Introduction:

Eclecticism, Casebooks, and Cases

John C. Norcross

Casebook of Eclectic Psychotherapy

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Introduction: Eclecticism, Casebooks, and Cases

The notion of psychotherapy integration has intrigued clinicians for many years (Goldfried, 1982a; Goldfried & Newman, 1986), but it has only been in the last 10 or 15 years that integration has become a specified area of interest. The literature on eclecticism is growing by leaps and bounds, and there is no dearth of theoretical writings on the subject. There is, however, a striking dearth of case histories, particularly verbatim accounts. The *Casebook* attempts to rectify this deficiency and to bridge the precipice between expounded theory and practical application.

The 13 cases in this compendium, all formulated and treated from systematic eclectic perspectives, are detailed. Steps were taken to ensure longitudinal and intensive accounts of integrative psychosocial treatment. The intent is to take the reader into the therapy session—to show what actually transpires, what the therapist is thinking, and how the patient is responding. The goals are to operationalize the therapeutic decision-making process, to discover how interventions are matched to patients and problems, to relate process to outcome, and to discover the breadth of treatment procedures and conceptualizations found in eclectic therapy. These are explored through the multiple and unique vantage points of the

psychotherapist, the patient, the interchange (via session transcripts), and fellow clinicians.

The present chapter is intended to review the broad context of eclectic psychotherapy and to consider the role of this *Casebook* within the integrationist *Zeitgeist*. First, I outline several definitions and manifestations of eclecticism with particular emphasis on systematic prescriptive eclecticism. Second, the growing need for an appreciation of casebooks are briefly discussed. Third, I comment on the organization of the book and the preparation of the cases. Finally, several "growing pains" of eclecticism are explicated and a developmental understanding recommended.

ECLECTICISM

The past 10 years have produced a burgeoning of psychotherapists across orientations and disciplines who claim an allegiance to eclectic psychotherapy. Clinicians of all persuasions are now coming out of their monogamous theoretical closets to proclaim their receptivity to the simultaneous employment of multiple theories and techniques (Held, 1984). Eclecticism has become the modal orientation of mental health professionals, with between one-third and one-half ascribing to it (e.g., Garfield & Kurtz, 1976; Jayaratne, 1978; Norcross, 1985; Norcross & Prochaska, 1982a; Prochaska & Norcross, 1983). Psychologists generally believe that eclecticism

offers the best hope for a truly comprehensive treatment approach (Smith, 1982). Historical trends and expert opinions portend increasing reliance on sophisticated integration in psychotherapy theory, research, and practice (Prochaska & Norcross, 1982).

The concomitant openness to contributions from diverse persuasions has given rise to numerous publications and organizations. Specific systems of eclectic practice (e.g., Beitman, 1986; Beutler, 1983; Driscoll, 1984; Garfield, 1980; Hart, 1983; Lazarus, 1981; Palmer, 1980; Prochaska & DiClemente, 1984; Thorne, 1973), influential anthologies (e.g., Goldfried, 1982b; Marmor & Woods, 1980; Norcross, 1986b), and compilations of prescriptive treatments (e.g., Frances, Clarkin, & Perry, 1984; Goldstein & Stein, 1976) have flourished. Several eclectic journals (e.g., *International Journal of Eclectic Psychotherapy*) and series of articles (e.g., Brady et al., 1980; Garfield, 1982; Goldfried, 1982a; Kendall, 1982; Wachtel, 1982) have appeared. Three interdisciplinary and non ideological organizations—the Society for Psychotherapy Research (SPR), the Society for the Exploration of Psychotherapy Integration (SEPI), and the International Academy of Eclectic Psychotherapists (IAEP)—also exemplify the spirit of open inquiry and growing collaboration.

Two serious obstacles to wider acceptance of an eclectic perspective are disagreement over terms and the absence of a generic psychotherapy

language (Goldfried & Safran, 1986; Norcross, 1986a). The term *eclectic*, in particular, has been employed indiscriminately and inconsistently. A vague and nebulous term, its connotations range from "a worn-out synonym for theoretical laziness" to the "only means to a comprehensive psychotherapy" (Smith, 1982). In some corners, eclecticism is prized as complex, relativistic thinking by people united in their respect for the evidence and in their willingness to learn about what may be clinically effective. In other corners, eclecticism connotes undisciplined subjectivity, "muddle-headedness," even minimal brain damage. Some have referred to eclecticism as the "last refuge for mediocrity, the seal of incompetency" and "a classic case of professional anomie" (cited in Robertson, 1979). It is surprising that so many clinicians admit to being eclectic in their work given the negative valence the term has acquired (Garfield & Kurtz, 1977).

There is recurrent debate whether eclecticism constitutes another theoretical orientation or the absence of one. Thorne (1973), among others, insists that eclecticism is the active acceptance of an orientation in its own right, albeit broader and more integrative. Garfield (1980), in contrast, uses eclectic to indicate that one is not an adherent of a particular school of psychotherapy. Beyond this, the term does not have any precise meaning. What binds most eclectics together is a stated dislike for a single orientation, selection from two or more theories, and the belief that no present theory is adequate to explain or predict all the behavior a clinician observes (Garfield &

Kurtz, 1977).

Webster's Collegiate Dictionary defines eclecticism as the "method or practice of selecting what seems best from various systems." Similarly, Brammer and Shostrom (1982) define therapeutic eclecticism as the "process of selecting concepts, methods, and strategies from a variety of current theories which work" (p. 35). If eclectics do indeed choose what appears to work best, few should oppose the movement (Garfield, 1982).

These definitions, though somewhat vague, imply that eclecticism should be *prescriptive* and *systematic*. Prescriptive eclecticism entails going beyond subjective preference, institutional custom, and immediate availability to predicate treatment selection on clinical experience and outcome research (see Dimond & Havens, 1975; Frances, Clarkin, & Perry, 1984; Goldstein & Stein, 1976; Hariman, 1986). Prescriptionism is concerned with that elusive, empirically driven match among patient, disorder, and treatment. With increasing refinement in the categorization of disorders and more precise delineation of change strategies, further advantages of specific treatments for specific conditions may be found. At that point, effective therapy will be "defined not by its brand name, but by how well it meets the need of the patient" (Weiner, 1975, p. 44).

Systematic eclecticism, as opposed to the unsystematic brand, is the

product of years of painstaking clinical, research, and theoretical work. It is truly eclecticism "by design"; that is, clinicians competent in several therapeutic systems who selectively choose interventions based on clinical experience and/or research findings. The strengths of systematic eclectic approaches lie in their ability to be taught, replicated, and evaluated.

By contrast, unsystematic eclecticism is primarily an outgrowth of pet techniques and inadequate training. It is eclecticism "by default," lacking sufficient competence for an eclectic approach and selecting interventions on the basis of subjective appeal. Eysenck (1970) has characterized this haphazard form of eclecticism as a "mishmash of theories, a huggermugger of procedures, a gallimaufry of therapies" (p. 145) having no proper rationale or empirical evaluation.

There are multiple manifestations of systematic eclectic psychotherapy, of which three subtypes predominate. Atheoretical eclecticism is an integrative perspective governed by no preferred theoretical approach (e.g., London, 1972, 1986). Synthetic eclecticism strives toward an integration of diverse contemporary theories (e.g., Goldfried, 1980; Prochaska & DiClemente, 1984). Technical eclecticism endorses the use of a variety of techniques within a preferred theory (e.g., Lazarus, 1967, 1981).

These three subtypes are all evident in contemporary practice (Garfield

& Kurtz, 1977) and in this *Casebook*. In a survey of clinical psychologists (Norcross & Prochaska, 1982a), eclectic respondents were asked to select the one type of eclecticism that best approximated their own views. Over half (61%) of these eclectics indicated they integrated a diversity of contemporary approaches, 29% responded that they use a variety of techniques within a preferred theory, and 10% claimed that they had no preferred theoretical orientation. Results from a second sample (Prochaska & Norcross, 1983) replicated the order of preference, namely, synthetic, technical, and atheoretical.

Lazarus (1967, 1977, 1981), the most eloquent proponent of technical eclecticism, emphasizes 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. For Lazarus and other technical eclectics, no necessary connection exists between meta beliefs and techniques. It is not necessary to build a composite from divergent theories, on the one hand, or to accept divergent conceptions, on the other, in order to utilize their technical procedures. "To attempt a theoretical rapprochement is as futile as trying to picture the edge of the universe. But to read through the vast amount of literature on psychotherapy, *in search of techniques*, can be clinically enriching and therapeutically rewarding"

(Lazarus, 1967, p. 416).

On the other hand, many (e.g., Loew, 1975; Maultsby, 1968; Simon, 1974) have taken exception to Lazarus' technical eclecticism and have emphasized the necessary and important link between theory and intervention. Synthetic eclectics insist that only in theoretical integration can treatments be prescribed in reproducible, testable, and explainable terms. That is, to retain theory in practice is to make psychotherapy more rigorous and consistent (see Held, 1984).

A few final words on the interrelationship of eclecticism and integrationism are in order. Integration refers to the incorporation of parts into a whole. Integrationists, many of whom abhor the label "eclectic," are persons working toward or from an integrative perspective.

Clinical practice can be viewed as a continuum ranging from a single orientation at one pole to an integration of all orientations at the other. The practice of orthodox psychoanalysis or radical behaviorism would represent one end. A hyphenated approach—say, cognitive-behavioral—would be one step further along the continuum. And just how many hyphens constitute eclecticism? Does interpersonal-cognitive-behavioral therapy qualify as an eclectic therapy? There is no arbitrary cutoff on a continuum, of course, and this seems to be a matter of labeling and taste. The ideal of integrating *all*

available psychotherapy systems is not likely to be met either. Somewhere between the hyphenated, two-orientation approach and the unattained integration of all theories lie the obscure boundaries of eclecticism.

In my opinion, integrationism is one variant, one manifestation of systematic eclecticism. It should be noted that others believe integrationism is the broader category subsuming eclecticism. In any case, integrationists seek to meld warring therapy factions, typically behavior therapy and psychoanalysis (cf. Arkowitz & Messer, 1984; Marmor & Woods, 1980; Wachtel, 1977; Yates, 1983), into a cooperative and harmonious whole. However, those integrationists restricting themselves to two therapy systems would not technically meet the "three systems or more" definition of eclecticism.

Relatedly, Beitman (Chapter 2) notes that the movement toward bringing together the conflicting schools of psychotherapy has advanced to a point at which two different terms are being used to characterize it. The apparent conflict between the terms "integrationism" and "eclecticism" stems from different intents: a sociopolitical revolution to reduce conflict by recognizing the commonalities in the former, and an attempt to construct one practical and systematic clinical model in the latter. In Beitman's words, "integrationists pave the way by knocking down barriers with attacks on ideological rigidity and systematic eclectics provide the alternative means."

From a different perspective, Gurman (this volume, Commentary to Chapter 9) characterizes eclecticism as adding together techniques and strategies derived from disparate models of therapy. Integrationism, in contrast, involves the careful elucidation of principles by which apparently incompatible views are brought together. Furthermore, according to Gurman, eclectic therapists choose a technique or theory to fit the patient; the integrative therapist chooses techniques or theories in a way that fits him/herself as well as the patient.

Despite the semantic disparities and technical differences, the objectives of integrationists and eclectics are quite similar indeed. Both seek an end to the "ideological cold war" (Murray, 1983) and "dogma eat dogma" (Larson, 1980) environment that has characterized psychotherapy for too long. Moreover, both are devoted to open inquiry, critical dialogue, and reciprocal enrichment among systems of psychotherapy.

CASEBOOKS

With virtual unanimity, psychotherapy researchers have argued that psychotherapy research should yield information useful for practicing clinicians but has failed to do so to date (Barlow, 1981; Elliott, 1983; Luborsky, 1972; Sargent & Cohen, 1983; Schontz & Rosenak, 1985; Strupp, 1982). As a result, psychotherapy research minimally influences practice—an

aloof relationship variously characterized as the dreaded precipice, a crisis of confidence, and an "anaclitic depression" (Parloff, 1980; Strupp, 1981). The standard litany of complaints against conventional clinical research includes irrelevant questions, atypical populations, unrepresentative therapists, unstandardized treatments, unrealistic settings, oversimplification of complex realities, reliance on statistical rather than clinical significance, and concentration on group outcomes rather than individual process-outcome linkages. Indeed, the typical psychotherapist does not engage in research, is reluctant to participate in research, and publishes little (see review by Morrow-Bradley & Elliott, in press).

A shift is needed in psychotherapy research because traditional research methods of experimental psychology—emphasizing isolation, simplification, and aggregate statistics—are not appropriate for studying psychotherapy (e.g., Elliott, 1983; Rice & Greenberg, 1984). Psychosocial treatments are *not* mechanically administered to passive patients, and interventions are *not* discrete, disembodied procedures. Rather, therapeutic skills and techniques are efforts on the part of the therapist to influence the therapeutic relationship and the patient's behavior. We need to turn to the clinical data and ask, as clinicians, "What has happened here and why?" (Butler & Strupp, in press).

Several writers (e.g., Peterfreund, 1971; Schafer, 1976, 1983; Spence,

1982, 1984) have proposed a new mode of clinical reporting which does not rely solely on therapists' recall and which jettisons confusing languages in the service of greater clinical relevance. We need to make a clear break with what Spence (1982) has called the "Sherlock Holmes Tradition" and develop methods of presenting case material which allow the reader to participate in the argument, allow him/her to evaluate the proposed links between evidence and conclusion, and which open up the possibilities of alternative conceptualizations and even refutation. Collectively, this would increase explanatory force and learning opportunities.

Therapists learn about therapy overwhelmingly from their own clinical experience. Second to experience, practical books are the most highly valued sources of clinical knowledge, particularly among experienced practitioners (Clark, Wadden, Brownell, Gordon, & Tarte, 1983; Morrow-Bradley & Elliott, in press; Norcross & Prochaska, 1982b; Sargent & Cohen, 1983).

Systematic case study is a viable research alternative and an attractive pedagogical method. The recent profusion of casebooks reflects both dissatisfaction with conventional research and satisfaction with education through observation. Casebooks attest to the growing recognition of and need for "learning through doing," rather than merely "learning through knowing." Casebooks have now appeared on "great cases" (Greenwald, 1959; Wedding & Corsini, 1979), child psychotherapy (Cooper & Wanerman, 1984), marital

therapy (Gurman, 1985), family therapy (Papp, 1977), time-limited dynamic treatment (Mann & Goldman, 1982), multimodal therapy (Lazarus, 1985), and hypnotherapy (Dowd & Healy, 1985). This volume, however, is the first casebook explicitly devoted to systematic eclectic psychotherapy.

When done right, casebooks have much to recommend to the practitioner and researcher alike. Experienced therapists present case histories from beginning to end and provide concrete guidance on the crucial questions of "why, how, and when."

It is case material that grounds soaring metapsychology and translates technical language into "felt experience." Cases provide a "frequent coupling of the abstract with the concrete, a marriage of concept and illustration" (Bonime & Bonime, 1978, p. 38). Theorizing becomes "pragmatic" (Driscoll, 1984) and "consequential" (Berger, 1985)—relevant to what transpires in clinical practice. The clinical data thus render books more readable, interesting, and most of all, useful.

When done wrong—and I fear many earlier efforts were—casebooks become collections of disembodied and anecdotal case material written by speculating practitioners. Specifically, as a practitioner and researcher, I have been frustrated by previous casebooks for several reasons: (a) total reliance on therapist recall (or reconstruction); (b) absence of complimentary or

alternative perspectives on the case; (c) incomplete description of the patient and approach; (d) treatment of ideal cases in their pristine form; and (e) lack of therapist rationale for his/her clinical decision making.

First of all, a case should not be presented solely from the therapist's perspective. Distortion, misrepresentation, even falsification are products of theory-bound and appearance-consumed practitioners. It is not the profundity of interpretation that impacts behavior change, but how the material is presented by the therapist and received by the client. Though it is readily apparent that clinical treatment is defined as *received* by the patient, in or outside of immediate awareness, we forget this and rely on what the therapist *thought* he/she provided (Schafer, 1983; Spence, 1982).

Moreover, our sympathy lies naturally with the author. This is particularly true for authors in complete command of the narrative voice and the rhetorical method. The Dora case, as Marcus (1977) made clear, is a clinical *tour de force* in which all significant features of the patient's life are presumably explained. The grounds for these explanations are less than convincing, and yet we come away persuaded and impressed by the clinical reasoning. Freud was able to turn a treatment failure into a literary success (Marcus, 1977; Spence, 1984).

The principal goal of psychotherapy is to bring about change in the

patient, not to present a reasoned argument that relies on public data and rules of evidence. When the clinical account is transposed to the public domain, however, it is no longer designed for the benefit of one individual but must now be accessible to all (Spence, 1984). Simply put, it is not sufficient to use the therapist's conviction to impress the reader. Let the "evidence" speak —evidence from different sources (e.g., other therapists, patient, family members) and of different types (e.g., self-report, transcripts, standardized measures).

Toward these ends, case contributors in this volume went beyond mere case study reconstruction by the addition of audiotape recordings, patients' impressions, and fellow therapists' commentaries. These editorial methods were employed to make the case accounts as complete and valid as possible. The Case Guidelines (see below) required verbatim session transcripts and patients' written reactions in order to facilitate multiple perspectives. Furthermore, two prominent clinicians interested in psychotherapy integration reviewed each case history and provided published commentaries. As presented to the commentators, their comments were "intended to stimulate thought and critical dialogue on the possibilities and varieties of eclectic psychotherapy. Commentaries should embellish a few points, provide complimentary or alternative conceptualizations, relate a transaction to theory or research, and generally discuss the case."

The Case Guidelines were also produced to guard against the remaining aforementioned pitfalls of casebooks, namely, incomplete description of the patient and approach, treatment of ideal cases in their pristine form, and lack of therapist rationale in his/her clinical decision making. The guidelines proscribed mandatory inclusion of salient patient material. Freud (1905/1963, p. 32), the intrapsychic master, cautioned us "to pay as much attention in our case histories to the purely human and social circumstances of our patients as to the somatic data and the symptoms of the disorder." One prerequisite for case contributors was that they had published extensively on their integrative treatment approaches. *The Handbook of Eclectic Psychotherapy* (Norcross, 1986) and auxiliary sources provide detailed information on the underlying theoretical models and clinical reasoning for these eclectic approaches.

Unlike many casebook editors, I was not interested in ideal cases or the pristine application of psychotherapy. The Case Guidelines instructed contributors to select representative cases, to present their therapeutic errors, and to concentrate on the positive as well as negative outcomes of treatment. We have tried to venture beyond the glitter of therapeutic packaging to present psychotherapy as it is experienced in daily practice. What these cases lack in purity is more than compensated by their realism. These 13 cases convey the richness, complexity, and realities of eclectic psychotherapy.

One of the pressing challenges in eclectic psychotherapy is to elucidate and operationalize clinical decision-making processes. Why does one turn right instead of left? At both the micro level—reflection versus question versus silence—and macro level—support versus desensitization versus genetic interpretation—we need to identify individual clinician's rules. This compendium reflects 13 psychotherapists' efforts to do so and, at the same time, attests to the difficulty of the task before us.

The Case Guidelines are presented below in condensed form as a guide to the reader.

CASE GUIDELINES

These guidelines have been prepared to promote comprehensiveness within cases, to facilitate comparisons across cases, and to answer frequent questions concerning the organization of the case histories. The topics covered here are representative and not exhaustive.

Case Structure

The guidelines are *not* designed to serve as an outline for the case. The primary goal is to present clear and detailed case histories from eclectic perspectives. Contributors are encouraged to employ whatever structure they feel best presents the required information and their eclectic approach.

It would be appropriate to begin with a synopsis of your eclectic perspective and the reasons for selecting this particular case. Background and theoretical information pertaining to your approach can be summarized here. It would also be appropriate to conclude with several paragraphs on the case, your approach, and eclecticism in general.

Case Selection

A wide variety of cases is sought, particularly complex cases involving multiple etiologies, modalities, and treatments. The case can deal with practically any problem or diagnostic type amenable to psychosocial treatment. The case should, however, be (1) illustrative of your eclectic approach, (2) completed at the time of writing the chapter, and (3) fairly typical of the types of patients or problems treated by your approach in the past. Additionally, the case requires (4) transcript excerpts (from audiotapes or videotapes) from several sessions, and (5) the patient's written impressions of several critical sessions and treatment as a whole (see Patient Impressions below). Finally, it is suggested that (6) the completed case be between 5 and 25 sessions in length, thereby reflecting the general duration of outpatient psychotherapy in the United States.

Patient Information

The case should contain identifying information, chief complaints, and a brief review of salient history. Demographically, include pertinent data such as age, ethnicity, marital status, living conditions, occupation, education, and family composition. The presenting problems, expectations for therapy, psychiatric history, previous treatment, personal and social history, family history, medical history, and referral source should all be summarized. Information brought to therapy with the client—for example, previous test reports—should also be summarized. Certain identifying information must be disguised or omitted, of course, to preserve the patient's anonymity and to meet ethical standards.

Treatment Information

The case should clearly present the treatment setting, frequency and length of sessions, and other clinical practices which may influence treatment. Routine psychological test or questionnaire results may be presented in narrative or tabular form. Written contracts, intake questionnaires, and similar forms may also be introduced here.

Starting with the initial contact, describe the processes and outcomes of treatment. Issues pertinent to psychotherapy practice and your eclectic perspective in general should be discussed. Representative topics include:

—intake and assessment procedures

—the process by which you reached a case formulation and diagnosis

—integration of assessment and therapy

—selection and prioritization of treatment goals

—explanation (if any) of your integrative/eclectic approach to the client

—the process of selecting specific treatments for specific disorders

—matching your behavior to the patient's problems

—explanation of your decision to employ a particular intervention at a particular time

—rationale of your behaviors at different points in treatment

—basic interventions and techniques

—the patient's response to treatment, particularly blocks and resistances

—development and evolution of the therapeutic relationship

—different stages or phases of treatment

—evaluation of therapeutic progress or change

—termination process

—outcome and follow-up

Session Transcripts

The case should contain numerous excerpts of verbatim session transcripts to illustrate the practice and process of your eclectic approach. Transcripts should ideally be employed to illustrate various phases or processes of therapy. One excerpt, for instance, could reflect the patient's functioning, his/her characteristic behavior, interpersonal relating, and self-presentation. Another excerpt could demonstrate a "critical incident" as judged by clinician or client. A third could trace a therapeutic impasse or specific choice point in treatment.

Therapist Remarks

The psychotherapist should describe and explain the sequence of events constituting treatment from his or her eclectic perspective. Particular attention should be paid to the decision-making processes culminating in the case formulation, treatment interventions, and therapeutic relationship. The reader should be made witness, to the extent humanly possible and personally comfortable, to the internal processes (e.g., emotions, cognitions, intuitions) that guide you as an eclectic therapist.

In commenting on the rationale (or lack of) for your therapeutic behaviors, it would be fruitful to discuss both the positive and negative aspects of the case. Presentation of technical errors, mistimed interventions,

poorly worded comments, and related mistakes will result in a more balanced case.

Patient Impressions

The case should contain the patient's reactions to treatment written after (or during) termination. Patients should be asked to provide critical descriptions of their therapy, concentrating both upon the negative and positive parts of treatment. Further, they should be asked for their candid impressions of critical incidents or transactions presented in the case transcripts. These impressions should ideally be written; however, verbatim remarks from audiotapes are acceptable. Specific patient responses—either spoken or written—are to be encouraged in order that the patient's and therapist's perceptions may be compared.

How are we to evaluate the adequacy of a psychotherapy case? The logico-scientific experimental approach is of minimal assistance. The alternative leads to what has been variously labeled narrative truth or hermeneutic-dialectical truth. It stresses meaning of experiences and their interpretation; it comes in the form of good stories, believable historical accounts, and a proper narrative fit (Messer, 1986).

Sherwood (1969, cited in Messer, 1986) offers three criteria to judge the adequacy of a narrative. The first, self-consistency, mandates that general

statements should be consistent with each other. The second, coherence, requires a fit between the parts and the whole and a resolution of the apparent incongruities in the text that are to be understood. The third, comprehensiveness, is the extent to which the narrative account covers the ground. The method is hermeneutic (Westerman, 1986) insofar as it involves perceived meaning and disciplined subjectivity.

In addition, a psychotherapy case presentation should possess "an intelligent and reasonable quality" (Dewey, 1966). Fellow clinicians should be able to assess the potential curative nature of the process and positive outcomes of the work. An *eclectic* psychotherapy case presentation, moreover, should make explicit its systematic and prescriptive nature.

CASES

Table 1 provides an overview of these 13 cases in terms of integrative approach, therapist names, therapy modalities, client description, presenting problems, and number of sessions. The cases are arranged alphabetically by author. Some readers may wish to order their reading on the basis of an alternative scheme, for example, by type of disorder, format of therapy, or length of treatment.

Table 1 An Overview of the 13 Cases

Chap.	Approach	Modalities	Clients	Presenting	# of

Author(s)				problems	sessions
2 Beitman	Systematic technical eclecticism	Individual and marital	Adult female	Depression	6
3 Beutler	Systematic eclectic psychotherapy	Individual	Adolescent female	Anger, depression, and narcolepsy	28
4 Burlingame, Fuhriman, & Paul	Eclectic time-limited therapy	Individual	Adult Female	Dependent stance and incestuous experiences	10
5 Clarkin & Rosnick	Differential therapeutics	Individual	Adult female	Depressed mood and dependent features	20
6 DiClemente	Transtheoretical therapy	Individual and marital	Adult male	Anxiety and authority problems	13
7 Driscoll	Pragmatic psychotherapy	Family and individual	Blended family	Child management and family relations	10
8 Dryden	Theoretically consistent eclecticism	Individual	Adult male	Lacks direction, social isolation	17
9 Grebstein	Eclectic family therapy	Family and individual	Family (4 children)	Divorcing, multi-problem family	30
10 Hart & Hart	Functional eclectic therapy	Group and individual	Psychotherapists in training	Various personal and professional	*
11 Murgatroyd	Structural-phenomenological eclectic therapy	Individual	Adult female	Apathy depression	8
12 Powell	Integrated	Individual	Adult male	Performance	14

	behavior therapy and psychotherapy			anxiety	
13 Robertson	Radical eclecticism	Individual and marital	Adult male	Obsessions and generalized anxiety	9
14 Steinfeld	TARET systems	Couples and individual	Middle-aged couple	Violence, infidelity, and mistrust	17

*Varied according to group member

The titles of these eclectic models reveal a great deal about their stated purposes and the state of contemporary eclecticism. Several authors (Beitman, Beutler) expressedly emphasize the notion of "systematic" eclecticism, as opposed to the unsystematic, seat-of-the-pants variant. Similarly, Dryden labels his approach "theoretically consistent" and Powell presents his as "integrated." Other contributors, like Driscoll and Hart, stress the bottom-line considerations of "pragmatic" and "functional," respectively. Still others have created novel titles (DiClemente's transtheoretical), intriguing acronyms (Steinfeld's TARET systems), and extreme positions (Robertson's radical eclecticism) to distinguish themselves from the garden-variety integrationism, which has acquired a negative valence in many professional circles.

To my mind, eclecticism refers to the integration of theoretical orientations/techniques *and* to the integration of therapy modalities.

However, the former has overshadowed the latter within the professional literature. Efforts to combine individual and marital/family therapy are occurring increasingly at both the conceptual and practical levels. Feldman (1985) has identified four basic forms of this integration: (1) *individually oriented*, in which the predominant format is individual with family interviews being utilized to enhance individual treatment; (2) *family-oriented*, in which the predominant format is conjoint family with individual interviews being utilized to enhance family treatment; (3) *symmetrical*, in which individual and family interviews occur with equal frequency; and (4) *sequential*, in which one approach temporarily follows the other.

Six of the thirteen contributors to this volume combined therapy modalities in their psychotherapeutic work. In two cases (Driscoll, Grebstein), the integration was family-oriented; in three cases (Beitman, DiClemente, Robertson), the integration was individually oriented. In the remaining case (Steinfeld), the format arrangement tended to be symmetrical. In all cases, the same therapist conducted the individual and marital/family interviews.

The case presentations are largely concerned with outpatient treatment of adults. Of the nine individually oriented cases, five pertain to the treatment experiences of adolescent and adult women. The presenting problems run the gamut of common psychopathology, devoid of psychotic disturbances, and are primarily neurotic (non psychotic) and functional (nonorganic) in origin.

All therapy, to my knowledge, was conducted on an outpatient basis.

Treatment length is multiply determined by numerous interacting forces. These include severity of the disorder, goals of therapy, setting for treatment, reimbursement for services, and the like. In addition, the length of treatment and selection of cases were probably influenced by the Case Guidelines (e.g., recommended duration of 5 to 25 sessions) and pragmatic considerations (such as preparation of transcripts). The reported number of sessions ranged from 6 to 30 and averaged 15. Though somewhat restricted by nonclinical factors, this number is nonetheless consistent with the length of psychotherapeutic services in the private sector. Similar estimates have been proffered by Taube, Burns, and Kessler (1984) for office based visits (Af = 12.5), by Koss (1979, 1980) for private clinic appointments (M = 13), and by Norcross, Nash, and Prochaska (1985) for the number of sessions in independent practice (M = 15).

Having now read and reviewed these cases on numerous occasions, I am struck by several recurring themes. For one, there is a venerable potpourri of innovative interventions throughout these cases. They undeniably employ multiple theories, techniques, and modalities. For another, all treatment is unavoidably rooted in and based on an *interpersonal* relationship. These patients' written reactions, like most retrospective accounts of therapy (Gurman, 1977; Strupp, Fox, & Lessler, 1969), highlight the importance of the

real relationship and the therapeutic alliance. The comments also reiterate the need for a description of psychotherapy offered to clients. Whether this goes by the name of role induction, expectation enhancement, or formal contract, explaining the nature of treatment is a human and therapeutic move.

Another lesson: psychotherapists need schemes to organize and prioritize the clinical material. Single theories reduce the information load considerably, but this advantage is lost when melding multiple theories. Beitman (Chapter 2) and Burlingame et al. (Chapter 4) emphasize treatment stages, DiClemente (Chapter 6) and Steinfeld (Chapter 14) emphasize levels of change, and Beutler (Chapter 3) and Clarkin and Rosnick (Chapter 5) emphasize the patient's personality style.

The contributors experienced marked difficulty in fully operationalizing their decision-making processes. We still rely largely on unarticulated, perhaps unconscious, rules for determining whether we "turn right or left" in the therapeutic arena. Dryden (1984, 1986), for example, outlines five major clinical decisions in any given case: selection of modalities, establishment of the therapeutic alliance, construction of frameworks to account for client variation, integration of various treatments interventions, and appreciation of changing therapeutic processes over time. Likewise, Frances, Clarkin, & Perry (1984; Perry, Frances, & Clarkin, 1986) organize their "differential therapeutics" around the choices of treatment setting, format (modality),

orientation, duration, and frequency.

These clinical cases are presented not as models of perfection to mimic, but as examples of fallible reasoning from which to profit. As in clinical pursuits, "coping models" are likely to be more acceptable and effective than "mastery models." John Dewey wrote (1966, p. 225) that "the method of science means 'emancipation,' it means reason operates within experience, not beyond it, to give it an intelligent and reasonable quality." This might be a motto for all psychotherapies: "an intelligent and reasonable quality."

In this context, my reading of the case commentaries leads me to conclude that they tended to be overly critical of incomplete eclectic models and fallible human practitioners. It is not, of course, our intention to disguise problems or to deny the existence of uncertainty. Nonetheless, our collective impatience with eclectic growth produces, in my judgment, premature criticisms.

This impertinent attitude toward psychological knowledge was eloquently described by Freud (1933/1965, p. 6):

> No reader of an account of astronomy will feel disappointed and contemptuous of science if he is shown the frontiers at which our knowledge of the universe melts into haziness. Only in psychology is it otherwise. There, mankind's constitutional unfitness for scientific research comes fully into the open. What people seem to demand of psychology is not progress in knowledge, but satisfactions of some other sort; every

> unsolved problem, every admitted uncertainty is made into a reproach against it.

Humans possess a nasty penchant for denigrating those who are most open and courageous in sharing their work. I have found psychotherapists to be of no exception in professional matters. If we were to critically evaluate our clients' vulnerabilities as harshly as those of our colleagues, few clinical practices would survive.

Nothing here should be interpreted as condemning critical evaluations and constructive criticism of nascent integrative/eclectic models of psychotherapy. Progress relies on research and reevaluation, and this *Casebook* represents a commitment to such progress. Still, we should heed Freud's (1933/1965, p. 6) warning that "whoever cares for the science of mental life must accept these injustices along with it."

GROWING PAINS OF ECLECTICISM

Sibling rivalry among theoretical orientations has a long and undistinguished history in psychotherapy. In the infancy of the field, therapy systems, like battling siblings, competed for attention and affection. Clinicians traditionally operated from within their own particular theoretical frameworks, often to the point of being blind to alternative conceptualizations and interventions (Goldfried, 1982b). Mutual antipathy

and exchange of puerile insults between adherents of rival orientations were very much the order of the day.

Perhaps these conflicts were a necessary precursor to sophisticated, mature eclecticism. Kuhn (1970) described this period as a pre paradigmatic crisis. Feyerabend (1970, p. 209) concluded that "the interplay between tenacity and proliferation is an essential feature in the actual development of science. It seems that it is not the puzzle-solving activity that is responsible for the growth of our knowledge, but the active interplay of various tenaciously held views."

Amid this strife and bewilderment, a therapeutic "underground" slowly emerged (Wachtel, 1977). Though not associated with any particular school and not detailed in the literature, the underground reflected an unofficial consensus of what experienced clinicians believed to be true. Adventuresome clinicians gradually employed strategies and modalities found successful without regard for theoretical origin.

On personal and organizational levels, eclecticism now seeks to define itself like the emerging child. Few universal rules exist, and identity is transitory. Under external pressure, such as a difficult therapy case or a theory-aligned convention, we can succumb to strong regressive pulls back to theoretical purity. Oh, how we can long for the simplicity of one-theory, one-

modality psychotherapy!

Integrative theory is rapidly outpacing practice (Prochaska, this volume) and training (Norcross, 1986). How we think and feel about therapy precedes how we practice therapy. Such is the contemporary state of systematic eclectic psychotherapy. And as Prochaska (this volume) aptly notes, changing our therapy practice requires taking action and maintaining this action lest we slip back into old habit patterns.

The integration of therapies, techniques, and modalities *is* a demanding, some would say an overwhelming, task. Thorne (1973) insisted that true eclectics are competent in *all* available forms of clinical intervention; only such a highly skilled and experienced therapist can possess the flexibility to be therapeutic for all clients. Lazarus (1967, p. 415) incredulously inquired, "Who, even in a lifetime of endeavor, can hope to encompass such a diverse and multifarious range of thought and theory?"

The expanding demands and boundaries of eclecticism raise profound questions. These demands challenge our tentative identity, test our human limits, and force a reevaluation of our goals. Following are representative questions with which I struggle.

- **How shall we identify ourselves?**

Perhaps as "eclectics," perhaps as "integrationists," or to avoid semantic confusion and ambivalent connotations, a new term derived from Latin or Greek. The issue runs deeper than titles, of course. How shall we feel about this new identity? A coherent identity (the me) requires repudiation of other roles (the not-me), be it psychoanalyst, behaviorist, existentialist, *ad nauseam*.

• Must eclectic practitioners be competent in all theories, techniques, and modalities?

A literal computation of all treatment possibilities staggers the imagination. One could make conservative estimates of 10 established theories, 100 interventions, and three modalities (individual, marital/family, group). The resulting combinations (10 x 100 x 3) would be 3,000 possible treatments! The delineation of a central and finite set of change principles or an enumeration of common interventions would reduce the magnitude of the enterprise dramatically.

• How many interventions or modalities can be integrated profitably within one brief psychotherapy case?

Several commentators point out that "more is not necessarily better" (Wilson, 1982). An inordinate number or mistimed combination of therapy practices can disrupt the flow and detract from priority goals. A delicate

balance must be maintained between therapeutic flexibility and treatment continuity.

• How do we empirically select among competing treatments?

Pioneering efforts to operationalize and codify the clinical decision-making processes are underway (see Frances, Clarkin, & Perry, 1984). Comparative outcome research has been, at best, a limited source of direction with regard to selection of specific conceptualizations and interventions. If our empirical research has little to say and if collective clinical experience has divergent things to say, then who is to say do A, not B? We may again be guided by selective perception and personal preference, a situation eclecticism seeks to eliminate.

• Where is the hard evidence that eclectic psychotherapy is more effective than non eclectic psychotherapy?

That is a very good question.

In closing, I firmly believe we need a "developmental" understanding of the status of eclectic psychotherapy, that is, to interpret the virtues and limitations of eclecticism within a developmental context. The field, though growing rapidly, is bound by its age, environment, and identity. The answers to these troublesome questions are the ultimate goals of eclecticism; the

mediating goals are to explore the possibilities.

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