposes of techniques from different schools also veil similarities. The techniques are embedded in theoretical propositions and therefore appear to support the theories. I, in company with Pentony (1981), argue that the theories are often elaborated after the technique has proved useful. Freud found catharsis useful and built his theories of strangulated affect from this observation. Rogers found empathic reflections useful and around it constructed his notions of individuation. The successful technique provides a vehicle for the elaboration of the author's own psychological theory but does not necessarily explain its usefulness in the psychotherapeutic process. Both catharsis and empathic reflections serve as useful engagement techniques by which the patient comes to appreciate the skills and interests of the therapist. These techniques also served to engage other therapists' interests in their practice of psychotherapy.

This pragmatic approach to technique helps to define the similarities among the psychotherapies. Each school has different justifications for its techniques, but each therapist must accomplish similar subgoals of the

therapeutic process with each patient. The pragmatics of interventions (the purpose, objectives, intended outcomes) pull the diverse approaches together. Each patient must be engaged, encouraged to define maladaptive patterns, helped to change, and disengaged. Up to now therapist–writers have warned followers to avoid certain goal-seeking techniques because they might be harmful. For example, Langs (1973) strongly limited the use of questions and prohibited the involvement of a significant other on very clearly described theoretical grounds. In the future, such caveats need to be substantiated on pragmatic rather than theoretical grounds. Until that happens, therapists may be encouraged to experiment with multiple methods for accomplishing the goals of each therapy stage.

THE SEARCH FOR COMMON FACTORS

Among those who have searched for unity in complexity are Jerome Frank (1976) and Judd Marmor (1976). Their pioneering efforts sought to illuminate what therapists *actually* do instead of what they *say* they do. Their influence has been restricted because much of their work was published before the current peak of interest in defining common principles. In addition, they did not pair their presentations of common factors with discussions of differences in ways that could be readily incorporated into clinical practice. Frank placed great emphasis upon the "demoralization" hypothesis. Demoralization results from the persistent failure to cope with internally or externally induced stresses that patients and those close to them expect them to handle (1976). A major function of all psychotherapists is to combat demoralization by instilling hope and providing the opportunity for self-mastery. Marmor and Frank agreed upon a number of common factors:

1. *A Good Relationship.* An intense, emotionally charged, confiding relationship built on trust is recognized as an essential element of most psychotherapy.

2. *Emotional Release.* In a wide variety of ways, therapists encourage their patients to express and experience pent-up feared feelings. Emotional release may strengthen the therapeutic relationship and may increase the potential for change.

3. *Cognitive and Experiential Learning.* Therapists teach their clients new information directly through verbal instruction and indirectly through experiment and other opportunities for self-discovery. Therapists may provide situations in which maladaptive beliefs about the self and others may be examined.

Through the strength of the patient's attachment to the therapist, a variety of influencing methods become available. These include positive and negative reinforcement (smiling, compliments, interest in certain topics) and identification with the therapist as a model for a better way to consider oneself.

4. Practice. Built into most therapies is the practice opportunity. Called "working-through" in psychodynamic therapies and related to maintenance and generalization in behavior therapies, the practice phase enhances the patient's sense of mastery over the new learning.

While Frank and Marmor placed themselves outside psychotherapy schools to look at the whole of psychotherapy, others have used the basic notions of their chosen orientation to discern common factors. Raimy (1975), for example, presented evidence that all psychotherapies attempt to challenge and change misconceptions about the self. The means by which these misconceptions are challenged may be selected from four basic methods: (1) self-examination – the therapist encourages the client to evaluate beliefs; (2) explanation – the therapist provides verbal evidence intended to change the misconception at issue; (3) self-demonstration – the therapist maneuvers the client into situations to demonstrate the misconception either in the therapeutic relationship or through real-life experiments; (4) modeling – the client observes one or more models performing activities thought to be impossible to perform.

Dewald (1976) asserted that "all psychotherapy, regardless of specific form or technique, is viewed as an interpersonal or intrapersonal process, and should be understandable from a psychoanalytic perspective" (p. 283). He described the various ways in which therapists of different schools manage the therapeutic relationship, anxiety, the drives and their derivatives, defense mechanisms, regression, identification, catharsis, and reinforcement.

THE "HYPHENATED" ECLECTICS

Concurrent with the search for common factors, other writers have sought to meld the "best" elements from two apparently contrasting schools of therapy. The most widely accepted of the hyphenated eclectics is cognitive-behavioral therapy. While a few diehard radical behaviorists may still have difficulty with speculations about the unmeasurable events that take place within the black box called the skull, many therapists are comfortable with the union. Some writers have attempted to bring together the very divergent schools of psychoanalysis and behavior therapy. While

numerous books and articles have endorsed this marriage (Birk & Brinkley-Birk, 1974; Fensterheim & Glazer, 1983; Marmor & Woods, 1980; Wachtel, 1977) there is little evidence that this form of hyphenated eclecticism has enjoyed widespread practice.

Any time two schools of therapy are concurrently popular, some therapists are likely to hyphenate them. Existential psychoanalysis, for example, at one time was popular enough to receive its own section in the *Comprehensive Textbook of Psychiatry* (Weigert, 1967) but since then has lost its place. During the heyday of transactional analysis (TA) and Gestalt therapy, many practiced a hyphenated form. Gestalt therapy provided access to emotions and the TA provided a conceptual grasp of interpersonal relationships. There are therapists practicing any number of hyphenated variables: Gestalt–Reichian (Brown, 1974), humanistic RET (Ellis, 1973a); Behavioral–Gestalt (Harper, Bauer, & Kannankist, 1976), and cognitive–psychoanalytic (Bieber, 1980).

THE SYSTEMATIC ECLECTICS

More psychotherapists define themselves as eclectics than as adherents to a specific school (Beitman, Chiles, & Carlin, 1984; Garfield & Kurz, 1974; Norcross & Prochaska, 1982). One of the personal advantages of this self label is the ambiguity associated with the term, which gives the practitioner license to practice his or her own idiosyncratic approach. In recognizing the need for a more systematic eclecticism, a number of writers have attempted to organize the diffuse practices of their colleagues according to a variety of schemes. Are they offering methods to integrate the psychotherapies or are they describing systematic eclecticism?

An integration of the psychotherapies is a splendid ideal through which the warring factions may come together to heal the gaping breaches between and among them. Integration implies the continued existence of each of the many schools of psychotherapy, now bound together by a common spirit of understanding and working with the group toward commonly agreed upon objectives. However, should it be possible for therapists of different schools to find a common meeting ground, then school boundaries will likely be threatened. There is little scientific basis for these ideological differences; only shared and mutually supported opinion. Should it happen, integration would be a temporary phenomenon giving way to a yet newer paradigm.

Systematic eclecticism, according to Wachtel (1985), is an oxymoron—a hybrid of two incompatible elements. How can one be systematic about haphazard choosing? In my view, both integration and systematic

eclecticism are transitional concepts that will give way to objective descriptions of the psychotherapeutic process with its key choice points and alternatives. Younger therapists are likely to find the conflicting ideologies distasteful and lean toward objective approaches. As with most paradigm shifts in scientific revolutions, the older ideas will die with the older therapists, as younger ones replace them with new perspectives (Kuhn, 1962).

Some of the systems offered by psychotherapists for organizing an eclectic approach will be described in the rest of this section. Each is the product of the mind of one or more people, and each makes a useful contribution to our total understanding of psychotherapy.

Arnold Lazarus

An early major contributor to behavioral therapy and theory, Lazarus developed a content eclecticism that stretched the bounds of behaviorism but did not break them. He could not accept many basic psychoanalytic ideas (Lazarus, 1971, 1976; Lazarus & Fay, 1982). Lazarus, recognizing that *b*ehavior in the environment is but one essential source of psychotherapeutic data, added *a*ffect, *s*ensation, *i*magination, *c*ognitions, *i*nterpersonal, and *d*rugs (physiological variables) to form the acronym BASIC I.D. (Lazarus, 1976). He continued the behavioral form of questioning—what, where, when, who, and how—and insisted that long-lasting change required attention to all modalities, a claim echoed by numerous other founders of schools who believed that they, too, had found the necessary and sufficient means for psychotherapeutic change. His position has likely helped numerous behavioral therapists to increase the range of content of their therapeutic investigations.

Sol Garfield

After 35 years as a psychotherapy researcher, teacher, and clinician, Garfield (1980) felt the need to crystallize his own views on the subject. Garfield noted the proliferation of psychotherapy schools and speculated about its meaning: Are some approaches better, are some better for some patients, or does this diversity express our relative ignorance? (p. 1). He set out to order the significant variables and phenomena of psychotherapy.

Garfield's book records the wisdom of a psychotherapist who has been immersed in the details of psychotherapy research, behavioral practice, psychoanalytic practice, and teaching. But it has no organizing

theme except for the underlying notion that their must be one. The reader can see the author struggling with decision making during psychotherapy, trying to make sense of the data, trying to generalize for the reader's benefit. Garfield's effort seems to represent the mind of many experienced psychotherapists who have broken away from specific schools and have consequently felt free to search in diverse places. He has some notion of what he does, of ideas he believes important, of basic elements of psychotherapy. But he has no system to impart, no general framework to guide his presentation.

Larry Beutler

In stark contrast to Garfield's unsystematic eclecticism is Beutler's (1983) highly systematic approach. More than any other eclectic to date, he has attempted to answer the question: what technique with what type of patient? The critical patient variables for Beutler are: (1) monosymptomatic or complex symptom, (2) reactance level (highly reactant people rebel against external direction), (3) external defensive style (project blame outward, somatize) or internal defensive style (exaggerates self-blame or avoids thinking about it). These variables then codetermine the therapist's approach. Beutler has carefully defined the techniques from the major schools in terms compatible with the general styles he believes to be best matched with each of these three patient characteristics. For example, clients with low levels of reactance should be directed, while those with high levels of reactance must be extended much greater self-direction. Monosymptomatic patients should be treated with narrow-band (e.g., behavioral) treatments, while complex symptoms need a broad-band approach (e.g., insight). Externally defensive patients require behaviorally oriented, externally focused treatment, while internally defensive people should have an internally focused (e.g., insight) treatment.

The obvious breadth of Beutler's system, and the wealth of the evidence he has marshaled to support it, make his ideas very compelling. Nevertheless, the presentation contains obvious gaps. Shouldn't diagnosis enter the algorhythm? What about the patient's own view of how treatment should proceed? Shouldn't some people who are internally focused learn to get out of that defensive style and act? Said Beutler (1983) about his work: "The problem with publishing ideas is that one frequently feels compelled to defend them rather than allowing them to evolve. In the best of all possible worlds, the written word could be viewed as a developmental process rather than as a collection of sacred truths" (p. *xi*).

James Prochaska and Carlo DiClemente

As a result of their work with smokers, with particular attention to those people who changed without help from therapists, Prochaska and DiClemente (1984) outlined the stages of change in their transtheoretical approach. People suffer without thinking about change (precontemplation); they think about change (contemplation); they act; and they maintain the change. Some relapse. These patterns are particularly highlighted in the addictive behaviors, in which the pattern to be changed is quite obvious. The authors tie together eight processes of change with each of the four stages of change. Contemplation requires "consciousness raising." The transition between contemplation and action requires self-reevaluation. Action requires self-liberation, a helping relationship (not necessarily a therapist), and management of reinforcement. Maintenance requires counterconditioning and stimulus control.

They added to this meshing of technique with stages, five levels of content generally to be discussed in the following order: (1) symptom/situational, (2) maladaptive cognitions, (3) current interpersonal conflicts, (4) family/systems conflicts, (5) intrapersonal conflicts. (If sufficient change does not occur at one level, then they advise therapists to proceed to the next level.)

The stages of change described by Prochaska and DiClemente may reflect a hidden consensus among many psychotherapy writers (see Chapter 7). Their processes of change as tied to the stages of change are thought provoking and deserve further analysis, but their levels of change run against the same stone wall that similar propositions tend to hit. No therapist can say what content should be discussed or in what order it should be discussed for all therapist–patient pairs. Some patients jump right into intrapsychic discussion because for them this level of analysis fits their theory of what is wrong. Like most schemes for organizing the data of the search for critical patterns, the transtheoretical hierarchy of content levels will be useful for some therapists and some patients.

Richard Driscoll

Beutler's system and the transtheoretical approach of Prochaska and DiClemente grew out of formal research in psychotherapy. Driscoll's (1984) pragmatic eclecticism is based upon the convergence of several philosophical systems and direct clinical observation. The term "pragmatic" is the fulcrum around which his ideas spin. The term refers to one of the three major aspects of language, the other two of which are syn-

tax (rules for ordering sentences) and semantics (the meanings of words). Pragmatics refers to the purpose or function of words, namely their intent to influence the listener. Driscoll, then, emphasized the increasingly recognized fact that therapists are attempting to influence their clients (see Chapter 9). Pragmatic also implies practical, utilitarian, atheoretical. As described by Driscoll, this approach also carries two other major features: (1) the use of common language instead of idiosyncratic terminology to structure observation and understanding of the data of therapy, and (2) emphasis on the "in order to" aspects of client as well as therapist behavior (p. 8).

He uses the notion of purposive action to develop a scheme for filtering and organizing the search for patterns. Each actor is motivated by some "want" (motivation, desire, craving, reason). Associated with the want is a "know" (a cognition, perception, understanding, belief) and a "know how" (competency, skill, ability). The "want," "know," and "know how" come together into a "performance" (movement, action) that has an "achievement" (effect, impact, change, influence) (pp. 28–29). This scheme has much in common with other often-used organizing methods, from the Stimulus→Organism→Response (S→O→R) approaches to the activating Event→Belief→Consequences of the cognitive therapists (Beck, 1976; Ellis, 1973b) to the systems analysis of family therapists.

Driscoll does not attempt to define what to do with which patient at what time in therapy but leaves those decisions to the individual situation. His emphasis is upon the personal experiences of the practitioner rather than on the elucidation of superordinate principles for each to follow.

Joseph Hart

After an introduction and historical review, Hart's *Modern Eclectic Psychotherapy* (1983) challenges the limitations therapists place on their role possibilities. In Hart's opinion, the usual doctor–patient, teacher–student, and scientist–subject roles could be extended to many others. His list includes: coach–athlete, attorney–client, manager–employee, minister–church member, master artist–artist, business representative–customer. After arguing that role plurality is an excellent model for clinical eclecticism, his arguments become more narrowly focused. His ideas come to represent an attempt to form a new school of therapy masquerading as eclecticism. More than the other eclectics described in this section, Hart "knows" that his form of therapy is the correct one. His central word is "functional," the definition of which resembles Dris-

coll's use of "pragmatic." The functional level of discourse asks what is happening around the person and in the person's experience and how is the person responding. After summarizing the ideas of his precursors (William James, Pierre Janet, Trigant Burrow, Jessie Taft, and Frederick Thorne) he declares that "functional eclecticism must be considered the core eclectic position around which all others diverge as peripheral viewpoints" (p. 28). What emerges is a highly refined approach to therapy based upon his notions of what content is to be discussed. His stages of change, on the other hand, are quite compatible with the sequence outlined in Chapter 7 of this book.

PSYCHOTHERAPY RESEARCH

Psychotherapy researchers have long pondered their lack of influence on psychotherapy practice (Garfield, 1980; Goldfried & Padawar, 1982). The schism appears to be narrowing. Clinicians are likely to increasingly rely upon researchers to justify expenditures by third-party payers for psychotherapeutic services. Psychotherapy may be becoming more definable; the work of psychotherapy researchers is leading to more specifiable research questions having definite bearing upon psychotherapeutic practice. The breakdown of psychotherapy schools is likely to allow practitioners to utilize the evaluation techniques employed by researchers in their own practice.

In my view, psychotherapy research has functioned like another school of psychotherapy. Its adherents shared similar belief systems, were dedicated to the operations defining its practice, and were cloistered away from other practitioners. Like each of the many schools of psychotherapy, some useful ideas have emerged from psychotherapy research. But the future of psychotherapy understanding is likely to belong increasingly to the careful delineation of the psychotherapy enterprise. With the dissolution of ideology, the emphasis on what works, and increases in understanding of the nature of human psychological functioning, the knowledge will be better defined. Careful and controlled observation will come to replace speculation.

Despite the volumes of data generated by psychotherapy researchers, firm conclusions have been difficult to reach. The question "Does psychotherapy work?" has become as meaningless as the question "Does surgery work?" Does it work for whom, done by whom, by what means, is the more compelling query. Generally speaking, psychotherapy seems useful. This conclusion is drawn from major overviews of psychotherapy research.

Comparative Sets

Luborsky, Singer, and Luborsky (1975) examined all "reasonably controlled" comparisons of psychotherapies by scoring wins, losses, and ties. The main sets of comparisons included group versus individual, time limited versus unlimited, client-centered versus other traditional psychotherapies, and behavior therapy versus psychodynamic psychotherapy. The authors suggested that the equivalent results could be explained by the fact that each psychotherapy provides patients with some plausible system of explanation for their difficulties and with principles that may guide future behaviors.

Meta-analysis

Smith, Glass, and Miller (1980) undertook a yet more massive project by systematically examining most of the controlled research in psychotherapy according to accepted methodological criteria. They treated each outcome study in a manner similar to the way single-subject data would be analyzed in a single controlled experiment. They included 475 studies comprising 1,766 different effects and including the magnitude of each effect and characteristics of the treatments, clients, therapists, settings, research design features, and outcome measures. The major findings were that psychotherapy was beneficial, that different psychotherapies do not yield benefits of different types or degree, and that differences in how psychotherapy is conducted (group vs. individual, length of treatment, experience of therapist) make very little difference in outcome. Of interest is the percentage of types of therapies examined: 21% systematic desensitization, 11% behavior modification, 9% vocational–personal and undifferentiated counseling, and 11% a variety of placebo treatments. Also, the clients tended to be young (mean age 23), had been solicited by the experimenter (46%), or came in response to an advertisement (16%). Therapists had modest experience (mean of 3.2 years). These data give an idea of the tremendous difficulty of performing research on standard clinical psychotherapy and also indicate that such research is necessary, especially on the long-term treatment of more difficult patients (Cohen, 1981).

APA Commission

The American Psychiatric Association's Commission on Psychotherapies (1982), concluded that psychotherapy was effective for a variety of symptomatic and behavioral problems. These include chronic moderate anxiety

states, simple phobias, depressive symptoms, sexual dysfunction, adjustment disorders, family conflicts, and communication difficulties. Psychotherapy may also be useful for postillness psychosocial rehabilitation. The commission report also mentioned that the most extensive review of the literature concluded that approximately 5% of patients in psychotherapy get worse because of the psychotherapy (pp. 222–225).

Other Research Contributions

The question concerning the relationship between specific psychotherapeutic approaches and specific diagnostic categories has received increasing attention. The lure of a diagnosis-related treatment has been influenced by the many instances in medicine in which a specific diagnosis implies a specific treatment with a high probability of successful outcome.

The treatment of the simple phobias (snakes, heights), is the clearest example of treatment specificity. A wide variety of treatments have proven successful in the treatment of simple phobias. The first and most celebrated was Wolpe's (1976) systematic desensitization. In this approach, anxiety-evoking situations are presented to the imagination of the deeply relaxed patient in rank order of their capacity to disturb. Each image is repeated until it totally fails to evoke anxiety. Other approaches include having another person carry out the feared behavior, either in real life or in imagination; rapid exposure to the feared situation, either in imagination or in real life; and gradual exposure in real life. Each approach has been shown to be of some utility. The key ingredient is exposure (Marks, 1978). The more complex phobia, agoraphobia, is also treatable through a variety of exposure methods. For longer lasting improvements, however, gradual exposure *in vivo* with the help of the spouse appears most useful (Barlow & Beck, 1984).

In reviewing the various forms of psychotherapy for depression, Weissman (1984) was unable to conclude superiority of one approach over any other. However, in a number of controlled trials, cognitive therapy (Beck, Rush, Shaw, & Emery, 1979) has been shown to be the equal of antidepressant medication (Blackburn, Bishop, Glen, Whalley, & Christie, 1981; Murphy, Simons, Wetzel, & Lustman, 1984; Rush, Beck, Kovacs, & Hollon, 1977). While interpersonal therapy (Klerman, Weissman, Rounsaville, & Chevron, 1984) has also been shown to be useful in depression, the results of current and future studies will define its relative efficacy. In one study, social skills training, time limited psychodynamic psychotherapy, and amitriptyline were each effective and none was superior (Hersen, Bellak, Himmelhoch, & Thase, 1984). Is there a specific factor (like exposure in the treatment of phobias) that underlies cognitive,

interpersonal, social skills training, psychodynamic theory, and drug therapy in the treatment of depression?

THE LIMITS OF PSYCHOTHERAPEUTIC KNOWLEDGE

Since Freud's thunderous pronouncements about the nature of psychotherapy, many other writers have proclaimed their true and correct ways to conduct the psychotherapeutic relationship. Each writer appears convinced of his or her beliefs. Each maintains that therapists are negligent if they fail to follow the prescribed approach. How can such contradictory pieces of advice be fully correct?

Perhaps the psychotherapies are truly different. Each has its own change mechanisms, its own data-gathering strengths, and its own powers of influence. To use a pharmacological analogy, each one may resemble a different class of medications, each of which can effectively treat subclasses of the same disorder. Depression, for example, may respond to lithium, polycyclic antidepressants and to monoamine oxidase (MAO) inhibitors, as well as to placebos. Each has a different mechanism of action that may yield the desirable positive outcome.

This perspective does not appear to be the majority view. The predominance of eclectics among psychologists (Prochaska & DiClemente, 1984) and psychiatrists (Beitman *et al.*, 1984) suggests that many therapists assume the existence of a common base onto which the variety of contributions from other schools may be placed. This common base has yet to be elucidated.

The overview of research studies described earlier has substantiated the general efficacy of the endeavor. Other work has demonstrated the lack of efficacy of individual psychotherapy without medication in the treatment of schizophrenia (Goldstein, 1984). Psychological help may prove to be cost-beneficial in the treatment of certain medical problems (Mumford, Schlesinger, Glass, Patrick, & Cuerdon, 1984). But these outcome studies do not define the nature of psychotherapy. Increasing attention has been paid to the nature of the therapeutic alliance (Docherty, 1985) thereby suggesting a growing consensus about the importance of this element of the psychotherapeutic process.

The cacophony of claims to psychotherapeutic supremacy and the small amount of clinically substantive data from psychotherapy research highlight the extent of our ignorance. Yet it is hardly a total ignorance. Professional psychotherapy is a complex process that is a unique subdivision of that problematic class of human activity known as interpersonal

relationships. To study ourselves being ourselves requires emotional and cognitive distance. To be objective about our subjective selves requires that we transcend ourselves.

Has enough information been gathered to define psychotherapy?