THE CONTENTION AND CONVERGENCE IN THE PSYCHOTHERAPIES

John C. Norcross
Nolan Saltzman
Lucia C. Giunta

Contention and Convergence in the Psychotherapies

John C. Norcross
Nolan Saltzman
Lucia C. Giunta

e-Book 2016 International Psychotherapy Institute

From *Therapy Wars: Contention and Convergence in Differing Clinical Approaches* edited by Nolan Saltzman and John C. Norcross

Table of Contents

Contention and Convergence in the Psychotherapies

John C. Norcross

Nolan Saltzman

Lucia C. Giunta

Observing patterns in the nine clinical exchanges and interpreting their significance is at once exciting and daunting. We are excited by the rich insights of thirty-three clinicians, the remarkable amount of information, the vigor of the exchanges, and particularly the novelty of the entire enterprise. Simultaneously, we are daunted by the challenge of doing justice to it all in a brief, concluding chapter.

Of the many topics that might have been addressed in an epilogue, we have selected three. First, we review the mission of the book, and we address, from several perspectives, the success in fulfilling it. Second, we share qualitative impressions formed while organizing, reading, and editing the contributions. Third, we present quantitative data from statistical analyses of the contributions. In these three ways, we hope to inform future dialogues on clinical material as well as research studies on psychotherapy integration.

Has Our Mission Succeeded?

Of diverse voices is sweet music made
So in our life the different degrees
Render sweet harmony among these wheels.

Dante (*Paradiso* Canto VI)

Have the diverse voices in this volume made sweet music? We must ask whether these clinical exchanges produced the intended benefits.

An affirmative response comes from the contributors. Behaviorally, all but one of those invited to contribute to the book agreed and subsequently did. These are busy and eminent clinicians, for whom a writing assignment is more often a chore than a prize. They offered a number of unsolicited remarks that, in our editorial experience, exceeded the norm for collegial compliments: “In all my years, I have never had such an opportunity”; “exciting project”; “very innovative idea”; “extremely stimulating”; “very valuable”; and so on.

A similarly positive response comes from the editors. We were particularly pleased that our emphasis on the process of exchange, as opposed to the outcome, was apparently evident to the contributors and to early readers.

To reiterate, the mission was not necessarily to produce rapprochement or synthesis. Neither exaggeration nor minimization of genuine differences was sought. Rather, the process of the exchange—encountering alternative, even rival, perspectives—was valued, and that may or may not eventuate in integration. Where differences remain, they should affect the world of human experience and clinical practice.

Now, for a few of the rewards of editing the Clinical Exchange section of the *JIEP* over the past four years and developing this book from it. We were surprised ourselves at how stimulating and downright educational for us the project could be at times. We have been apprised of unfamiliar techniques, and we have learned much about the range of therapist stances toward clients—from delicate and self-effacing to abrasive and directive.

When Alvin Mahrer (Chapter Three) responded to Michael's excuse for being late—that he had been up for two nights anticipating the session—with the remark, "That's something! You started to leave for here two nights ago?" we laughed and knew Michael was in good hands.

When Janet Bachant (Chapter Seven) interpreted Hal's dread of dying as a feeling that his life was already over, that his mortality was not just something that would happen to him, but was present within as his experience of himself, we felt the shudder of insight.

When Janus Fraillon (Chapter Ten) queried, “What harvests do the Banners reap?” we were boosted to a higher philosophical perch from which to think about the assumptions of therapy. And so on throughout the book.

Similar moving moments occur elsewhere in the literature, but they are rare. Clinicians, like other people, do not appear at their best while controlling all the variables to create a favorable impression. When psychotherapists provide themselves with the perfect illustration of their own therapies, they tend to be less spontaneous and convincing than they appear here, where the challenge of responding to cases not of their own choosing evidently opened the window of inspiration. It has been a joy to share that inspiration with our contributors and to pass it along to our readers; and we hope that our gratifying experience may inspire future symposia on clinical cases.

Qualitative Impressions

We expected the clinical exchange to be an interplay of discovery and justification in which one’s formulations and intuitions were provisionally advanced without denying the possibility of alternatives. No recommendation was to be beyond cavil, but the discord would be respectful and factual. Many responses were indeed in this vein. However, we received something different in some cases; some exchanges were more hostile, more divisive, and less provisional than we had anticipated.

In this section, we share consensual impressions formed while organizing, reading, and editing this volume—the excessively critical tone of several exchanges, the miscomprehension among some panelists, and the paucity of informed pluralism or integrative attempts in the exchanges. In so doing, we are acutely aware of the irony of criticizing our collaborators for being overly critical at times. The objective is not to place blame, but to illuminate barriers to genuine comprehension and possible integration of disparate psychotherapies. Alexis de Tocqueville once wrote, "Men will not receive the truth from their enemies, and it is very seldom offered to them by their friends." Our intent is to offer friendly and constructive criticism.

The occasionally hostile tenor of the exchanges was manifested in the word choice: "social manipulative games," "therapeutic misadventure," "wildly speculative," and "superficial interpretation." These do not convey the respectful disagreements one hopes to hear from eminent clinicians. The propensity for hostile discord is apparently ingrained in many of us from our earliest professional socialization and reinforced throughout our careers—so ingrained, in fact, that there is an implicit expectation that one should find cardinal disagreements. This expectation led to an ironic apology from one of our panelists: "Sorry, but I did not find many points of contention with respect to my fellow contributors' responses."

We had an overall impression that many psychotherapists shun

approaches with which they lack experience, or for which they have a temperamental disinclination. There were moments as we read the "Points of Contention and Convergence" section concluding each chapter when it appeared that the more some clinicians are exposed to what others are thinking and doing, the more defensive they become to protect the purity of their own approaches (Goldfried, 1980). In these instances, *Therapy Wars* seemed an appropriate title as proponents of other views were indeed treated as opponents and as the tone of debate turned petulant.

Sometimes our panelists' theoretical orientations not merely kept them from appreciating their colleagues' views, hence foreclosing integrative possibilities, but also, apparently, caused them actively to misread their colleagues' responses. One of the pernicious effects of theoretical orientations (Adams, 1984; Norcross, 1985) is that inveterate proponents consciously or unconsciously miscomprehend alternative perspectives. We fully expect that many contributors, upon reading the contentious remarks made about their treatment recommendations, will complain that they were misunderstood. As Goethe put it, the world has not really known me.

Miscomprehension breeds debate on the misrepresented version. If the reader did not catch these lapses, there is a good reason: we generally deleted them or added a phrase to correct them. It may have been worthwhile, for the sake of accurately reflecting the state of our movement, simply to observe

that a misreading had occurred, without mentioning the culprit by name. But we declined in several instances to let the misreading pass where it would have detracted from an otherwise valuable debate. We were not entirely consistent in this policy, because there were instances in which the necessity to preserve contention won out. Still, our focus was on the contributors' many valid points of contention (and convergence), not on these occasional excursions to fence with straw men. Here are three instances of the latter.

1. An author in the panel on "The Diplomat" (Chapter Three) misrepresented Mahrer by alluding to "instincts closer to the center of Michael's conflicts"; but instincts is not a word that Mahrer used or would be inclined to, even if some mean editor rationed the number of times he would be allowed to write inner experiencing in any one paragraph.

2. A panelist on the case of "The Survivor" (Chapter Six) ignored that Saltzman states that he elicits climactic expression as part of a learning experience, "never for ventilation." Further, the panelist also cites a dearth of evidence for the therapeutic value of "ventilation without redirection," and relatively good evidence for harmful effects of "such escalation." Since Saltzman does not propose ventilation, but a different process—emphasizing spontaneous validating responses—with a different theoretical basis, it is not relevant evidence that is being invoked against his approach, but a conclusion probably extended beyond its range of applicability.

3. A respondent found the presenting psychotherapist for "The Returning Hero and the Absent Wife" (Chapter Nine) to have a rather patronizing and pathologizing attitude toward the couple, even going so far as to say that the description of Carl as "ethical" was condescending. In fact, Carl and Trudy were much admired by the presenting therapist as survivors and vital human beings. An objective reading does not detect condescension here.

Nor can the lively debate be solely attributed to disparate pure-form psychotherapies. The discord in Chapter Four, in which three eclectic/integrative therapists responded, demonstrates the fallacy of the "uniformity myth" (Kiesler, 1966). Competent clinicians can always locate deficiencies in a colleague's work, even one of the identical theoretical orientation. We echo Beutler's belief (Chapter Six) that generic categorization of psychological treatments into brand names is of little value.

Another overall impression of the exchanges is that they did not adequately exhibit modest and informed pluralism. The definitive nature of the formulations and the warlike quality of the debate are hardly justified in the absence of broad consensus on the psychotherapies of choice for most mental disorders. More provisional recommendations would be more consistent with our knowledge base. This modest attitude could be modeled on Saltzman's (Chapter Six) admission that, since he had not treated clients by the means he declined, his preference is nothing more than his preference.

We—any of us—could be wrong.

Surprisingly few contributors acknowledged the well-validated finding that tested psychotherapies tend to work equally well with most clients (Lambert, Shapiro, & Bergin, 1986; Luborsky 8: Singer, 1975; Smith, Glass, & Miller, 1980). Technically diverse psychotherapies produce approximately equivalent outcomes—the *equivalence paradox,* as it has become known (Stiles, Shapiro, & Elliott, 1986).

Several contributors did, however, explicitly recognize in their remarks the potential efficacy of disparate approaches. Milton Kline emphasized the selection of intensive dynamic psychotherapy using hypnosis in the case of "The Spaceman," but he did "not feel that other therapeutic modalities would not be effective." Douglas Powell was struck by how many ways there were to do right by "The Diplomat"; significant benefit would occur by working with any of the panelists in that case. By the same token, both Martin Textor and Robert Sollod in Chapter Nine embraced integrative pluralism in accepting the validity of a number of experiential and therapeutic domains. As editors, we were delighted by these respectful and integrative remarks.

In the panels' responses to the case vignettes in the *JIEP,* integration did not come easily, and often it did not come at all. Early on, "Clinical Exchange" editor Saltzman wrote editor-in-chief Norcross, "How long before my

colleagues ask me, 'What are you trying to do, prove integration can't work?' " A similar sense is reflected by Douglas Powell considering the other three panelists' responses to the case of "The Diplomat" (Chapter Three). Yet, if his own integrative approach is more efficacious than it would have been years ago, we are making progress. Beyond rational attempts to assimilate, the psychotherapist, like an artist in any medium, will be subconsciously influenced by what others are doing and thinking. In this vein, Carlo DiClemente (Chapter Five) observed, "Psychotherapy continues to elude formal consensus and integration, while becoming more homogeneous at the level of practice."

Quantitative Data

The psychotherapy integration movement, by common decree, lacks empirical research on both the process of synthesizing various approaches and the outcomes of these integrative or eclectic treatments (Beitman, Goldfried, & Norcross, 1989; Lambert, 1986; Wolfe & Goldfried, 1988). Indeed, inadequate empirical research on integration is rated one of the most severe impediments to psychotherapy integration (Norcross & Thomas, 1988). Proposals to advance therapeutic rapprochement and the integrative process typically stem from battle-weary experience, questionnaire surveys, or armchair speculation. Further, there is little unambiguous evidence of the

clinical superiority of a theoretically integrative or technically eclectic approach over a pure-form or "brand-name" approach. However, it is important to note that the reverse is true as well (Wachtel, 1983).

Integration without clinical and research documentation is likely to fail (Prochaska & Norcross, 1986). Integration becomes an academic exercise by ignoring the clinical realities and complexities of psychotherapy. Conversely, integration becomes a clinical exercise by slighting empirical discovery and verification. Hence, clinicians and researchers both have critical roles to play in documenting the applicability and efficacy of integrative models of practice.

We conducted a quantitative analysis of the thirty "Points of Contention and Convergence" responses to provide preliminary empirical data on the integrative process and to complement our qualitative impressions of the same responses. We did so, however, only after considerable reflection and friendly debate on honing the questions and on establishing the criteria prior to "crunching the numbers," because in the desire to make observations scientific, it is easy to make them too narrow.

Many are the potential pitfalls of transforming complex clinical reasonings to countable yeas and nays. The results can depend on implicit grouping decisions or unconscious biases. Gross categories of accord and

discord can wind up comparing plates of apples and crates of oranges. As one breaks down the questions into finer probes, the discriminations become more meaningful, but the numbers get smaller and less representative. Moreover, reasonable humans can arrive at reasonably different conclusions as to what constitutes contention or convergence. A case in point is Paul Wachtel's remark (Chapter Four) that a psychoanalyst's "interpretation" can really be behavioral—a punishment of the patient.

With our ambivalent mix of distaste for simplistic number crunching and respect for empirical research, we proceeded to examine two broad questions related to convergence and divergence in clinical practice. First, what content areas are most likely to lead to accord or discord among clinical practitioners? Our experience in editing the "Clinical Exchange" and in reviewing fifty publications that proposed therapeutic commonalities (Grencavage & Norcross, 1990) led us to believe convergence was possible, more often than not, on the recommended therapeutic relationship. Alternatively, Goldfried (1980) observed that it is unlikely we can ever hope to reach common ground at the theoretical or philosophical level, and he contended that the search for commonalities across approaches in the realm of specific techniques would probably not reveal much more than trivial points of similarity. Goldfried suggested that the possibility of finding meaningful consensus exists at a level of abstraction that he labeled *clinical*

strategies, somewhere between global theory and specific technique. The experimental method and coding system of the following analyses (see Table 11.1) were designed as a provisional test of Goldfried's proposition and ours.

The second broad question we attempted to address concerned what might be termed the rhetoric of justification. Specifically, if you reject a formulation or a technique of another panelist, why? What are the sources of evidence for your disagreement? From the research literature? From your theoretical underpinnings? From clinical experience? (See Table 11.2 for the coded sources of accord and discord.)

Method. True to clinical realities and our fears, problems were encountered both in counting agreements and disagreements and in classifying them into mutually exclusive categories.

Table 11.1. Frequency of Agreements and Disagreements by Content.

	Agreements		Disagreements	
Content	Frequency	Percentage	Frequency	Percentage
Obtaining particular information	12	4%	3	1%
Patient characteristics/Case formulation	72	27%	48	23%

Therapist qualities	11	4%	7	3%
Treatment structure/Therapy format	26	10%	16	8%
Therapeutic relationship	39	14%	16	8%
Treatment goals	28	10%	12	6%
Specific techniques	33	12%	48	23%
Clinical strategies/Change processes	34	13%	14	7%
Global theory	3	1%	24	12%
Not codable	13	5%	18	9%
Total	271	100%	206	100%

Table 11.2. Explicit Sources of Agreements and Disagreements.

	Agreements		Disagreements	
Source	*Frequency*	*Percentage*	*Frequency*	*Percentage*
Clinical experience	0	0%	6	3%
Research literature	1	<1%	14	7%
Clinical intuition	0	0%	0	0%
Theoretical orientation	8	3%	36	17%
Personal values	10	4%	1	<1%
Combination of above	4	1%	6	3%
Not specified	242	89%	125	61%

Not codable	6	2%	18	9%
Total	271	100%	206	100%

It was difficult to discern on occasion whether agreement or disagreement was intended by the respondent. For example, how does one code Larry Beutler's statement (Chapter Six) "I do not disagree . . . but I urge caution"? (We took him at his word and did not count it as evidence of discord.) Arnold Lazarus (Chapter Four) provided another illustration with his comment that a particular case formulation was "debatable." This was considered a disagreement, as was Marvin Goldfried's statement (Chapter Seven) that "nonspecific use of free association . . . was too open-ended."

The objective was to record the number of fellow panelists with whom each agreement or disagreement was made, offering no distinction between a major or minor point. We often experienced difficulty in differentiating between a central disagreement and a corollary or extension of that same point of contention. Moreover, there was no attempt on our part to account for the magnitude of agreement or disagreement. Thus, Milton Kline's (Chapter Two) mild and tentative reframing—"Perhaps the use of indirect rather than direct advice might be more consistent with my overall approach"— received the same weight as Albert Ellis's (Chapter Two) strong and definitive "Hogwash!" Our quantitative ratings do not reflect these differences.

Several psychotherapists expressed general accord or discord with the other panelists without specifying individual points. Alvin Mahrer (Chapter Three) stated, “On all other points, I seem to differ with all three other respondents.” Martin Textor’s (Chapter Nine) section proved to be a unique instance of collegial affirmation: “Thus, I agree with nearly all of Sollod’s and Safran’s thoughts on how to treat Carl and Trudy.” Janus Fraillon (Chapter Ten) tartly but indirectly took exception to the clinical formulations and treatments of his fellow respondents. However, the abundance of oblique criticisms and the absence of specific disagreements made it a particularly difficult response to code. As a final example, Janet Bachant (Chapter Seven) implied agreement and disagreement based on the theoretical perspectives of the other contributors to the case. In this and other instances, we made consensual judgments on the basis of the theoretical orientation of the contributors.

A final coding problem embodies the inseparability of technique, strategy, and relationship in actual practice. Specific delineation among these categories was not always evident. When George Strieker (Chapter Three) and Bernard Beitman (Chapter Eight) shared a colleague’s emphasis on empathic responding, were they agreeing with a technique, a strategy, a stance toward the therapeutic alliance, or all three? Similarly, are exposure and psychoeducation specific techniques, clinical strategies, or entire

theories?

These coding quandaries reminded us that the value of a clinical intervention is inextricably bound to the relational context in which it is applied. Hans Strupp (1986a) offers the following analogy to illustrate the inseparability of the constituent elements of psychotherapy: Suppose you want a teenage son to clean his room. One technique for achieving this is to establish clear standards. Fine, but the effectiveness of this technique will vary depending upon whether the relationship between you and the boy is characterized by warmth and mutual respect or by anger and distrust. This is not to say that the technique is useless, merely that how well it works depends upon the context in which it is used.

Results and Discussion. These methodological problems and prefatory caveats notwithstanding, the statistical analyses yielded interesting data on general patterns and preliminary answers to our two broad questions. The length of the "Points of Contention and Convergence Responses," defined as the word count prior to light, prepublication editing, averaged 830 words, with a standard deviation of 374. On the low end were Milton Kline, Gertrud Ujhely, and Shridhar Sharma with fewer than 400 words each. Unquestionably at the upper extreme was Albert Ellis with more than 2,000 words—over 600 more than the closest wordsmith.

Did accord or discord win the day, numerically speaking? For individual respondents, the average number of coded agreements was 9.0 (SD = 6.2), with a range between 0 (Janus Fraillon) and 27 (Douglas Powell). The average number of coded disagreements was 6.9 (SD = 4.9), with a range between 2 (Shridhar Sharma) and 26 (Alvin Mahrer). Sixteen of the thirty psychotherapists expressed more agreements than disagreements; three therapists expressed exactly the same number of each. For the entire group, as shown in Table 11.1, total agreements numbered 271 and total disagreements totaled 206. Individually and collectively, convergence was more frequent than contention.

Why, then, are many readers, including us, left with the impression of more quarrelsome and contentious exchanges?

One reason lies in the differential length of the agreements and disagreements. Accord is typically expressed briefly by words to the effect that "we all agree that . . "—in contrast to the lengthy explication of discord and presentation of an alternative. The differential length is probably attributable to professional socialization, which rewards promulgation of distinctive elements but accords little glory to identification of common features (Frank, 1973), and to our editorial instructions, which enjoined contributors to provide short explanations for agreements and disagreements so that we could move beyond glib generalizations. Few contributors

elaborated on the convergence; however, virtually all elaborated on their divergence. Unless the reader attends closely to the text—or literally counts as did we—then length alone can mask genuine accord and exaggerate discord.

To test this hypothesis, we correlated the number of words in a contribution with both its number of agreements and number of disagreements. The correlation with frequency of accord ($r = .05$, $p = .39$) was statistically and clinically insignificant. However, the correlation with frequency of discord was highly significant ($r = .46$, $p = .006$), confirming our impression that length was systematically related to discord.

Table 11.1 presents the frequency of explicit agreements and disagreements among contributors by specific content area. To illustrate our coding system for content area, we present a representative example for each of the nine categories in which agreements and disagreements were counted.

Obtaining Particular Information. In the case of "The Spaceman," Marmor expresses the need for more information about the client's developmental history and personality patterns "before arriving at a definitive diagnosis." Ellis agrees that more information is necessary; however, he disagrees with Marmor on the type of information needed. Specifically, Ellis highly values information on Ken's main irrational beliefs

and his reactions to the first few therapy sessions.

Patient Characteristics/Case Formulation. The case of "The Diplomat" provides an excellent example of this category. For example, Strieker agrees with Rice's assessment that Michael is appealing, with Powell's overall formulation of the case, and with Mahrer's interpretation of Michael's fantasies.

Therapist Qualities. Sollod, in "The Returning Hero and the Absent Wife," expresses concern about his own (and others') incomplete understanding of the case and encourages a more empathic and tentative stance. He also addresses the therapist's attitude toward clients, criticizing Textor's account as reflecting a "pathologizing attitude."

Treatment Structure/Therapy Format. In the case of "The Adopted Sister," we scored an agreement and several disagreements on structure and format. All the panelists would arrange separate sessions with each individual in the family (besides the other formats). Both Guerney and the Kirschners propose a conjoint family format; however, the Kirschners specifically recommend individual or couple sessions, or both, to address marital problems.

Therapeutic Relationship. There is some agreement among the

psychotherapists on being relatively nondirective for "The Envious Lover," although their reasons for being nondirective vary. Bugental advocates an approach that is less therapist focused than that of Davidson. Davidson, however, says his approach would be the same regardless of diagnosis, implying that the diagnosis is secondary to the relationship.

Treatment Goals. In the case of "The Returning Hero and the Absent Wife," all the panelists delineate goals of their therapeutic encounters. Safran would like to see the clients become more aware of their feelings and learn to communicate them to one another. Textor hopes to help improve the parental performance of the clients. Sollod proposes helping Carl and Trudy understand their own and each others' disorders.

Specific Techniques. In the case of "The Make-Up Artist," Beitman and Messer decline Lederman's bio-energetic techniques, and Lederman declines Beitman's triple-column diary. These and other disagreements on specific techniques probably reflect deeper differences in assessing the patient and in the role of therapy.

Clinical Strategies/Change Processes. In the case of "The Survivor," there are several instances of accord and discord on clinical change strategies. Eth and Harrison agree with Beutler's warning against "mobilizing" volatile emotions. They also agree with Saltzman's proposal to confront Anne's use of

the word “punishment.”

Global Theory. In “The Don Juan,” Bachant’s orientation emphasizes a “focus on the development and emergence of unconscious material” and on the analysis of transference. By contrast, Greenberg and Goldfried adopt substantially different theoretical approaches to the case—approaches that reject Bachant’s focus.

Looking at agreements again in Table 11.1, we found that patient characteristics, therapeutic relationships, and clinical strategies received the most endorsement. Specific techniques, patient characteristics, and global theory, on the other hand, were the most frequent areas of disagreement.

Both our and Goldfried’s predictions on the content areas most amenable to consensus received moderate empirical support. Agreements on the desirable therapeutic relationship accounted for 14 percent of all agreements, but only for 8 percent of all disagreements. Similarly, accord on clinical strategies accounted for 13 percent of the agreements, but only for 7 percent of the disagreements. This pattern was reversed, as Goldfried (1980) predicted, on specific techniques and global theory. These content areas accounted for 12 percent and 1 percent, respectively, of total accord, but for 23 percent and 12 percent of total discord.

A failure of research such as that represented in Table 11.2, which was intended to show the sources of agreement and disagreement, is customarily not published. When a preponderance of the data falls into the "not specified" category, the routine "scientific" treatment is to blot out any trace of the original query. However, in research as in life, one can learn from one's failures. Here, the fact that clinicians did not articulate (in 89 percent of their agreements and in 61 percent of their disagreements) the requested rationale for the acceptance or rejection of their colleagues' recommendations turns out to be an unexpected value of the research.

One searches in vain for explicit justifications in many exchanges. Frequently implicit was the message "I disagree because I personally wouldn't do it that way." This pattern is problematic, in our view, for many reasons. First, although exchanges of this type promote diversity and intellectual stimulation, they are often not productive because they essentially pit one person's opinion against another's. Second, there is no opportunity for confirmation or disconfirmation. Everyone does his or her own clinical "thing," and who or what is to say one is better than the other? Third, we find the paucity of explicit justification for clinical preferences dismaying in that psychotherapists' treasured proficiencies, rather than outcome research and client needs, seem largely to dictate clinical decision making.

Correspondingly, the research literature was rarely brought to bear on the rhetoric of justification. Only 8 percent of the disagreements—7 percent coded as research literature plus 1 percent included in the combination category—cited literature to justify a contrary position. Put another way, only seven of the thirty respondents in the "Points of Contention and Convergence" sections made even one explicit use of the extant research to defend their points of view. Albert Ellis (Chapter Two) and Larry Beutler (Chapter Six) were encouraging exceptions to this pattern in that both repeatedly turned to the empirical literature.

Of course, the lack of a compelling empirical base for differential treatment decisions is hardly limited to this volume (Beutler & Clarkin, 1990). Several years ago, Norcross and Prochaska (1983) examined how hundreds of clinical psychologists, the plurality (31 percent) of whom were eclectic, selected their theoretical orientations. Of a list of fourteen possible influences on this selection process, outcome research ranked a disappointing tenth. The average rating fell between "weak influence" and "some influence." Our hope for future replication studies and future clinical exchanges is that the influence of outcome research will rank much higher.

Returning to Table 11.2, we discover that theoretical compatibility was employed as an explicit justification twice as frequently as research literature for both coded agreements (5 percent versus 1 percent) and coded

disagreements (17 percent versus 7 percent). The contributors admit relying on theory far more than on research or even the circumstances of the client. John Davis, in his response (Chapter Four), articulated basic differences among the recommended approaches, probably owing to the therapists' conceptual, ideological, and personal commitments and having little to do with the client. Carlo DiClemente (Chapter Five), in similar fashion, acknowledged that we are directed by our theoretical frames, however broad or limited they are, more than we are by particulars of the case.

Disparate theoretical orientation and professional discipline clashed in "The Make-Up Artist" for a full-fledged therapeutic conflict. Kevin Thompson, a cognitive-behavioral psychologist, expressed dismay that the use of cognitive-behavioral techniques was not advocated by his fellow panelists. Bernard Beitman, an integrative psychiatrist, voiced incredulity that his colleagues would deny the value of medication in this case. In turn, Elisabeth Lederman, a humanistic psychotherapist, and the only woman on the panel, was the only one to articulate the real probability that the patient had been sexually abused.

Largely ignored in our quantitative analysis are client factors. Are some clients more likely to create contention or convergence? We cannot bring empirical data to bear on this question since the client factors presented in this volume are hopelessly confounded within individual cases and by

unequal representation of contributors' theoretical orientations. Systematic manipulation of client variables in a case format or a survey questionnaire completed by large numbers of psychotherapists would be required to address this issue empirically.

Nonetheless, it is our distinct impression that achieving a consensus will be most difficult until we agree more specifically on therapeutic goals. A transtheoretical analysis of psychotherapy systems shows how much they agree on the processes producing change while they disagree on the content to be changed (Prochaska, 1984). In other words, different orientations probably do not dictate the specific interventions to use as much as they determine the therapeutic goals to pursue (Beutler, 1983).

Convergence will be facilitated to the extent that we can agree on client problems to be treated, on mediating therapeutic goals, and on the kinds of evidence to be accepted for successful therapy. For example, on a panel discussing treatments of choice for a specific disorder—a simple phobia—proponents of disparate psychotherapy persuasions agreed that psychoanalysis was contraindicated for efficient removal of phobic behavior. However, if the phobia was conceptualized as reflecting an underlying characterological problem, then a different therapeutic goal—and thus a different treatment recommendation—was advanced (Norcross, in press).

Concluding Remarks

We shall not cease from exploration

And the end of all our exploring

Will be to arrive where we started

And know the place for the first time.

T. S. Eliot

Having now arrived at the end of this volume, we have a final opportunity to share what we learned on our journey. Like the tireless traveler in Eliot's poem, we have rediscovered our origins, especially a few fundamental lessons about the practice and integration of psychotherapy. We knew in principle before we began that a science advances when its hypotheses are set forth in a way that invites their disproof; but our thwarted effort to count sources of agreement and disagreement, as revealed in Table 11.2, brought us home to this implication for clinicians: we had better strive to articulate our rationales. Otherwise, psychotherapy integration will remain dependent on each practitioner's personal preferences. We also confirmed, as shown in Table 11.1, that the therapeutic relationship and broad clinical strategies are two fruitful areas of convergence among clinicians.

Furthermore, our appreciation of the need for respect for professional

differences has been enhanced; the clash of views we refereed has made us more provisional in our conceptualizations and inclines us toward more modesty in our claims. We find ourselves more acutely aware than ever that our profession must stay open to new data and nascent perspectives. No one who has been involved with the material of this book over the past four years would be likely to suppose that the future of psychotherapy can or should be limited to integrating just the canon of theories and procedures that have prevailed in recent decades.

We began with a fantasy that became the "Clinical Exchange," so it is fitting that we conclude with a fantasy. We look forward to a series of books, perhaps modeled in some respects on this one—say, a new book each passing decade. In the sequels to *Therapy Wars,* the panel members would take progressively greater responsibility for their motives in convergence and divergence—and for receptivity to comparative evaluation of procedures, as well as to theories and practices not within their immediate repertoire. The future editors and contributors would consider, perhaps regard as likely, that better ways to conceive psychotherapy, to practice it, to integrate what is known, and to study what is unknown may yet be waiting to be discovered by clinicians born in the twenty- first century.

Authors

Nolan Saltzman is director of the Bio Psychotherapy Institute in New York City and was formerly clinical exchange editor of the *Journal of Integrative and Eclectic Psychotherapy.* He received his B.A. from Columbia College in biological sciences, his M.A. from Columbia University in biophysics, and his Ph.D. from Indiana Northern University in human relations psychology. He has published extensively for clinicians and is a fellow of the International Academy of Eclectic Psychotherapists.

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.* He

received his B.A. from Rutgers University in psychology, his M.A. and Ph.D. from the University of Rhode Island in clinical psychology, and he completed his internship at the Brown University School of Medicine.

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.