THE CLINICAL EXCHANGE

Toward Integrating the Psychotherapies

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A metamorphosis is occurring in the mental health profession—the integration of the psychotherapies (Gurman, 1980; London, 1988; Moultrup, 1986). The last decade in particular has witnessed the stirrings of therapeutic rapprochement and a decline in the ideological cold war. The debates across theoretical systems appear to be less polemical or, at least, more issue specific. Clinicians of all persuasions are coming out of their theoretically monogamous closets (Held, 1986) to acknowledge the inadequacies of any one theoretical system and the potential value of others (Norcross, 1986).

The psychotherapy integration movement has experienced dramatic and unprecedented growth of late (Beitman, Goldfried, & Norcross, 1989). Consider, for example, that the plurality of American psychotherapists, between one-third and one-half, now identify themselves as eclectics or, increasingly, as integrationists (Norcross & Prochaska, 1988). Specific eclectic therapies (e.g., Beutler, 1983; Lazarus, 1981; Prochaska & DiClemente, 1984) and compilations of prescriptive treatments (e.g., Beutler & Clarkin, 1990;

Goldstein & Stein, 1976; Frances, Clarkin, & Perry, 1986) have appeared before receptive professional audiences. Leading counseling and psychotherapy textbooks (Brabeck & Welfel, 1985) demonstrate a growing trend toward an eclectic perspective, and when one evaluates the predictions of psychotherapy experts (Prochaska & Norcross, 1982), one discovers that eclecticism is likely to increase in popularity more than any other therapy system in the 1990s. Several interdisciplinary organizations committed to advancing the movement have been formed in the past ten years, notably the Society for the Exploration of Psychotherapy Integration (SEPI). (SEPI membership information may be obtained from George Strieker, Derner Institute of Advanced Psychological Studies, Adelphi University, Garden City, New York 11530.)

Even the federal government has gotten into the act. The National Institute of Mental Health (NIMH) sponsored a workshop on research in psychotherapy integration (Wolfe & Goldfried, 1988) in the expectation that treatments of greater efficacy, efficiency, and safety will result from efforts to integrate the best elements of different schools of psychotherapy. In addition, research on integrated treatment models may well lead to the development of a comprehensive model of psychotherapy process that will have solid empirical backing.

The notions of integrating various therapeutic approaches and of

securing an empirical base for clinical practice are hardly new. Indeed, eclecticism as a point of view has probably existed as long as philosophy and psychotherapy. In philosophy, a third-century biographer, Diogenes Laertius, referred to an eclectic school that flourished in Alexandria during the second century a.d. (Lunde, 1974). In psychotherapy, as is well known, Freud consciously struggled with the selection and integration of diverse methods (Frances, 1988).

However, it is only recently that integration has developed into a clearly delineated area of interest (Goldfried & Newman, 1986). A confluence of mutually reinforcing factors has produced the contemporary preoccupation with psychotherapy integration (see London, 1983; Norcross & Grencavage, 1989). Briefly stated, these factors are as follows:

1. The proliferation of brand-name therapies, leading to fragmentation, a deafening cacophony of rival claims, and excessive choice

2. The nascent consensus that no one approach is clinically adequate for all problems, patients, and situations

3. The equality of therapeutic outcomes, with some exceptions, ascribed to empirically evaluated therapies or, in the words of Perry London (1988, p. 7), "Meta-analytic research shows charity for all treatments and malice towards none."

4. The resultant search for convergence and common components across diverse schools

5. Socioeconomic pressures, such as the growth of the therapy industry and escalating demands for accountability, which have led to more intertheoretical cooperation and a more unified psychotherapy community

Three main thrusts have become evident in the contemporary movement to integrate the psychotherapies (Arkowitz, 1989; Norcross & Grencavage, 1989). *Eclecticism* refers to the technical, relatively atheoretical combination of clinical methods. As exemplified by the work of Lazarus (1967, 1989b) and Beutler (1983, 1986) among others, technical eclecticism is empirical in that it involves the pragmatic selection of extant procedures on the basis of their demonstrated efficacy, not their theoretical heritage. By contrast, *integration* denotes the conceptual synthesis of diverse theoretical systems. Theoretical integration, as manifested in the work of Wachtel (1977, 1987), Prochaska and DiClemente (1984, 1986), and others, is more conceptual than empirical in developing superordinate or metatheoretical models of psychotherapy. *Common-factor approaches,* as represented by Frank (1973) and Garfield (1980, 1986), seek to determine the core ingredients different therapies may share in common, with the eventual goal of constructing more efficacious treatments based on these components.

Consensual distinctions among these three thrusts have been established in the minds and practices of psychotherapy researchers (Wolfe & Goldfried, 1988), editorial consultants (Norcross & Napolitano, 1986), and most important, self-designated eclectic and integrative clinicians (Norcross & Prochaska, 1988). Accordingly, throughout this volume we will preserve these semantic distinctions. However, when referring to the general concern of synthesizing the psychotherapies, which includes technical eclecticism, theoretical integration, and common factors, we will use the terms *integration movement* and *psychotherapy integration.*

The Clinical Exchange Arrives

In 1982, the movement toward integrating the psychotherapies was marked and solidified with the founding of the *International Journal of Eclectic Psychotherapy* by Australian Jusuf Hariman. Beginning in 1986 with the journal editorship of John Norcross, a section called "Clinical Exchange" was launched under the stewardship of Nolan Saltzman. The journal's title was subsequently modified to the *Journal of Integrative and Eclectic Psychotherapy (JIEP)* to reflect the multiple paths toward synthesizing therapies, including theoretical integration and technical eclecticism. Over the years and despite improvements in the journal, the "Clinical Exchange" section has been consistently rated the most popular in *JIEP.*

The present book derives from the "Clinical Exchange" of the *Journal of Integrative and Eclectic Psychotherapy.* In the four years from 1986 through 1989, fourteen challenging cases were sent to panels typically composed of four authorities of differing clinical approaches. Their responses were compiled and published in the "Clinical Exchange" without benefit of dialogue or debate. In preparing this volume, we recontacted the panel members and asked them to review their original contributions for accuracy, clarity, and possible additions. More important, we enclosed reprints of their fellow panel members' journal contributions, and we asked them all to write to tell us where they agreed and disagreed regarding the therapeutic relationship, method, and process. Which of their colleagues' recommendations did they accept? Which did they reject? How much overlapping or blending of techniques did they acknowledge? We requested brief explanations for agreements and disagreements from their theoretical perspectives so that we could move beyond glib generalizations to fundamental convergences and divergences. This second round of responses was aggregated and is here published for the first time in the "Points of Contention and Convergence" sections at the ends of Chapters Two through Ten.

Virtually no opportunity exists for highly esteemed psychotherapists to consult with the same patient at the same stage of his or her treatment. (Note that we will employ the terms *patient* and *client* interchangeably because

neither term satisfactorily describes the therapeutic relationship and because we wish to remain theoretically neutral on this point.) "The Clinical Exchange" simulates this kind of situation by offering clinicians from various orientations a written account of a client at a particular time in therapy—typically at the initial consultation or at a moment of impasse. While the prospect of responding to a vignette on paper rather than to a person in the flesh may seem daunting, there are benefits in such an exercise. One is that the level playing field allows the reader to see what each panel member found or construed in the client or, as some might argue, projected onto the client. Furthermore, the reader begins on the same level playing field. Identical information is provided to everyone, and as the reader finishes the vignette, he or she is in exactly the same place as the contributors—facing the challenges of understanding patients and of assisting them. The potential for education, interchange, and dialogue is evident.

The "Clinical Exchange" section began with the brief case of a young man—Ken, the Spaceman (see Chapter Two)—who had already been seen by several mental health professionals and had been variously diagnosed as suffering from paranoid personality disorder, bipolar personality disorder, and schizophrenia. While the first panel was grappling with Ken and his extraterrestrials, we solicited future case material from the editorial board of the *JIEP* and selected members of SEPI. We also decided to include more

information on each patient and to ask standard questions of each contributor in subsequent exchanges.

Case contributors were reminded to alter the patients' names and to omit identifying information, while retaining characterological details and a close-enough depiction of circumstances. Since the cases were to be sent to practitioners using different approaches, there had to be enough data for everyone—enough history for the psychodynamicists to explore, enough behavior for the behaviorists to modify, enough thought for the cognitive therapists to restructure, and enough lively emotion to make the experiential therapist resonate with empathy. As "Clinical Exchange" editor, Saltz man persuaded clinicians to stow diagnostic jargon and replace it with the vivid original material of the sessions.

Saltzman also favored vignettes that retained some ambiguity as to diagnosis or severity of the disorder. It was anticipated—and hoped—that there would be different interpretations and recommendations. Specifically, an implicit premise was that the cases would, in most instances, be suitable for psychological treatment on an outpatient basis, but medication or even hospitalization could not be ruled out if a panelist's reading of a case required it.

We followed five general ground rules in choosing contributors. First,

the panels were composed of clinicians recognized as effective in dealing with the kind of challenge offered by the client in terms of possible diagnosis, demographic variables, and conditions of therapy. In selecting contributors, we recognized that some authors are proficient at describing an ideal version of their therapy but only fair to middling with real persons before them, while there are clinicians who, although less published, are well regarded by their peers for achieving exemplary outcomes. Both types had something to offer our enterprise and were invited to participate. Second, we made a conscious attempt to approximate current statistics on the prevalence of the various schools; thus, exponents of psychodynamic, eclectic/integrative, and cognitive-behavioral theories were invited relatively often because there are more practitioners working from these orientations. (Refer to Table 1.1 for the theoretical orientations of the case contributors.) Third, each panel member was to approach the case differently; that is, not more than one behaviorist or one psychodynamicist should be on any given panel. Fourth, we attempted to have at least one woman on each panel. And fifth, to help preserve the international flavor of the journal and to enhance perspective, Saltzman attempted to include foreign authorities on most panels.

Our original list of authorities to be solicited for contributions comprised clinicians who had published on integration and eclecticism and recognized exponents of one or another of the major approaches. In our

attempt to have at least one woman on each panel, we added the names of several women who had published less but who had stellar reputations as psychotherapists or supervisors in the training process. Nevertheless, since the list of potential panel members still included more males than females, the approximately even attrition of males and females from the list of invited contributors (individuals who generally cited inabilities beyond their control to respond within our publication deadlines) led to a mathematically determined consequence—an increase in the ratio of male contributors to female contributors.

For the purpose of this book, we have selected nine "Clinical Exchanges" from a pool of fourteen existing sections. Judging any exchange as more informative than another is admittedly a subjective and difficult matter. We were guided in our decisions by the vitality of case material, prominence of the contributors, diversity of the patient's demographics and presenting problems, and representativeness of the panel members' theoretical orientations and professional affiliations. In a few instances, we decided against publishing a response from an original contributor in the interest of length, and in two instances (Rice and Beitman), we invited new contributions to the original cases in the interest of balance.

In all instances, members of the panels were asked to address four central issues. These are as follows.

I. Diagnosis and characterization

    A. What is your diagnostic impression or problem formulation?

    B. What else would you need to know, and how would you typically obtain the information?

II. Therapeutic relationship

    A. What type of therapeutic relationship would you strive to create?

    B. How would you anticipate the client responding to this relationship?

III. Treatment methods

    A. What format or modality would you recommend?

    B. What would be your principal techniques or interventions?

IV. Therapy process

    A. How would therapy proceed from the first session?

    B. What would you expect and be wary of as therapy progressed?

Our Purpose

Within the context of the integration movement, this book was designed

to foster open inquiry and transtheoretical dialogue in terms of actual psychotherapy cases. Specifically, the purpose is for *eminent clinicians of diverse persuasions to share, in ordinary language, their clinical formulations and treatment plans for the same psychotherapy patient—one not selected or nominated by those therapists—and then to discuss points of convergence and divergence in their recommendations.* The novelty and popularity of the "Clinical Exchange" can, perhaps, be best understood by considering the constituent elements of its purpose.

First, we sought the participation of *eminent clinicians* who were widely recognized as authorities in the field. The objective was to compile responses not merely from representative, competent clinicians, but from prominent practitioners, authors, and researchers of psychotherapy. The list of contributors reads like a virtual *Who's Who in Psychotherapy*; few experienced therapists will fail to recognize immediately the names of Arnold Lazarus, Judd Marmor, Albert Ellis, Allen Frances, James Bugental, and Paul Wachtel, among others.

Table 1.1. Theoretical Representation of Case Contributors.

Theoretical Orientation	Chapter Number	Contributor
Psychoanalytic/Psychodynamic	2	Marmor
	2	Kline

	3	Strieker
	4	Wachtel
	5	Sharma
	7	Bachant
	7	Ujhely
	8	Messer
Person-Centered	3	Rice
Cognitive/Rational-Emotive	2	Ellis
	5	Davison
	7	Goldfried
	8	Thompson
	9	Safran
Behavioral	3	Powell
	5	Davison
	7	Goldfried
Experiential/Gestalt	3	Mahrer
	6	Saltzman
	7	Greenberg

Humanistic/Existential	5	Bugental
	8	Lederman
	10	Fraillon
Systems/Family	9	Textor
	10	Guerney
	10	Kirschners
Eclectic/Integrative	2	Frances
	4	Lazarus
	4	Davis
	4	Wachtel
	5	DiClemente
	6	Beutler
	6	Eth and Harrison
	8	Beitman
	9	Sollod
	10	Guerney

Second, the invited contributors were purposefully of *diverse persuasions,* because meaningful transtheoretical dialogue and knowledge

acquisition require the active interplay of various tenaciously held views (see Feyerabend, 1970; Kuhn, 1970). Our thirty-four members represent all the leading systems of psychotherapy, as is evident in Table 1.1. Indeed, the proportional theoretical representation closely parallels that found among mental health professionals throughout the United States. Eclectic/integrative and psychoanalytic/psychodynamic vie for the most common orientation, followed by family/systems, cognitive, behavioral, and humanistic approaches closely grouped together (cf. Norcross, Strausser, & Faltus, 1988).

Both the editors and the contributors experienced difficulty in placing psychotherapists under a single, crude rubric of theoretical orientation. The result of this necessary, categorical evil was to list contributors under two theories or under eclectic/integrative at times. In ten years, and in subsequent books of this nature, we hope the impact of the psychotherapy integration movement will have made such classification along theoretical lines unnecessary and obsolete.

Representative diversity of two other sorts—professional discipline and biological gender—was also desired. With regard to the former, our contributor list comprises twenty-three psychologists, seven psychiatrists, three psychotherapists, and one psychiatric nurse. However, for reasons previously mentioned, only six of the contributors are women.

Third, each psychotherapeutic tradition has its own jargon, a clinical shorthand among its adherents that widens the precipice across differing orientations. The so-called language problem, as it has become known, confounds understanding of one another's constructs and, in some cases, even leads to active avoidance of those constructs (Goldfried, 1980). Isolated language systems encourage clinicians to wrap themselves in semantic cocoons from which they cannot escape and which others cannot penetrate. Code words are used to express one's theoretical identity, one's sharing in the brotherhood, one's expertise with the rituals (Colby & Stoller, 1988). As Lazarus (1986a, p. 241) tartly concluded, "Basically, integration or rapprochement is impossible when a person speaks and understands only Chinese and another converses only in Greek!"

Accordingly, contributors to this volume were asked to write in *ordinary language* in order to facilitate communication and comprehension. Ordinary, descriptive language by itself will not establish theoretical consensus, of course (Norcross, 1987a). However, before we can agree or disagree on a given matter, we need to ensure that we are in fact discussing the same phenomenon. Punitive superego, negative self-statements, and poor self-image may indeed be similar phenomena, but we cannot know with certainty until they are defined operationally and consensually (Strieker, 1986).

Fourth, responses to each case from the "Clinical Exchange" focus on *the*

same psychotherapy patient—one not selected or nominated by those therapists. Many observers have lamented the failure of psychotherapists to concentrate on the specific issues and circumstances of particular patients (cf. Siberschatz, Curtis, & Nathans, 1989). Strupp (1986a), among others, has concluded that psychotherapy research will advance to the extent it is geared to the specific dynamics of particular patients and in-therapy interactions. Much of the apparent disparity among theoretical prescriptions is precisely this neglect of idiographic case material and the concomitant proliferation of nomothetic formulation. We can begin to compare psychotherapies intelligibly and to examine their potential convergence in terms of treatments of the same patient with identical information available to all.

As psychotherapy trainees, we were impressed that the clinical cases presented by textbook authors were, invariably, beautifully formulated and successfully treated. We were rarely apprised in our readings of clients who were referred elsewhere, who terminated prematurely, or who were unsuccessful in their therapeutic quests. Little did we realize back then that these idyllic outcomes were as much due to the psychotherapist's biased reconstruction and selective recall as they were to the facts of the case.

One colleague, after listening incredulously to his cotherapist's tale of clinical heroics with a mutually known client, quipped, "Any resemblance of this case presentation to any actual case is purely coincidental." It is a sad but

accurate observation on many published psychotherapy cases.

The cases in *Therapy Wars,* by contrast, were not hand-picked by the contributors to illustrate a theoretical point or to validate a therapy system. These cases feature complicated clients, realistic clients, frequently resisting therapy or at an impasse in their treatment—just as one encounters daily in clinical practice.

Finally, after sharing their clinical formulations and treatment plans of the same patient, these psychotherapists *discuss points of convergence and divergence in their recommendations.* This dialogue stands in marked contrast to the overwhelming bulk of case material, which does not afford alternative conceptualizations or opportunities for consensual validity of the posited conclusions. Our format makes a clean break with what Spence (1982) has labeled the "Sherlock Holmes tradition" by developing case presentations that allow the reader to participate in the dialogue, to evaluate the proposed links between evidence and conclusions, and to consider the possibility of alternatives, even of refutations. Collectively, this format increases learning opportunities, explanatory force, and respectful exchange.

The Cases

Case material rightfully counterbalances soaring metapsychology and

concretely illustrates technical concepts. Cases provide a coupling of the abstract with the concrete, the intellectual awareness and the felt experience. Theorizing becomes pragmatic (Driscoll, 1984) and consequential (Berger, 1985)— relevant to what transpires in clinical practice. Clinical data render books more readable, interesting, and most of all, useful (Norcross, 1987b).

Table 1.2 provides an overview of the nine cases in terms of title, patient demographics, and diagnostic impressions. Demographically, the cases concern young and middle-aged adults presenting for therapy individually. The cases are primarily, but not exclusively, middle-class Caucasians. The patients range in age from nine to forty-four. There are no clients past middle age, which is probably a shortcoming. In seven of the cases, one individual is the focus of the interview; one case each addresses a married couple and an intact family. Three women and four men make up the seven individual cases. This gender ratio is a refreshing change from the traditional reliance on female cases presented by male therapists.

Table 1.2. Patient Demographics and Diagnostic Impressions by Case.

| Chapter Number | Case Title | Patient Demographics | | Diagnostic Impressions |
		Age	Gender	
2	The Spaceman	20	male	Paranoid or Borderline Personality Disorder

3	The Diplomat	28	male	Anxiety Disorder Passive-Aggressive Personality Disorder
4	The Wallflower	30	female	Dysthymic Disorder Borderline or Masochistic Personality Disorder
5	The Envious Lover	29	male	Substance Abuse Mixed Personality Disorder
6	The Survivor	28	female	Post-Traumatic Stress Disorder Depersonalization Disorder
7	The Don Juan	44	male	Panic Disorder Schizoid or Borderline Personality Disorder
8	The Make-Up Artist	27	female	Borderline or Narcissistic Personality Disorder
9	The Returning Hero and Absent Wife	38 32	male female	Marital Problem Hypertension Compulsive or Schizoid Personality Disorder Post-Traumatic Stress Disorder
10	The Adopted Sister	9	female and family	Family Problem Attention Deficit Disorder with Hyperactivity

Diagnostically, these cases run the gamut of common presenting problems and psychopathology, excluding psychotic disturbances. The diagnostic impressions presented in Table 1.2 are the product of the coeditors' consensus based on the case material available. These diagnoses are not necessarily those advanced by the contributors, who often disagreed among themselves on the specific disorder and even the utility of formal diagnoses.

Significantly, six of the seven individual therapy patients carried the

consensual diagnosis of a personality disorder. Our penchant for these difficult and challenging cases may have contributed to the prevalence of Axis II diagnoses. Nonetheless, personality disorders are being diagnosed with increasing frequency in clinical practice, whether due to artifactual or real increases in their prevalence, and a sizable portion of contemporary clinical practice concerns itself with these clients.

Here, then, are nine stimulating psychotherapy cases and the instructive responses of first-rate clinical minds. We hope that you will find the cases as intriguing, and the exchanges of the panelists as enjoyable, as we did.

Authors

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Dr. Saltzman has taught at New York University, Pace University, and the New School for Social Research. He has made presentations on integrative psychotherapy at Downstate Medical Center, State University of New York, and at the National Institute of Mental Health. He maintains his strong scientific interests through research and teaching at the City University of New York, where he gave the "Brain, Mind, Behavior" lectures in conjunction with the Public Broadcasting System. He lives in New York City with his wife and son.

John C. Norcross is chair and professor of psychology at the University of Scranton, a clinical psychologist in part-time independent practice, and past editor-in-chief of the Journal of Integrative and Eclectic Psychotherapy.

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Author of more than eighty publications, Dr. Norcross's main research interests pertain to integrative psychotherapy, self-change, and the person of the therapist. He has authored/ edited several books, most recently the Casebook of eclectic psychotherapy (1987). He has served as a clinical and research consultant to a number of organizations, including the National Institute of Mental Health and "CBS This Morning." He resides in Mt. Cobb, Pennsylvania, with his wife and two children.