

Why I am an Integrationist (Not an Eclectic)

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The author's integrative search for common factors aided by pragmatic theory is based upon several concepts: (1) counselling is a series of events through time and may be called a process; (2) general principles are to be valued over the gathering of bits of data; (3) counselling is a practical endeavour intended to help people change, and therefore (4) its theories must be connected to practical goals, requiring a giving up of major efforts to develop theories of personality and theories of the origins of psychological difficulty; (5) theories and models must be developed for the process of counselling, for factors maintaining psychological difficulty and for the process of change; and (6) emphasis must be placed on the self of the counsellor as a key component in integrative therapy. Following a personal history of factors contributing to his development as an integrationist, the author outlines his early model of the therapeutic process and moves on to several integrative principles, including: convergence among schools; the heuristic value of stages in counselling; the interpersonal nature of counselling in both its form and its major purposes; and the flexibility required by the striving for prescriptive approaches developed out of integration. Finally, the unfortunately limited value of research in integration and eclecticism is discussed.

To answer the query posed in the title, one must find acceptable definitions of integration and eclecticism. There are three major forms of integration: systematic eclecticism, common factor integration, and theoretical integration (Arkowitz, in press). My own predisposition is towards common factor integration. Lazarus's form may be called systematic technical eclecticism, against which my form is to be contrasted. One must also offer a definition of eclecticism itself, for that concept too is to be contrasted with my own views.

First comes the problem of systematic technical eclecticism. What is it? I, like Norcross (this volume), consider it to be a form of integration. Immediately this placing of a type of 'eclecticism' under the rubric of integration distorts the apparent dualism of the title's question. The title implies a thesis and antithesis; yet, from the beginning, I dissolve the dualism by claiming that systematic technical eclecticism is part of the integration movement. Furthermore, I believe that Lazarus's BASIC ID is an excellent example of systematic technical eclecticism. Perhaps some

would want the paper to end at this point, claiming no contest. In my view, however, there is much to distinguish my own form of integration from that of Lazarus, and this distinction will inform much of the body of this essay. Furthermore, my approach and that of Lazarus are each quite different from simple eclecticism, by which I mean technical selection in a haphazard, unsystematic way. While this is what I mean when I use the term 'eclecticism' without an adjective, in many respects the concept is a straw man. I believe that many counsellors possess some notions of why they do what they do but that they often have not articulated their schemas.

I do not claim to represent all integrationists, although I believe I have defined in the stages of psychotherapy (engagement, pattern search, change and termination) fundamental aspects of counselling and psychotherapeutic relationships. I am less interested in theories of personality and theories of psychopathology. I am most interested in developing a model against which idiosyncratic and school-bound approaches may be contrasted so that the stage model may be further elucidated. Through this contrast the individual approaches may also be clarified by understanding their similarities to other approaches as well as their distinctive contributions.

In line with this way of thinking is my disagreement with the premise of this symposium: namely, that eclecticism (or more precisely systematic technical eclecticism) and integration are fundamentally incompatible. I do not share this assumption. I see Lazarus as having made an excellent contribution to the manner in which we approach maladaptive patterns as part of the initial evaluation and the second stage of counselling. His approach, however, ignores engagement, self-observer alliance and termination among other critical concepts for the counselling relationship. In my view the concept of stages broadly encompasses the whole enterprise. Most such relationships begin with attempts to work together (engagement), efforts to define maladaptive patterns (pattern search), and attempts to initiate and maintain change (change), followed by termination. There is no mystery to this sequence. It is an outline of the steps taken when people attempt to work together to solve problems.

In this essay I pay attention to the word 'I' which is also contained in the title created by the editors. In what follows I briefly describe influences in my own history which contributed to my desire to find common factors in a variety of approaches, a desire based on the tragedies perpetrated by the despotic aspects of the world's religions and political systems. I also describe an early form of my model and the thinking that went into forming it. These sections are followed by an outline of the stages of psychotherapy, some integrative principles and comments on research in psychotherapy. First, I shall discuss some considerations preceding integrative concepts.

Considerations prior to developing integrative conceptions

Before developing concepts for integration, one must outline the framework upon which such conceptions lie.

First, what is counselling? I define individual counselling as a relationship between two people which proceeds over time and has as its purpose the psychological change for the better of the one called client. A series of events through time may be called a process. I believe in the process of psychotherapy: not only that it exists but that trusting this process, moving it along, nurturing it, and removing impediments to it, is essential to carrying out its purpose.

Second, I believe in discovering a few general principles which may be applied to a large number of situations rather than primarily gathering many bits of data which apply to limited situations. Eclectics, on the other hand, seem to gravitate primarily toward many bits of data. I search for common factors using the same basic idea I use for discovering coherence in the behaviours, thoughts and feelings of my clients. I look for repeated patterns. The word 'pattern' comes from the word 'patron' (father): it is the source of its derivatives, the children. I am guided in this search by my own personal experience, the teachings of persuasive others, and my clients. I generally consider all psychotherapists and counsellors to be practising variations on a set of basic themes. I read the self-descriptions of other psychotherapists, listen to them talk with each other in group settings and watch myself and others on videotape. I look for repeated patterns in client-counsellor interactions. These repeated patterns then emerge as fundamental aspects of psychotherapy and form the foundation of integrative psychotherapy. Lazarus seems to rely primarily on what has been shown to work and what seems scientific in the data-supported sense. As an integrationist I use research-supported findings to guide my practice, one of the most compelling of which is that technique itself accounts for a small portion of the outcome variance (Lambert, 1986). Evidence is accumulating to suggest that for specific problems like panic disorder, or depression, specific techniques are useful. But for the practising counsellor removed from the fabricated world of protocol restrictions, client and relationship variables are pre-eminent.

Third, I believe that psychotherapy is a practical endeavour with its roots in the real world, the world of action, thinking and feeling. Psychotherapy is often discussed in abstract terms but any valid conception of psychotherapy must take into consideration the bottom line: psychotherapy is intended to help people change in their lives outside the office.

Fourth, theory is alluring, attractive and necessary, but we need to determine what theories are within the province of psychotherapists. Currently there are theories of personality, theories of how people get disturbed (aetiology of psychopathology), theories of what maintains psychological difficulty and theories of change. In regard to theories of

personality and theories of the aetiology of psychopathology, counselling is but one of many ways to gather information to answer these questions.

Unfortunately, some counsellors have believed that they can generalise from their office experience far beyond the capabilities of these data. Genetics, brain biochemistry and childhood development research are other very important sources of data for building theories of personality and psychopathology. To ask a psychotherapist who has developed an effective technique to formulate a theory of psychopathology would be like asking a psychopharmacologist who has developed an effective medication to tell us how the brain functioned in mental illness. The ability to alleviate a mental problem must be distinguished from the ability to define the manner in which the problem originated.

Fifth, I argue for the use of both models and theories. While there is some ambiguity between these terms, they need to be differentiated. A model is an abstraction from observables; it condenses the multiple manifestations of a general phenomenon into a comprehensible configuration. A theory is primarily an attempt to explain causation, to answer the question why. Its value comes from the well-established belief that knowing the why of a phenomenon helps to change it. Psychotherapy needs models of the process of therapy (e.g. Beitman, 1987), of factors maintaining psychological difficulty (e.g. homeostasis (Pentony, 1981), and of the process of change (e.g. exposure (Barlow and Cerny, 1988; Marks, 1976) and deviation amplifying feedback (Pentony, 1981)). Psychotherapy also needs theories of the process of therapy (e.g. why is a therapeutic alliance usually necessary in psychotherapy?), theories of the maintenance of psychological difficulty (e.g. interpersonal (Strong, 1987), cognitive (Beck et al., 1979), the repetition compulsion and the reinforcement properties of avoidance) and theories of the process of change (why is change so rarely sudden and permanent and so often slow with set-backs?).

Sixth, one of the more irksome aspects of Lazarus's approach is his lack of emphasis on the individual personality of the counsellor. In his view there exist no odd, strange reactions by the counsellor to the client. I use the psychodynamic term counter-transference for this ubiquitous phenomenon. In addition, an implicit assumption of multimodal therapy is that all therapists may apply BASIC ID to all clients. It does not appear to take into consideration the varying abilities, predispositions and training of the counsellors and psychotherapists. I strongly believe that the individual personality of the counsellor plays a great part in determining the form of integration selected, the strategies and tactics embraced and the success and failure of the efforts.

With that view, I turn now to my personal journey to integration. As you will see, I could not tolerate simply being pragmatic: I had to know the background, the context of my thinking. I wanted a road map that offered more than simple expediency.

Personal journey

I was born in 1942 in Detroit, Michigan, and am a son of Nazi persecution. My parents fled from Germany, my mother in 1934 and my father in 1937. Had they each not been forced to flee, they would not have been likely to meet and marry. One of my uncles was lost in the Nazi death machine. It was a cold and frightening time for my parents, huddled with friends and relatives on Kelly Street in New York City, learning more and more about deaths of fellow Jews in Germany and in other countries surrounding Germany. My grandfather had come reluctantly because he was first a German. The land on which he had lived and the town in which he had resided had been his family's before him. My father had reluctantly left with him in the beginning of 1937. I am told my grandfather stood over my crib when I was six weeks old and visiting him on Kelly Street, and rejoiced in my existence – his seed had been planted in the next land. I was the first son of the first son going back five generations.

I grew up feeling that there was great danger in the way people thought about other people's religion. I learned that the most devastating and cruel wars were fought in the name of religion. I hated the arrogance of those who killed knowing that they were right because their deity told them so.

Because of the disturbing influences of my mother on my development, I entered psychiatry with the intent stated, but unclear, that I wanted to understand her. Later I realised that I wanted to understand her influence on me and, later still, my mother in me. I began my first-year psychiatric residency eager to understand psychotherapy but found there were many schools competing for superiority, each one saying: 'I know what's right'. I met several psychoanalysts and discovered that the analytic promise of personal perfectability was not manifested by these people. The analytic culture seemed too rule-bound; silence was idealised while action was sharply curtailed. Its inhabitants also seemed to be living out its myths. Some analysts, for example, seemed to create the Oedipal conflict in their children. I thought other psychotherapeutic schools also had useful contributions to make, just as I had come to think that each of the world's many religions had much to teach us as did each of the world's many political systems. Furthermore, each of these religions and each of these political systems might be right for specific peoples nestled in specific geographical areas, rather than one system being right for all people. I learned to be sceptical of 'revealed truth', especially when it was revealed to someone else and not to me. I was also indoctrinated into 'scientific' thinking which brought me to test ideas for myself. Sometimes I tested out in my imagination the truth value of various propositions, as Einstein had studied the laws of light and gravity by performing thought experiments using elevators hurtling through space (Holton, 1979; Shapiro, 1986).

I wanted to find what was useful from each psychotherapy school. I needed a place to stand, to get away from the conflicting ideologies and to

be able to look from a distant place for what was useful about each school. I needed to be like Archimedes who said 'Give me a place to stand and I can move the world'. I needed the leverage of distance to become a self-observer for psychotherapy.

With this history so influenced by experiences demonstrating how individual and group behaviour is determined by models people hold of the world, I could not be satisfied with collecting techniques. I wanted to conceptualise psychotherapy, to develop a model of it. I wanted the model to be firmly rooted in undeniable general principles closely tied to the real-world behaviour of clients and counsellors. I also wanted it to be flexible enough to suit the special and varying circumstances of the many practitioners. I wanted to find a way to embrace both similarities and differences.

Ontogeny recapitulates phylogeny

I found a pre-Aristotelian idea to help me to integrate the various schools. In the late 19th century it was called Haeckel's Law or the biogenetic law: 'ontogeny recapitulates phylogeny'. It suggested that the embryo of the individual in some way recapitulated, repeated, the historical development of the species. Following this reasoning, anatomists could become palaeontologists by studying the developing embryo to see the structural development of its predecessors. Freud used this then-popular idea as well. He thought that individual neurosis was a recapitulation of the individual's early development. This exciting notion allowed Freud to develop his theories of psychopathology and individual development from his observations in his consulting office (Sulloway, 1979). At the time I came to the idea and applied it to psychotherapy, it had come into disrepute and was being ignored by contemporary biologists. I examined some older biology texts to get ideas about it (e.g. de Beer, 1958) and gradually developed the following notion: *the individual psychotherapeutic relationship recapitulates the historical development of psychotherapy.*

Like most model builders, I tried to confirm what I had constructed. And, of course, in some general way, I was able to do so, as I applied it to the development of psychotherapy in the United States. I saw Freud as the master of the basic structure of psychotherapy, as the originator of psychotherapy as we know it now. He clarified the need to listen, and to comprehend resistance, transference, and counter-transference: each of these are ubiquitous phenomena, the importance of which varies with the client, the therapist and the nature of their relationship. Freud tried to be an observer of the psychotherapeutic process without doing much to impede it or to distort it. Of course he was observing it, therefore participating in it, therefore changing it, as suggested by the Heisenberg uncertainty principle. Freud defined the essential ingredients of the therapeutic contract and the therapeutic process.

In the 1940s Carl Rogers recognised some limitations in psychoanalysis, not the least of which were its complications. He offered a simpler approach by teaching his followers not only to listen but to let their clients know they were being heard. He suggested that therapists should reflect back what they hear, using the words and the emotion of the client (Rogers, 1942). This active listening continues to be a fundamental technique for the engagement stage.

Also in the 30s and 40s, the inquiring Harry Stack Sullivan threw aside psychoanalytic silence while working with obsessives and schizophrenics. Sullivan recognised that if he did not ask any questions, he would not be able to get much clear information from these patients. He instituted the 'detailed inquiry' described in his book, *The Psychiatric Interview*, published posthumously in 1953. Sullivan helped to clarify the second stage of psychotherapy, the hallmark of which is active inquiry.

The 60s saw much transformation in psychotherapeutic technique. In 1959 Wolpe published his book on systematic desensitisation, *Psychotherapy by Reciprocal Inhibition*, which helped to revolutionise our approaches by insisting that behaviour is a critical component to therapeutic change (obvious as that may now appear). Albert Ellis in 1962 published his book, *Reason and Emotion in Psychotherapy*, emphasising the need to change cognitions. During the latter part of the 60s, Fritz Perls (e.g. Perls, 1969) rose to prominence among many counter-culture psychotherapists and moved gradually into the mainstream with his emphasis on emotion (Rice and Greenberg, 1984). In this general way, the triad of cognitions, emotion, and behaviour became the foci of change, the third stage of psychotherapy.

The 70s saw more third-party influence in psychotherapy and the need to be able to shorten the number of sessions. During that time the importance of termination and particularly of short-term therapy arose. As the 70s came to an end, two new influences appeared that were beyond what I had been thinking about in the early 70s when I was developing my model of psychotherapy. Family systems approaches have now gained a permanent place in therapeutic thinking, and the integration movement has begun to flourish. Both share the notion that the parts have some important contribution to make to the whole.

The structure of each stage

In this section I shall describe the practical details of the stage model as it has evolved since its early days (adapted from Beitman, 1987, pp. 25–30). Each stage may be seen to be composed of six elements: goals, techniques, content, resistance, transference, and counter-transference.

Goals. Goals define the boundaries of the stages. Once a goal is accomplished, the stage associated with it has been transversed. However, patient-therapist pairs must often retrace their steps to firm up their

engagement or to clarify and develop patterns. The goals of engagement include the patient's development of trust and confidence in the therapist as well as a willingness to be influenced. The pattern-search goal is the development of a pattern or set of patterns that, if changed, will bring about a satisfactory psychological shift. One pattern may not be sufficient; multiple patterns may be examined and discarded before some elements that can lead to an adequate resolution are defined. The goals of change are tied to its sub-goals: the relinquishing of the old pattern, the initiating of the new, followed by practice and maintenance. The goals of termination include separating early enough to maintain goals already achieved while not extending the relationship unnecessarily.

Techniques. A wide variety of techniques may be used to accomplish the goals of each stage. Some techniques are most useful in the engagement stage (e.g. empathic reflections) and others are better suited for change (e.g. behavioural rehearsal), although many techniques may be useful in all stages. The critical question is what techniques may be most useful for accomplishing the goals of each stage in therapy, and for which clients. For patients who see themselves as students of the therapist, homework assignments may prove excellent engagement techniques.

Content. The content of therapy is the least predictable aspect of psychotherapeutic process. The wide variety of personality and psychopathology theories attests to the uncertainty therapists have in knowing what to talk about. There appear to be some general themes. Engagement is concerned with trust and competence. Pattern search is most often associated with problems in daily living surrounding interpersonal relationships. Termination is concerned with trying out new actions alone and having to say good-bye.

Resistance. During the early years of psychotherapy, when the over-reaching fact was psychotherapeutic ignorance, Freud and his followers required of themselves that they listen with minimal intervention. But allowing the patient to determine much of the process while confronted with a silent listener resulted in the patients beginning to distort the person of the therapist and the process of the therapy. The therapist became more than just a physician-listener; therapy became a threatening enterprise. Patients began to subvert the therapeutic intent. They failed to free-associate, and chose to talk about inconsequential matters. The form and content of these blocks to the therapeutic flow were first thought to be great nuisances. Gradually Freud and his followers found that these resistances offered useful ways of understanding the person and his or her problems. The manner in which patients avoided problems in therapy resembled the ways in which they avoided problems outside the office.

Transference. People enter into new relationships with perceptions and attitudes derived from previous relationships. The more intimate the new relationship, the more likely it is that old, idiosyncratic attitudes will

emerge. During the engagement stage, clients tend to react to the surface appearance of the therapist (age, sex, dress, manner, accent). As intimate self-revelation takes place, more stereotyped attitudes are likely to be disclosed. They may be derived from past interpersonal experiences; they may also be samples of the patient's intrapsychic dynamics. For example, a person who criticises herself for any feeling of self-compassion may react critically to demonstrations of concern by the therapist. Apparent distortions of the person of the therapist may not have their primary source in the previous experience of the client. Therapists themselves may trigger realistic responses by their own distortions of the person of the patient. For example, a sexually stimulated therapist may unwittingly induce a feeling of being helplessly in love in a susceptible client who otherwise would have remained grateful with feelings of affection.

Counter-transference. Therapists also perceive their clients in terms of their own previous relationships. In addition, patients may induce responses in susceptible therapists that are similar to reactions other people have to these patients. Once the therapist's own idiosyncratic personal responses are distinguished from the effects the patient is creating, some very useful information can emerge. First, the therapist has the opportunity to further explore the personal sources of neurotic distortions. Second, the therapist can explore the reasons for his or her own personal vulnerability to such people. Third, the therapist can gain a richer appreciation of the reasons other people have trouble relating to these patients.

Table 1 contains an outline of the stages and their basic elements.

Integrative principles

Ideally, psychotherapists should and often do operate by a limited number of flexible principles (Kelly, 1955). I will list here some of these 'good ideas' which I believe integrative therapists should incorporate.

(1) The continuing acceptance of well-defined schools is of increasingly less use but the belief in their value will not disappear quickly. Many teachers of psychotherapy have developed review courses covering the many schools. Yet fewer practitioners will be able to wade through the volumes of texts concerning each school, and gradually they are likely to become historical anachronisms. We are witnessing much convergence and the recognition of common factors (Goldfried, 1982). Counsellors need to search for the unique contributions of each school while also taking into consideration their similarities.

Commonalities, however, may be obscured by different terms. For example, the concept of self-observation has received several other names including 'observing ego', 'self-monitoring' and 'self-reflection', each with different connotations. Another concept that has many terms is the common failure of clients to follow the therapist's expectations. Some of

Table 1: The stages of individual psychotherapy

	<i>Engagement</i>	<i>Pattern search</i>	<i>Change</i>
GOALS	Trust Credibility Ground rules Self-observer alliance Motivation	To define patterns of thought, feeling and/or behaviour that, if changed, would lead to a desirable outcome.	1. Relinquish 2. Initiate 3. Practise 4. Maintain
TECHNIQUES	Empathy Role definition Managing the contract Specialised knowledge Effective suggestions	Questionnaires Listening Questions Homework Role-playing Incongruities	Placebo response Exhortation Interpretation Reframing Modelling
CONTENT	Presenting problems Underlying fears Distrust Therapist decisions about type of treatment	S→O→R Deviation amplifying feedback Emotion Expectations Interpersonal style Intrapsychic conflict	Specifying Responsibility Responsibility Therapist coping
RESISTANCE	To trust competence ground rules self-observer motivation	To ground rules self-observer pattern-search methods pattern-search content	To change Patient limit Therapist Patient-th
TRANSFERENCE	To therapist's surface presentation (age, sex, dress, accent, race, physical attractiveness, style of therapy)	As samples of key interpersonal and key intrapsychic patterns. As products of previous therapy, expectable events of current therapy, or therapist counter-transference	Fear of loss Sample of change for crea
COUNTER-TRANSFERENCE	To patient's surface presentation (age, sex, dress, accent, race, attractiveness, diagnosis)	Therapist-induced Patient-induced (informs therapist how patient affects others)	Fear of loss Use of un how pa therapist (e.g. se

the terms used for this are 'resistance' or 'awareness blocks' or 'non-compliance', depending on the school of therapy. Another ubiquitous concept with different names is called 'exposure' in behaviour therapy, upon which it has based a great deal of its success. No matter what its form (*in-vivo*, rapid v. slow, therapist-aided v. spouse-aided v. alone), exposure has been shown to be successful in the treatment of phobias (Marks, 1976). More recently, it has come to be applied to panic attacks which are in part thought to be triggered by phobic reactions to internal, somatic sensations and therefore treated with interoceptive exposure (Barlow and Cerny, 1988). Without using the term, however, exposure is also used in other approaches. Cognitive therapists expose clients to frightening automatic thoughts and may ask 'so what?' (Beck, *et al.*, 1979). Gestalt therapists may bring frightening feelings to awareness and ask clients to stay with them (Perls, 1969). Psychoanalysts have long exposed their patients to forbidden impulses, memories and images either slowly or rapidly.

(2) The stages of psychotherapy appear to be a heuristic concept for guiding us through the often tumultuous, uncertain terrain of the psychotherapeutic experience. By knowing the current stage, one is given objectives to accomplish. For example, with a difficult borderline patient I am currently seeing, it became obvious that she would not develop a self-observer alliance with me and that this resistance required investigation. Her resistance was based on her fear of actually getting closer to me by working with me and therefore having to trust me. She had this fear in spite of the fact that she professed great love for me and wanted me to step out of my role and into a sexual affair with her. Trust became critical and the self-observer alliance became the focus. To move to change immediately would have been premature.

In pattern search, one tries not only to define the patterns which are in need of change but to define them in ways that imply change. This effort requires careful selection of terminology. The terminology should conform to the patient's world view and world experience.

While each of the stages may have sub-stages, it is the sub-stages of change that appear most clear. During the first sub-stage of change, clients often are required to give up an old pattern before beginning a new one. This giving-up sometimes involves grieving and may involve much fear. Giving up the old pattern can be frightening because the new is uncertain while the old is tried and familiar and at least predictable. The second sub-stage of change requires the initiation of new ways of thinking or acting. If these ways of acting are not reinforced by the environment, one gets into trouble. After initiating new behaviours, they must be practised in positively reinforcing environments. Negative environments make successful practice difficult; couples and family therapy may then become obviously necessary.

(3) Psychotherapy is an interpersonal process. This is not to suggest that

certain specific problems such as depression and panic cannot be approached in a non-interpersonal (e.g. cognitive) way (see Beck *et al.*, 1979; Barlow and Cerny, 1988). Often, however, one is using an interpersonal method to solve a problem in the person's interpersonal environment. It is also critical for therapists to recognise that patients are attempting to influence therapists as well as to acknowledge that we are trying to influence them. Acknowledging to oneself the manner in which a client is attempting to control, manipulate, and/or persuade us, tells us a great deal about the manner in which other people are indirectly asked to behave by the patient. This tendency to emit subliminal interpersonal commands has been called by many names: I prefer the term 'meta-communication' (Watzlawick *et al.*, 1967). Whatever term one prefers, it is important to recognise that we are registering both consciously and unconsciously the other person's interpersonal commands on us. Our internal responses become additional data about the client's interpersonal manoeuvres (see Strong, 1987).

(4) Counsellors must build flexibility into their approaches to their clients. This flexibility may be imagined as the counsellor's moulding around the other, a fitting with the client, rather than forcing the patient into the therapist's own theoretical bed. This flexibility may lead to our ability to prescribe certain responses for certain situations. Perhaps the most critical problem is determining the client's level of difficulty. Beutler (1983) has made a distinction between monosymptomatic and polysymptomatic presentations. For example, some people may simply have panic attacks and no personality problems or major depression. On the other hand, some people who have concurrent panic disorder and major depression are more likely to have social phobia (Stein and Uhde, 1988) and to have personality disorders – most commonly passive dependent disorder and sometimes borderline disorder. A therapist may be fooled by the presence of an apparently simple difficulty and find himself/herself entering into a very confusing and difficult arena. Making the distinction between the easier and more difficult problems will aid in determining the required flexibility.

Therapists often need to adapt to clients' vocabulary. They talk in a variety of languages and come from a variety of backgrounds. Engineers, teachers, farmers, low v. high socioeconomic groups, each may have different ways of thinking and expressing themselves to which therapists should be able to adapt.

Clients may be skilled at certain change mechanisms and not skilled at others. Some may be more attuned to focusing on emotional awareness; some may be more focused on cognitions; some may rather change behaviour first. The situation may be seen to call for certain types of responses.

(5) Psychotherapy and counselling are practised in a complex social,

political and cultural context. Integrative models and theories must incorporate flexible conduits by which new ideas may be entered and tested. Rigidity to outside influence and change must be guarded against. Change must be anticipated. For example, cybernetics helped to spawn systems theory and its derivative, family systems psychotherapy. With this advance, therapists can no longer pretend that the individual psyche is separate from its interpersonal environment. The women's movement is helping to shift clinical attention from the woman as major source of difficulty to considering male authority and rationality as critical problems (Luepnitz, 1988). The length of therapy is currently strongly influenced by the willingness of society to pay for it (Kuper, 1988).

Research, integration and eclecticism

Lazarus would have us believe that his technical choices are based upon research evidence supporting the use of one approach over others. There is much in his own writing to suggest that this is not the case. One of his major claims, for instance, is that 'From a multimodal perspective . . . it is therapeutically deleterious to aggrandize any particular modality – they are all important' (Lazarus, 1976, p. 41). How does he know this? Upon what research other than his own careful clinical observation does he base this statement? Where are the reports that demonstrate poorer outcome when 'sensations', for example, are left out of the therapeutic content? It would take a tremendous number of clients and researchers to substantiate this claim. Furthermore, he includes among his seven modalities 'imagery', claiming by inference that the use of imagery in therapy has been well established. He recorded many useful clinical concepts in his small book on the use of imagery (Lazarus, 1977) but there is little research evidence to substantiate the use of the techniques he describes.

Research in psychotherapy has primarily investigated established approaches; it has not been the source of innovation but rather of confirmation or disconfirmation of commonly accepted techniques. As a source of technical information, the research literature functions as good criticism in that it guides the reader to focus on the optimally effective. However, there are grave limitations to relying only upon research data to guide clinical practice. Culture, clients and politics are continually changing, and therapists need new perspectives. Psychotherapy research has only reacted to what is being practised, and has only tested what is being done rather than put together new schemes or techniques.

Another problem is the research requirements demanded by research protocols. Patients must be willing to go along with what is being asked of them. Usually a good deal of co-operation and practice outside the sessions is required. Thus much sophisticated work is being done with panic disorder (e.g. Barlow and Cerny, 1988), but some patients just do not have the time, the energy or a sufficiently organised life to carry out assign-

ments. Such clients may be termed 'non-compliant' and dropped from the protocol. Unfortunately many people in clinical practice also would be dropped from such protocols. In this way research may tell therapists about an approach that can be effective and therefore provides an ideal towards which to reach. However, other information must be added to make effective use of such clients' limited resources.

As for research that does exist, one must again fall back upon opinion to judge its clinical value. The conclusions from meta-analysis research are matters of statistical opinion. As for 'data pertaining to specific treatment of choice for a variety of problems' (the careful phrasing used by Lazarus at the end of his paper), one cannot avoid knowing that exposure in many forms is useful for phobias. As for depressive disorders, several candidates are vying for the prizes including cognitive-behavioural (Beck *et al.*, 1979), interpersonal (Klerman *et al.*, 1984), and social skills (Hersen *et al.*, 1984). How is the clinician to choose? For obsessive compulsive disorders, psychotherapy is difficult, with relatively low yields compared to medications which are probably the best place to start. I claim this is hardly sufficient information to guide clinical practice which includes many people with personality disorders.

Lazarus takes issue with my unproven claim that individual personality plays a great part in therapeutic choice. However, he unwittingly illustrates this point with his own approach. He wants research to guide his practice and so he says that it does. I claim that clinical experience explains a far greater portion of the variance in his choices since so many clinical problems have yet to be carefully addressed by research. In addition, several of the content areas of his BASIC ID (emotion, sensation, imagery) have not been the subject of research scrutiny from which firm conclusions can be drawn. He clearly dislikes psychoanalysis, comparing it to phrenology. How can experienced clinicians deny the existence of transference, resistance and counter-transference? Although I believe that there is much confusion, hyperbole and sophistry in psychoanalytic theory, some of its clinical insights are requisite parts of any therapeutic scheme. Although he does not mention it, I assume that Lazarus would prefer not to delve into existential concerns like death, responsibility, isolation and the meaning of life (e.g. Yalom, 1980). I sometimes find these ideas useful. But Lazarus is a behaviourist by choice and therefore he chooses to ignore these non-behavioural contributions. I consider his approach to be a behaviourally-oriented systematic eclecticism which has made and continues to make valuable contributions to the movement towards psychotherapy integration.

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