THE TECHNIQUE OF PSYCHOTHERAPY

WHAT IS THE "BEST" KIND OF PSYCHOTHERAPY?

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From *The Technique of Psychotherapy* Lewis R. Wolberg

What Is the "Best" Kind of Psychotherapy?

Comparative studies of current psychotherapies have not been able to answer the question of which psychotherapy is best. Among the most interesting are the investigations of Luborsky, Singer, and Luborsky (1975), who in a detailed survey of a large number of reasonably controlled outcome studies discovered insignificant differences in results obtained by the various categories and brands of psychotherapy. This "tie score" applied to individual versus group psychotherapy, time-limited versus time-unlimited therapy, client-centered versus psychoanalytic, neo-Freudian versus Adlerian therapy, and behavior therapy versus traditional psychotherapy. A detailed "meta-analytic" investigation of 400 outcome studies by Smith et al, (1980) has yielded ambiguous results regarding the superiority of one type of treatment over the others. This is not surprising considering the many variables that interfere or enhance the techniques being employed. (See Chapters 3, 4 & 5). All we can do at this point in time is to express some hunches about the relative value of different techniques for specific conditions. Even here *how* the techniques are utilized and the skill of their application will be the determining factor in the results achieved. Considering that psychotherapy is so expensive, it would seem prudent to select that model of treatment best suited to help a patient's particular problem. To a large extent, however, confusion about the value of different forms of psychotherapy is due to the fact that contingencies responsible for therapeutic improvement are still unclear. Psychotherapists are apt to credit their results, not to kindred events common to all psychotherapies, but to casual epiphenomena unique to their own methods of treatment. Accordingly, they have—some with undaunted hubris-made global assumptions about the values of their personal ideologies and techniques.

The thesis that all psychotherapies score similar results is, however, open to a good deal of question. The quality of improvements achieved and permanence of beneficial effects will vary. There is a great deal of difference between an "improved" patient who achieves mere symptom relief and one who in addition to symptom relief and problem solving is helped to self-under-standing and true personality change. These factors are usually not considered in random outcome studies. Nor is, perhaps, the most important variable emphasized, namely the therapist himself or herself—in terms of training, experience, expertise in working with a special technique, and capacity for empathy, sensitivity and

perceptivity—ingredients that are more important than the identifying labels pinned onto treatment interventions. In other words, the value of any psychotherapy is no greater than the competence of the therapist who implements it.

It is probable that the great leveling agency in many of the outcome studies is the sophistication, judgment, experience, and training of the involved psychotherapist—a detail that is glaringly missing in the design descriptions. It may be that the results obtained by the effective versus the ineffective therapists in each of the psychotherapies balance themselves off resulting in the typical bell-shaped improvement curve. This in no way depreciates the importance of research in therapeutic outcome studies; it merely emphasizes the need to include some idea about the therapists who take part in the studies. After all, a scalpel is no better than the surgeon who wields it, and an adequate therapeutic regimen may be blemished by inexpert or undisciplined operations. On the other hand, many worthless procedures in the command of zealous practitioners may yield astonishing bounties as a result of their placebo and other non-specific influences.

Enthusiasm is no substitute for competence. The fact that a therapist is convinced that his or her method is superlative does not make it so. Unfortunately, some of the more undisciplined approaches attract aggressive, charismatic leaders whose bag of tricks lure many followers only too willing to subscribe to their methods, whether these involve nudity, eye balling, touching, screaming or other oddities. Obviously, some of these unconventional interventions while seemingly useful in the hands of one therapist may prove valueless for other therapists. Waging chemical warfare on the neurosis with megavitamins, breaking the sex barrier with "love treatments," massaging the brain with electronic devices, persistently and violently reproducing the regressed conditionings of the infantile period and other specious tactics appear dramatic, even infallible.

It is easy to become oversold on techniques that seem to produce results. Yet caution should remain the keynote in appraising the effectiveness of any method no matter how convincing the outcomes may seem to be. Are positive consequences due to a unique group of patients who constitute the therapist's present caseload? Does a specific therapist possess an affinity for a special technique, applying it with dedicated zeal? In the latter case the patients will respond more to the therapist's conviction and enthusiasm than to the treatment maneuvers themselves.

Statistics reveal that during the early development of each "new" approach there is approximately 90 percent recovery or improvement. This is followed by a period of therapeutic pessimism as the placebo element wanes and failures become apparent. If the improvement rate stabilizes in the 50-60 percent range, the method may foster continued acceptance (Tourney, 1966).

In each of the new approaches there is a narrowing down of the many vectors that enter into interpersonal relationships to a selected group of variables. These are presumed to constitute the essence of the therapeutic process. A common error perpetuated by the average therapist, who is convinced of the validity of his or her theory and virtues of personal method, is that the focus is on obtaining data that will authenticate the individual bias. While unraveling the tangled skeins of a patient's life, the consecrated theoretician may become a prisoner of an unsound model. Having committed themselves to a single point of view, therapists are invariably impaled on the sword of their own postulates. In the midst of present-day Promethean scientific discoveries, we should expect a greater willingness than now exists to introduce more threads of objectivity into the fabric of psychological thinking.

CHOICES OF TECHNIQUES

No psychotherapeutic method exists today that is applicable to all patients or germane to the operations of all therapists. Techniques by which transformations come about accord with the skill of the therapist who applies them and with the facility of the patient to accept and utilize the preferred interventions. Since psychotherapy is a learning process, the techniques to which a patient is exposed will work best if they coordinate with his or her unique methods of learning. Some persons learn best through cognitive operations, finding out the reasons that underlie their problems and acquiring an understanding of their self-defeating behavior and its origins. Such persons are attracted to insight methods. Others learn by following suggestions of authoritative persons or those they respect. Some learn through action and doing, i.e., achieving positive reinforcements in their environment for adaptive behavior; some through experiencing a corrective emotional experience with their therapist or with another human being who is used as a substitute therapist; others through example (modeling) and philosophical precepts (identification), which provide them with modes of thinking and behavior. Some learn best when subjected to psychological shock, attack, or confrontation that challenges their habitual defenses. These and additional kinds of learning usually act in combination within each individual.

What is challenging for a therapist is discerning the form of learning that each patient can best utilize and then working to adopt techniques that are best suited for the patient's learning propensities. An important area of research is a way of detecting a patient's optimal modes of learning. If we can pinpoint these, we may then more precisely determine the best means of therapeutic operation.

SYMPTOMATIC VERSUS INSIGHT APPROACHES

The variant methodologies have implications for the mental health field that go beyond the mere appraisal of what kind of therapy is best. They accent controversial contemporary issues among the different psychological schools, including a reciprocal challenging of the validity of the somatic, conditioning, psychoanalytic, and eclectic psychotherapeutic approaches. In the main, two philosophies of therapy are currently in vogue. The first contends, "Treat the symptom and the person as a whole will benefit." The second avows, "Treat the person as a whole and the symptom, which is only a byproduct of conflict, will abate or vanish." These viewpoints embrace more than a mere matter of emphasis. They encompass contrary hypothetical formulations, discrepant ideological preconceptions, and contrasting values. The first, which, punctuates symptom removal as the prime force in treatment, is founded on the premise that faulty responses to anxiety are produced by an unfortunate "programming in" of information leading to destructive habits that tend to generalize. The second, which exploits insight as the prime force in treatment, looks upon symptoms as manifestations of unconscious conflicts that are shaped by such mechanisms as condensation, displacement, projection, and symbolization. It considers the relationship of the individual to important persons in life preserved by transferring and discharging dangerous feelings toward symptomatic tokens.

Having identified what each considers the cause, adherents of these two credos deal with it through special procedures, each author proclaiming the virtuosity of a preferential method, which, in description, sounds effective and impressive. Thus a symptomatically oriented therapist, dedicated to somatic treatment, may launch an attack on the complaint factor itself, dissociating the symptom from the psyche as a whole by phenothiazines or tranquilizers, or making available greater amounts of energy by administering energizers, which may help foster the integration of the symptom into the bodily economy. A behavior therapist will attempt to break up the connections between stimulus antecedents and the "habits of anxiety responses" through a desensitization technique. A classical analyst will direct

"insightful" efforts toward expanding the strength of the ego, resolving resistances to unconscious conflict, and working through the infantile neurosis in the transference neurosis. A non-Freudian analyst, acknowledging the unconscious origin and defensive intent of symptoms, may work toward their understanding and mastery by a number of psychoanalytically oriented techniques, perhaps blended with directive stratagems, which are often labeled with some original tags. The methods leading to symptom resolution are more or less short term; those geared toward insight, long-term.

When we compare results of the symptom-oriented versus the insight-oriented therapies, we must admit that the former are considerably in the lead insofar as rapid elimination of symptoms themselves are concerned. A leaky roof can expeditiously be repaired with tar paper and asphalt shingles. This will help not only to keep the rain out, but also ultimately to dry out and to eliminate some of the water damage to the entire house. We have a different set of conditions if we undertake to tear down the structure and to rebuild the dwelling. We will not only have a water-tight roof, but we will have a better house, that is—and this is most important—if the fundamental foundation of the house is strong, if the carpenter is good, and adequate financing is available. Too often we find attempts at reconstruction of both houses and personalities on foundations that are too weak to support new edifices or that are fabricated by builders who are inept. Personality reconstruction is a long-term, tedious, expensive, and risky process. Not all efforts terminate in success; where they do, the results can be most rewarding. The tolerances, however, in terms of therapist competence and patient accessibility are fine. If our object is merely to keep the rain out of the house, we will do better with the short-term repair focused on the roof alone and not bother with the more hazardous, albeit ultimately more substantial, reconstruction.

It is unfair to compare the symptom-directed and insight-oriented therapies. We deal in both with different dimensions and distinctive therapeutic goals. It may be possible to bring about symptomatic relief quite rapidly with various devices as suggestive hypnosis, drug therapy, behavior therapy, and numerous other supportive and reeducative modalities, but to effectuate character change will require a lengthy process that involves a working through of many resistances and defenses. Insight therapy may not produce any immediate symptomatic benefits; if it is effective, these will show up much later.

In appraising comparison studies it is important to remember that no single therapist can apply himself or herself equally well to all techniques. The therapist will have a bias toward and dedication to

one or another procedure, and results will then be influenced by the therapist's allegiance to and sophistication with that system. An orientation toward a theory and methodology is far different from intensive training in and experience with these commodities. Above all the personality of the therapist as it displays itself in the treatment relationship is of utmost importance. One's capacity for empathy and understanding, one's sensitivity and one's ability to control and utilize countertransference are crucial in all forms of psychotherapy.

What is it, then, that helps our patients to overcome disorganizing psychological handicaps and to arrive at greater self-fulfillment? Is it the techniques that we use? Is it the *way* the techniques are implemented? Is it the agency who administers the therapeutic stratagems—the healing impact on the patient of subtle empathic qualities and personality traits of the therapist? Is it the insight the patient gains into the antecedents, manifestations, and the consequences of the repetitive-compulsive maneuvers? Is it the corrective resolution of the transference situation? Is it the experience of relating and of communicating in a climate that permits of a reconceptualization and reconsideration of one's basic credendas? Is it the influence of a host of adventitious, intercurrent forces, such as the placebo effect, emotional catharsis, projection of an idealized parental relationship or suggestion that automatically are set loose in any authority-subject relationship?

It is probably all of these things and more. One hypothesis that seems to be clinically substantiated is that in any emotional disorder a continuum of pathology may be observed: from physiological to intrapsychic, to interpersonal, to social, to spiritual. Therapeutic intervention along any link of this continuum will have a feedback effect on the other links of the chain. Thus an assault on the disturbed physiological vectors, i.e., on the biochemical components that make for anxiety, by a phenothiazine, and/or the secondary depression by an energizing drug will dissociate the symptom from its emotional underpinnings and make available psychic energy that promotes a sense of confidence and well-being and a reintegration of the experience into the general psychological economy. The feedback may result in a harmonious realignment of the intrapsychic structure, improved interpersonal relationships, and a more wholesome life outlook. The same results may come about if we properly organize an attack on the conditioning process that sustains a faulty learning experience. Restoration of stability that eventuates from the progressive vanquishing of anxiety will usually have a constructive effect on the total cognitive, affective, and behavioral field. In the insight therapies recognition of the childish underpinnings of

characterologic distortions provides the incentive for a working through of these aberrations, resulting, in successful therapy, in a reconditioning of habit patterns. There will obviously be salutory interpersonal and physiological concomitants in such change.

The philosophical note that we may sound from these observations is that no one school of thought has the monopoly on psychological wisdom. Each deals with *partial* weavings in the total tapestry of truth. We may learn much from our colleagues who happen to indulge a different way of looking at things—provided we face the shortcomings of our theories and methods honestly, accept critical challenge of our ideas, and not allow ourselves to bleed too copiously from narcissistic wounds when people do not happen to agree with us. The heritage of the scientist, in the words of Norbert Wiener, father of cybernetics, is "to entertain heretical and forbidden opinions experimentally." But such apostasy must be imbedded in an atmosphere of tolerance for the ideologies of our peers; otherwise psychotherapy may never be lifted from its present morass of speculation and placed firmly in the family of sciences as a respected member. (See Treatment Planning).

ARE PSYCHOANALYTIC APPROACHES ESSENTIAL FOR RECONSTRUCTIVE CHANGE?

A vital question is whether techniques other than psychoanalysis may have a reconstructive influence on the psychic structure. The answer to this question is the pivot around which rotates much of the current controversy in the psychotherapeutic field. In the main, the answer is "yes." Reconstructive changes are occasionally possible in individuals with flexible personalities in the medium of productive life experiences. They are possible in a therapeutic interpersonal relationship that does not repeat for the patient traumatizing expectations deriving from the past, even though the relationship itself is not the focus for investigation. They are possible in therapeutic relationships that deal with transference, without an actual eruption into transference neurosis, provided that transference is properly interpreted and the resistances handled. The latter contingency is what occurs in psychoanalytically oriented psychotherapy in which transference is encouraged but modulated in its manifestly expressed intensity.

Psychoanalysts, however, recognizing the failure of some patients to give up their neurotic behavior even with years of "depth" therapy, may question the efficacy of "superficial" therapies that

circumvent the unconscious. How, they ask, without free association, dream analysis, exploration of genetic material, and incisive dealings with resistance and transference is it possible for any person to reconstitute the basic personality structure and to get well? Implied is a denigration of psychotherapeutic efforts that deal exclusively with conscious elements. Benefits accruing from a mere rearrangement of defenses, with temporary circumvention of the Oedipal core, are presumed to be cancelable at any time in the future.

This line of thinking may reasonably be questioned. There is no evidence that psychoanalysis is the one agent capable of altering the unconscious. Definitive relearning, influencing personality on a depth level, may occur as the result of fruitful life happenings and wholesome relationships with people. A "superficial" therapeutic experience may thus serve as a means of changing the neurotic constellation on conscious, preconscious, *and* unconscious levels. Kolb and Montgomery (1963) describe an interesting case in which a patient achieved (1) spontaneous insights into his feelings about both his father and men in general, as these were being projected into his relationship with his therapist, and (2) an understanding of his psychosexual development. His therapist, who was an inexperienced person, was completely unaware of what was going on. As a result of "ego modification with change in perceptual capacity" the patient manifested lasting reconstructive effects. The authors conclude, "The borderline between psychoanalysis *per se* and psychotherapy, whether this be administered by a physician, or a member of any other profession, is likely to become less distinct. The various efforts to discriminate the varieties of psychotherapy are unlikely to hold with the expanding capacity" of psychologically minded persons to carry out effectively "procedures that have for long been considered the prerogative of highly trained therapists."

Since the etiology and pathogenesis of most psychiatric ailments are unknown, as are explicit criteria for assignment to special psychotherapies, it behooves us to adopt an empirical approach based on the widest flexibility of method (Guze & Murphy, 1963). The question may be asked, "Is it antithetical to science to adopt theoretical systems in proportion to how useful they prove themselves to be"? Practically speaking, it may be necessary for the therapist who wishes to benefit the majority of patients to step down from a platform of purism. At the same time, as scientists, therapists may wish to examine the variables that have brought health to their patients in the hope of evolving hypotheses that can be subjected to later testing, toward the goal of replicating good results. Progressive psychotherapists

constantly examine their data, developing hypotheses, testing their inferences, scrutinizing their methods, and observing patient responses to these, not hesitating to backtrack and to revise their approach, until the one is found that is best suited for the particular patient and the special problem that is being dealt with at the moment. There are many techniques available for the experimental psychotherapist that will expand the quality and quantity of one's results.

A TRIPARTITE APPROACH TO PSYCHOTHERAPY

In evolving an effective therapy, some therapists must give special consideration to at least three levels of psychological operation present in all individuals and that in the healthy person operate in concert. These levels also act autonomously with a feedback influence on one another. They correspond roughly to, but are not identical with Freud's superego, ego, and id.

The first level is contained in a group of mental operations in the form of values or "meaning systems" through which are filtered perceptions from the outside world, inner sensations, and memories. In large measure values are unconscious, and the individual clings to them tenaciously, since they give one identity and add substance to one's life. Behavior is usually organized around these systems and values, in this way reinforcing their validity. Meaning systems, which in the rank of mental operations are primary, are to some extent modifiable through such agencies as: (1)suggestion, (2) conformity to authoritarian injunctions, (3) group identification, and (4) education and progressive self-understanding.

The second functional level embodies intrapsychic processes that govern interpersonal relationships, modes of managing external stress, mechanisms of coping with inner conflict, and defenses against anxiety. Defects in the machinery through which the individual attempts to regulate relationships with other people are generally the product of: (1) defective organic equipment, constitutionally determined, that limits the adaptive capacities of the individual and (2) problems produced by destructive and ungratifying childhood experiences with important past personages that have engendered reparative and protective devices that survive in adulthood, even though they no longer serve constructive purposes. Intrapsychic processes are less amenable to change than are the first level meaning systems.

The third level involves the organic continuum, biological residues, which containing alterations in the neural structure are least amenable to psychological influence.

Unless these three functional levels are recognized in the treatment of patients, the therapist may focus attention on one or another without considering that they operate in unity. Thus the therapist may educationally attempt to change values by inculcating in the patient a different philosophy through which it is hoped there will evolve new ways of behaving, feeling, and thinking. Illustrative therapies in this group are persuasion, reeducative existentialist approaches, and meditation. Other psychotherapies —for example, insight therapy or psychoanalysis—may concentrate on intrapsychic processes, hoping to bring the individual to an awareness of their existence, their genetic origins, and the inconsistencies and consequences of their operations. Finally, some therapies may mediate the biochemical milieu (psychopharmacology) or refashion conditioned reflexes through methods derived from learning theory (behavior therapy), attempting to divert the individual from destructive habits by substituting new and constructive ones.

While the correction of one of the functional levels may influence the others through feedback, the chances of this are less than where the therapist specifically directs efforts at all implicated levels. One of the reasons why a fusion of methods is resisted is that in our "scientific" immaculacy we tend to adhere to, and often are frozen in, the conceptual framework of one system. Admittedly, no single theoretical model can embrace all existing levels of behavioral operation. Spiritual, dynamic, behavioral, and neurophysiologic models do not mix. But, irrespective of how disparate their conceptions, *methods* derived from all of these models may have a pragmatic utility if they are combined with discretion and forethought and if they are focused on the patient's needs, and not determined by the theoretical denomination with which the therapist is identified.

We may find much to criticize in the theories of any of the pioneers in the mental health field. But, however much we disagree with such theories, we cannot ignore them. Nor must we downgrade the richness of their contributions simply because we repudiate certain aspects of their thinking. The original discoveries of the workings of the unconscious by Freud, the role of human relationships in education and child guidance by Adler, the formulations of personality types by Jung, the origins of love and hate in early life described by Melanie Klein, the broad sociological vistas opened by Fromm, the

excursions into character structure by Horney, the biological conceptualizations of Rado, the anthropological explorations of Kardiner, the distortions of interpersonal relationship described by Sullivan, the holistic directions of Adolph Meyer, the conditioning experiments of Pavlov—these and other offerings from innovators in the field have fashioned many of our contemporary ideas about how people develop, function, become psychologically ill, and get well again.

Unfortunately, self-appointed guardians of the scientific torch tend to run pragmatic and eclectic approaches into the ground. They warn against their dangers, comparing them to a "shot-gun" prescription that is exploded in the hope that one piece of buckshot will find its mark. Yet it is not the variety of methods that is important—but the intelligence with which they are employed. One does not scatter out techniques in desperation with the frantic prayer that one will work. Rather one selects those suited to a particular occasion and need. Thus an alcoholic may, in addition to psychotherapy, require antabuse and regular contacts with Alcoholics Anonymous. A woman in deep trouble with her adolescent child and her husband may be helped by supplementing her individual treatment with family therapy. A phobic patient, once brought to an awareness of the unconscious roots of the problem, may need to be helped to extinguish any anxiety responses through behavior therapy.

TOWARD A BALANCED ECLECTICISM IN METHOD

Data filtering into the field of mental health from neurophysiology, biochemistry, genetics, behavior genetics, ethology, animal experimentation, conditioning experiments on humans, long-term clinical studies of personality development, learning theory, social theory, role theory, group dynamics, cultural anthropology, communication theory, information theory, cybernetics, philosophy, and field theory are now influencing our traditional ideas about psychotherapy by affirming the conception of function and structure as dynamically interrelated within a field of forces that range from the remotest regions of the environment to the innermost recesses of the organism (Wolberg, L, 1966). In a never ending transactional feedback, the individual develops a personality in all of its cohesiveness and uniqueness. This consolidates a basis for interdisciplinary and eclectic approaches to mental health. An eclectic viewpoint is more than justified by the fact that the various schools of psychiatry, psychology, and other behavioral sciences have made significant contributions to psychotherapy.

Information from fields affiliated with psychotherapy has many practical applications for the psychotherapist.

1. From neurophysiology we may gain an understanding of the mechanisms of emotion, the bodily responses to stress, the nature of the recording of memories, the biology of sleep and dreaming, the functions of selected brain areas, and the dynamic interactions of the neocortex, reticular system, limbic system, and hypothalamus. Such information helps to organize a rationale for the somatic therapies.

2. From biochemistry we gain perception of how the energy resources of the body are governed, the role of enzymes, neurotransmitters and neurohormones, the chemical regulation of brain metabolism, the mechanisms of mood formation and psychoses, and the influence of drugs on specific areas of the brain. This provides a basis for the employment, where essential, of the psychoactive drugs during phases of psychotherapy when depression, excitement, cognitive disorganization, or intense anxiety interfere with the psychotherapeutic process.

3. Genetics supplies leads on how hereditary influences may interfere with proper metabolic operations within the brain, rendering some individuals more susceptible to psychological disorders. Behavior genetics yields clues regarding the ubiquity and uniqueness of inherited response patterns among different individuals and their potential modifiability through learning.

4. Ethology points out the role of fixed neuromuscular coordinations in man that are operative normally or that are released during neurotic or psychotic adaptations.

5. Conditioning theory forms a structure for knowledge of how: personality organization evolves, higher and lower brain structures interact, and disorganizing and maladaptive behavior is learned. It supports a premise for comprehending the behavioral therapies.

6. Data from animal experimentation, principally the development of experimental neuroses and their removal by various stratagems, introduce avenues for approaching human neurosis. A grasp of the dynamisms of stress and adaptation are vital for discernment of what has happened to the neurotic individual whose coping mechanisms no longer keep one in homeostasis.

7. Developmental and personality theories, which essentially deal with ontogenetic maturation, occupy the psychotherapist's interests, since the therapist will arrange hypotheses around forces in the patient's life that have shattered adaptive potentials.

8. Learning theory grants a foundation for studying the acquisition of disorganizing habit patterns; it introduces principles that, incorporated in the therapist's interviewing procedures, may help facilitate the therapeutic process.

9. Psychoanalytic theory—classical, ego analytic, neo-Freudian, and object relations—presents the therapist with a rich body of formulations that delineate conscious and unconscious intrapsychic operations, subsidizing a systematized methodology. It also opens views to the therapist of his or her own irrational emotional projections toward the patient (countertransference).

10. Social theory and role theory are viable systems for the understanding of social process and interpersonal conflict as a means toward environmental and casework approaches.

11. Group dynamics delineate tactics of altering attitudes and patterns through interaction.

12. Anthropology illuminates the cultural atmosphere that shadows the patient's attitudes and responses. It supports the need to evaluate character structure in terms of family and cultural patterns.

13. Philosophy enables an appreciation of the power of value conflicts and apprises the therapist of the responsibility for altering value systems in a patient that prevent the expression of basic needs and interfere with proper adaptation.

14. Communication and information theories focus the therapist's attention on problems that are expressed through altered symbolic activities.

15. Field theory permits a perspective of neurotic problems in relationship to environmental, interpersonal, intrapsychic, and physiological variables, as well as a gauge of therapeutic goals in terms of the broadest social objectives.

Added to the above are the contributions from psychobiology that have introduced the philosophy of considering the human being an integrate of a variety of functions and have stressed the need for a practical assay of existing assets and liabilities in working out a treatment plan. The casework field has evolved a whole body of supportive approaches, along with carefully formulated interviewing and supervisory processes. The field of psychology, has contributed certain nondirective and directive counseling techniques, along with a number of procedures in play therapy, art therapy, speech therapy, vocational guidance, and rehabilitation. Finally, from the field of medicine there has come the consideration of the reciprocal relationship that exists in physical and psychic illness.

The ultimate effect of these new trends and trajectories from the behavioral sciences is toward a reasoned technical eclecticism (Lazarus, 1967; Halleck, 1971; Woody, 1971; Feather & Rhoads, 1972; Astor, 1973; Thorne, 1973; Simon, RM, 1974) identified by various titles such as *multimodal therapy* (Lazarus, 1976) and *differential therapeutics* (Frances et al, 1984). Eclecticism does not presuppose a disordered conglomeration of disparate devices thrown together into an expedient potpourri. Rather, it involves the selection and studied amalgamation of therapeutic interventions from varied sources that are compatible with and reinforce one another. In this way a fusion of concordant methods buttresses up weaknesses in the individual systems. The synthesis, harmonious as it may seem for the moment, is subject to constant reorganization as new ideas and approaches make themselves available. Unfortunately, eclecticism has come to connote unprincipled and even counterfeit opportunities practiced by those who sacrifice integrity of doctrine for temporary rational consistency or utilize it as "a cover-up for lack of scientific commitment" (Maultsby, 1968; Ornstein, 1968; Eysenck, 1970). The uncritical syncretism characteristic of the ancient philosophic sect of eclectics does not apply to the present-day eclectics, although purists and formalists are apt to consider the thinking of modern eclectics too loose and unsystematized. On the whole, the eclectic direction has proven a refreshing diversion from the rigid, oracular, and dogmatic schools and systems—some of whose members refuse to compromise their positions under the mistaken conviction that if they are not God's chosen people, they are at least his principal scientific missionaries.

Eclecticism in method is also justified by the fact that a number of things can be done for a person with an emotional problem that will make one feel better, temporarily or permanently. These include (1) alleviating or removing the symptoms, (2) adjusting the life situation so that it imposes a minimal burden on one, (3) inducing an alteration in disorganizing attitudes and life goals, and (4) investigating what conflicts are at the bottom of the difficulty and dealing with them on various corrective levels.

All psychotherapies approach one or more of these aims, being better adapted to some than to others. Different therapists, by virtue of their unique personalities and specialized training, apply themselves to one or another technical procedure with greater or lesser facility. And patients selectively respond to some therapeutic methods and not to others.

There is, therefore, no "best" kind of therapy except that which happens to suit the patient's needs

most at the time of application for treatment. When we consider the preferred type of psychotherapy—supportive, reeducative, or reconstructive— we must keep in mind exactly what we are trying to accomplish. A patient with even a sound and well-organized personality structure may have gone to pieces in the face of severely traumatizing environmental circumstances. The only help that may be required is a short interval of supportive therapy, which will suffice to bring the patient back to the customary adjustment level. To embark on a long and costly course of psychotherapy would be ill-advised, unless the patient failed to show improvement after the immediate stress source was resolved. A second person may suffer from problems in adjustment that interfere with an ability to get along with people; yet the person may be sufficiently flexible to alter patterns of living once these distorted patterns are brought to light. The preferred treatment here would be some kind of reeducative therapy. Another person may come to treatment with what seems to be a minor work or marital problem. Our examination may reveal that the compliant factor is merely the superficial manifestation of a serious personality disorder and that the complaint cannot be remedied until a drastic reorganization of the person's character structure takes place. This will require perhaps years of reconstructive therapy.

Since psychotherapy is an interpersonal relationship, the personality of the therapist, as reflected in the capacity to relate to patients, is fully as important—if not more important—than the method employed. Indeed, the personality of the therapist influences the choice of method as well as modifications introduced in implementing any set technique. Thus, some therapists, by virtue of their basic characterologic passivity, do better with "passive" techniques, such as nondirective therapy. Other therapists, possessing more active character structures, are unable to play a passive role in therapy and are inspired toward executing supportive approaches, directive reeducative therapies, non-Freudian psychoanalysis, or psychoanalytically oriented psychotherapy. Most patients seem to do well with selected methods of treatment, provided the therapist is skilled in a particular approach and is capable of setting up and maintaining a good working relationship with the patient. This does not mean that goals are interchangeable in supportive, reeducative, and reconstructive therapies because, as has been indicated, there are definite limitations in the extent to which emotional problems may be influenced by the technical methods employed. Yet, within each of these three large groupings, considerable flexibility in method may be displayed consistent with the therapist's training and personality set.

The beneficial effects wielded by psychotherapy, irrespective of type, are to a large extent due to a

restoration of the patient's sense of mastery. This results from a constructive use of the therapeutic relationship in a number of ways. First, patients may gain from therapy sufficient emotional support, sympathy, and understanding to help them to endure and to conquer inner tensions and external demands. The relationship, while supportive, is ideally utilized in such a manner that it does not inhibit, but indeed encourages, impulses for assertiveness and independence. Second, the relationship facilitates the cathartic release of disturbing feelings, with alleviation of guilt and fear. Third, patients are helped to mediate an external or internal stress source or to adjust themselves to it. Fourth, shattered repressions are rebuilt and habitual defenses restored, with alteration of those defenses that are destructive to adjustment. Fifth, a reevaluation of the self develops with modification of certain unrealistic attitudes and strivings and substitution for them of productive patterns that lead to more congenial relationships with people.

Where the therapist's personality and technical skills facilitate the above effects, the results of therapy are usually good. Where the therapist's personality or methods block such effects, results will be poor no matter what school of thought the therapist espouses or how thoroughly conversant he or she is with theory.

In instances where the patient achieves a good therapeutic result, the therapist may assume falsely that what has effectuated the cure or improvement was the focus on a specific theoretic orientation rather than because of important processes evolving out of the patient's constructive use of the relationship in the indicated ways.

THE NEED FOR A UNIFYING CONCEPTUAL FRAMEWORK

In our eclectic effort to expedite psychotherapeutic method, some of us are apt to extrapolate from the affiliated sciences contours that are applied uncritically to our own field. Particularly prevalent is the practice of applying alien theories to systems with which they have little affinity. A chaotic practice moreover has been the utilization of language pertaining to one system to describe what goes on in other systems. Thus employing the vocabulary and structure of information theory to describe intrapsychic processes, or of neurophysiology to interpret social phenomena, has done little to clarify the intricate exchanges that are taking place within and between these units.

During the past few years a new perspective has evolved in the behavioral field that conceives of the human being as a balanced composite of multiple units functioning in the orbit of a larger group of systems. So intimately bracketed are self and milieu that alteration of constituents in either moiety must inevitably effectuate some change in the total structure. Accordingly, the focus has shifted from operations within single systems to consideration of the commutations and interchanges *between* the systems. Isolated concern with biochemical, neurophysiological, learning, psychodynamic, interpersonal, social, and philosophic models have yielded to the study of transactions of the individual in multiple negotiations within and outside of the self. What has become apparent, since behavior is so reticular, is that we need to develop a better mode of organizing appropriate configurations of models. Unfortunately, we do not yet possess the syntax even to describe these configurations precisely in a meaningful way. Attempts to arrive at a universal language of science have not yet proven successful. Provocative are current efforts that are being made of developing a "general systems theory" that deals with the interface properties of multiple systems, their interactional and transactional patterns, and their hierarchical structuring (Gray, 1966). A reexamination of human behavior has been taking place within the framework of ecological phenomenology that focuses, among other things, on conceptual schemes and communications in the different disciplines (Auerswald, 1966). These concepts have important implications for psychotherapy since theories and methods abound that are related to the different subsystems, each approach being advanced by its proponents as the preferred means of dealing with emotional illness.

The recognition that changes wrought by the varying modalities—somatic, conditioning, psychodynamic, interpersonal, environmental, and philosophic—on selected aspects of behavior can influence all other links in the chain and thus transform the nature of the chain itself, may serve to explain why patients benefit by a wide variety of methodologies. Moreover, the understanding that structure and function are dynamically related to the field of forces operating on the individual in his milieu has tended to shift interest from intrapsychic to extrapsychic, from concern with forces of superego, ego, and id to relationships with extrafamilial groups.

From the convenient dyadic, long-term model of therapy geared toward "insight," we see explorations into various kinds of group approaches, the joint treatment of married couples and entire families, conditioning procedures aimed at specific symptoms, milieu manipulations that may extend to

the structuring of an entire therapeutic community, and the combined employment of psychotherapy with somatic treatments, especially psychotropic drugs. Short-term therapy directed at both abbreviated and reconstructive goals is attracting greater interest, being encouraged by insurance coverage for emotional illness that is limited to a set number of sessions. The preoccupation with intrapsychic content is supplemented with consideration of the interpersonal transactions within the therapeutic situation, exploring the varying roles that the patient is playing with the therapist and others. The laboratory of the psychotherapist is being extended into the community, fostering the working in a consultative capacity with various professional persons who deal with problems of people on a broad level, for example, educators, law enforcers, clergymen, physicians, dentists, and lawyers. Community mental health, so vital to the interests of society, has necessitated the acquisition of new knowledge and skills regarding the social and cultural networks that envelop people and institutions. Finally, there is greater recognition of how formulations from certain philosophical systems may be blended with therapeutic techniques. In this context there is increasing awareness of cultural forces as they influence the value orientations of patients as well as therapists, in addition to the need to deal with these forces as part of the therapeutic task.

On the whole, this direction has been promising. However, in some instances the shift has unfortunately resulted in an aversion toward and neglect of the intrapsychic dimension, abandonment of which has resulted in a void that has left the treatment process denuded and incomplete. The consideration of the transactional links in the chain of behavior complements rather than eliminates other affiliated links. Transactional and intrapsychic are both of vital importance.

What is apparent in studying the existing diverse theoretic systems and methodologic approaches is that no one person nor school of psychologic thinking has all of the answers. It would seem, in fact, as if each variant were dealing with a partial truth, one aspect of a total truth. When we examine critically what successful psychotherapists do, we find that, irrespective of the school to which they belong, and in spite of what they say they do, methods are modified to suit the needs of particular patients and situations. The more experienced the therapists, the more flexible they become in the kinds of techniques utilized. This eclecticism in approach is of the greatest significance if the therapist really wants to help each patient achieve effective relief from symptoms and expanded personality growth.

Obviously, no therapist can be expected to master all approaches. At the most, one's expertise will encompass a few techniques that coordinate with one's professional identification model and personality style. Nevertheless, the therapist will probably have to know, in addition to preferred individual therapeutic measures, as a minimum, something about the indications for the use of psychotropic remedies and group therapy, and, if possible, marital and family therapy. Grounding in dynamic theory should not interfere with the ability of the therapist to employ goal-abbreviated therapies, such as behavior therapy or hypnosis, where indicated. The least we may expect of competent, ethical therapists is that they realize their own limitations and will refer patients to a therapist specialized in an approach that may potentially be more suitable for them.