INTEGRATION IN PSYCHOTHERAPY: PART 1

Chapter l6: CONVERGENCE. In Patterson & Watkins, *Theories of Psychotherapy, 1996. Part 1 of chapter*. (References in Part 2)

The objective of every science is to arrive at, or develop, an integration of all the evidence, or facts, in a field, to resolve apparently opposed or conflicting facts. For example, Stephen Hawking is devoting his life to discover or develop a principle or law that will reconcile Einstein's unified field theory (the theory of relativity) and quantum mechanics. It would appear that the objective of the field of psychotherapy would be to develop a universal theory or system. However, this does not seem to be the case. Few would agree that such an objective is possible, or even desirable. Yet there is an interest in attempting to integrate differing methods, if not theories.

THE MOVEMENT TOWARD INTEGRATION

Early attempts to relate learning theory to psychotherapy occurred in the 1930s and 1940s (see Introduction to Part (II). The book by Dollard and Miller (1950) was the first major attempt to integrate behavior theory and psychoanalytic theory. Wachtel's (1977) book was the next major attempt at integration of these two approaches and was continued in a series of papers. In 1984 Arkowitz and Messer (1984) edited a book titled *Psychoanalytic Therapy and Behavior Therapy: Is Integration Possible?*

During the 1980s interest in integration broadened beyond the psychoanalytic-behavioral focus. In 1979 Marvin Goldfried, Paul Wachtel, and Hans Strupp initiated an association of those interested in integration in psychotherapy, which circulated a newsletter. The group became the Society for the Exploration of Psychotherapy Integration (SEPI). The *International Journal of Eclectic Psychotherapy,* which began publication in 1982, became the *Journal of Integrative and Eclectic Psychotherapy*. The *Journal of Psychotherapy Integration* began publication in 1991 as the journal for SEPI. Norcross (1986) wrote that: "The psychotherapy Zeitgeist of the 1980s is rapprochement, convergence, integration" (p. ix).

The movement toward integration in psychotherapy does not have the development of a single, universal system of psychotherapy as its goal. It does not agree with the statement that "The objective of any movement toward eclecticism or integration in psychotherapy must be the development of a single comprehensive system of psychotherapy, including philosophical and theoretical foundations" (Patterson, 1989). Although Norcross (1986) earlier noted that "the promise of eclecticism is the development of a comprehensive psychotherapy based on a unified body of empirical work," he called Patterson's statement "patently false" (Norcross, 1990). Others are also in disagreement with this as an objective of integration. Arkowitz (1992), in his review and evaluation of integrative theories, expressed concern that "the integration of today may become the single-school approach of tomorrow.... Such a path takes us full circle back to where we started (p. 273). Yet the development of numerous differing integrations or integrative therapies poses the same problem: whether there will be

competition among specific schools of integrative therapy. . ." (Arnkoff & Glass, 1992, p. 684).

It does appear that the integration movement is not likely to move in the direction of a universal theory or system in the near future. Lazarus and Beutler (1993) have even said that integration is not desirable: "We believe that integrationist views, as opposed to the technical eclectic approaches, may retard progress and lead in unproductive future directions" (p. 382). Goldfried and Castonguay (1992) in an article titled "The Future of Psychotherapy Integration" wrote:

> It is doubtful that the integration movement will provide the field with one grand theoretical integration. Given the epistemological differences ... it is hardly likely that this is possible. Moreover, we would maintain that as long as there exist theoreticians, it is likely that there will always be competing theories. (p. 8)

Norcross (1986) wrote: "The ideal of integrating all available psychotherapy systems is not likely to be met" (p. 6).

THE PHILOSOPHICAL ISSUE

It would appear that the two views of the nature of human beings (Chapter 15) are irreconcilable. But Allport (1962) pointed the way to a reconciliation: "The trouble with our current theories of learning is not so much that they are wrong but that they are partial.... The plain fact is that man is more than a reactive being" (pp. 379, 380). The reactive model is a limited model, applying to a limited range of human behavior. Compared to animals, relatively little of the behavior of adult humans is the result of classical or operant conditioning; such behavior occurs mainly in highly controlled, restricted situations such as experiments in a laboratory or an institution such as a mental hospital. Nor is adult behavior determined by uncontrolled internal drives or motives.

Psychotherapy is concerned with the total individual, with current perceptions, thoughts, feelings and emotions, future goals, as well as innate drives and conditioned behaviors. While this would appear to be a reasonable philosophy on which a theory of therapy could be based, it does not appear to have led to an integrative system of therapy. The two differing images of humans as reacting to the environment or to internal drives are involved in the attempt to integrate behavior therapies and psychoanalytic therapies. Messer and Winokur (1984) felt that this difference was important at not only a philosophical level, but at a clinical level, preventing a real integration. Franks (1984) also felt that this difference precluded integration at a conceptual level.

THE ECLECTIC SOLUTION

Eclecticism in psychotherapy is not a new development, although it has gained increasing attention in the past ten to twenty years. Most therapists were probably eclectic in the first half of the century, before the rise of the numerous current theories. Psychoanalysis and its derivatives were the first theories to develop and most of those therapists who were not eclectic adhered to some form of psychoanalysis or

psychoanalytic (dynamic) psychotherapy. The so-called Minnesota point of view of E. G. Williamson (see Patterson, 1966b, 1973, 1980) was an eclectic position. Frederick Thorne's system of clinical practice (see Patterson, 1966b, 1973, 1980, 1986) was perhaps the first to adopt the term *eclecticism,* and is still the most comprehensive and detailed system.

The numbers, or percentages, of psychologists-therapists who considered themselves eclectic during the 1940s and 1950s are not clear. Frederick Thorne (personal communication, June 2, 1967) stated that there were no members of the American Psychological Association (APA) who identified themselves as eclectics in 1945. (The source of this figure is not known.) Shaffer (1953), as part of an extensive study of clinical psychologists, noted that 35 percent of those who practiced therapy identified themselves as eclectic when required to limit their choice to analytic, nondirective, or eclectic. In 1961, Kelly reported a survey of APA clinical psychologists (Fellows and Members, with a 40 percent return) in which 40 percent identified themselves as eclectic. Since then numerous surveys of varying groups of psychologists have found percentages from 30 to 65 percent, fluctuating around 50 percent (Fee, Elkins, & Boyd, 1982; Garfield & Kurtz, 1974, 1976; Jensen, Bergin, & Greaves, 1990; Kelly, Goldberg, Fiske, & Kilkowski, 1978; Larson, 1980; Norcross & Prochaska, 1982; Norcross, Prochaska, & Gallagher, 1989; Prochaska & Norcross, 1983; Smith, 1982; Swan & MacDonald, 1978; Watkins, Lopez, Campbell, & Himmel, 1986; Watkins & Watts, 1995). Though eclecticism is the most frequently chosen label, the statement by Lambert and Bergin (1994; cf. Lambert, Shapiro, & Bergin, 1986) that "the vast majority of therapists have become eclectic in orientation" (p. 181) is an overstatement.

Eclecticism in psychotherapy has been subjected to extensive criticism, falling into disrepute among many writers and theorists who hold to a particular school of thought. Rogers (1951, p. 8) referred to this attempt to reconcile various schools as "a superficial eclecticism which does not increase objectivity, and which leads nowhere," and referred to a “confused eclecticism," which "has blocked scientific progress in the field" of psychotherapy (Rogers, 1956). Snygg and Combs (1949) wrote that "an eclectic system leads directly to inconsistency and contradiction, for techniques derived from conflicting frames of reference are bound to be conflicting" (p. 82). Thus, from the point of view of research and of practice, eclecticism has been considered undesirable. In research, "it is only by acting consistently upon a well-selected hypothesis that its elements of truth and untruth can become known" (Rogers, 1956, p. 24). In practice, a consistent frame of reference is desirable.

A problem with eclecticism is defining what it is, or what it consists of in specific terms. Garfield and Bergin (1986) stated that "there is no single or precise definition of an eclectic orientation.... It is exceedingly difficult to characterize an approach in terms of either theory or procedures" (p. 8; cf. Garfield & Bergin, 1994, p. 7). Garfield's (1982) earlier characterization still holds: "Eclecticism is perceived as the adherence to a nonsystematic and rather haphazard clinical approach" (p. 612). Strupp and Binder (1984) made a similar statement: "The term *eclectic,* which many therapists use to describe their orientation and practices, is so fuzzy it defies definition" (p. xii). Arkowitz (1992) stated that "Eclectism is a strategy of selecting whatever seems best from a variety

of alternatives ... on the basis of what they think will work for the particular person or problem." (p. 284). Lazarus, Beutler, and Norcross (1992) stated that "the term frequently conveys nothing of substance--it simply implies that concepts from two or more of the more than 400 separate schools of psychotherapy (Karasu, 1986) have been blended, often in an arbitrary, subjective, if not capricious manner (Franks, 1984; Lazarus, 1988)" (p. 11).

Norcross's edited book (Norcross, 1986) includes chapters by authors of the major eclectic positions, including Beutler (1983, 1986), Garfield (1980, 1986b), Hart (1983, 1986), Lazarus (1981 a, 1986), and Prochaska and DiClementi (1984, 1986). Goldfried and Newman (1986) provide a historical background, and Dryden (1986), Goldfried and Safran (1986), Messer (1986), and Murray (1986) provide critical comments. More recently we have related efforts by Norcross and Goldfried (1992) and Stricker and Gold (1993). In effect, there are as many eclectic approaches as there are eclectic therapists. While there is a verbal commitment to empirically valid techniques, in fact each therapist operates out of his/her unique bag of techniques, on the basis of his/her particular training, experiences, biases, and intuition on a case-by-case basis, with no general theory or set of principles as guides. Thus, there is no single eclectic therapy. Goldfried and Safran (1986) note that "there exists a real danger that ... we may ultimately end up with as many eclectic models as we currently have schools of psychotherapy" (p. 464).

Various kinds of eclecticism have been proposed; theoretical eclecticism, prescriptive eclecticism (Dimond, Havens, & Jones 1978), strategic eclecticism (Held, 1984), radical eclecticism (Robertson, 1979), and probably others. The lack of theoretical foundations has been acknowledged. Prochaska and Norcross (1983) noted

> The need for theoretical orientation has been frequently recognized, but few, if any, adequate models of systematic eclecticism have been created.... Beyond its conceptual relativity and personal appeal, eclecticism in its current state may not possess adequate clinical utility or validity for increasing numbers of therapists. (p. 171) The real challenge for synthetic eclectic therapists and theorists alike is to construct models of systematic eclecticism that have both empirical validity and clinical utility (p. 168).

Murray (1986), discussing the contributions to Norcross (1986), said: "In the contributions of the eclectic therapists in this volume, theoretical orientations play a relatively small role" (p. 405). He continued: "However, true integration requires a coherent theoretical structure, which does not exist. We are still waiting for our theoretical integration" (p. 413). London (1988) recognized that "Integration involving continuity across all techniques is still missing, and it is missing for a good reason, I think. It may not be possible" (P. 10).

A true eclecticism is neither nontheoretical nor haphazard. English and English (1958) defined it as follows:

> *Eclecticism.* n. In theoretical system building, the selection and *orderly combination of* compatible features from diverse sources, sometimes from

> incompatible theories and systems; the effort to find valid elements in all doctrines or theories and to combine them into *a harmonious whole*.... Eclecticism is to be distinguished from unsystematic and uncritical combination, for which the name is syncretism. (p. 168, italics added)

As a matter of fact, most of what is currently called "eclecticism" is actually syncretism.

There have been attempts to develop a systematic--though not theory based--eclectic psychotherapy. Foremost among these have been Lazarus and Beutler. Lazarus (1967) proposed the ten-n *technical eclecticism* to apply to "procedures drawn from different sources without necessarily subscribing to the theories that spawned them" (Lazarus, Bentler, & Norcross, 1992, p. 12). "To attempt a theoretical rapprochement is as futile as trying to picture the edge of the universe. But to read through the vast amount of literature on psychotherapy, in search of techniques, can be clinically enriching and therapeutically rewarding" (Lazarus, 1967, p. 416). Lazarus developed his approach in a number of later publications (Lazarus, 1971, 1976, 1981a, 1981b, 1986).

Lazarus began as a behavior therapist and was associated with Wolpe for several years. He abandoned behavior therapy and became critical of it (Lazarus, 1971, 1976) when a follow-up of his patients found that many of them had not continued the improvement seen at the conclusion of treatment. He did not, however, give up all behavioristic techniques. He also adopted some cognitive therapy techniques. He first referred to his approach as multimodal behavior therapy (Lazarus, 1976) but later left out the "behavior" (Lazarus, 1981a). He also uses many other techniques, including imagery and fantasy, Gestalt exercises, and client-centered reflection. He coined the acronym *BASIC I.D.* to indicate the breadth or comprehensiveness of his approach: behavior, affect, sensation, imagery, cognition, interpersonal relationships, biological functioning, or drugs. The patient is assessed in all these areas, and then each is dealt with in order of judged importance.

Beutler's systematic eclectic therapy (Beutler, 1983, 1986; Beutler & Clarkin, 1990) is, as noted in the last chapter, based on the specific treatments for specific conditions paradigm. There is an attempt to support treatment choices with empirical research, but no attempt to provide an overall theory position. The matching of pertinent variables with techniques is broadened to include therapist variables, the therapist-patient relationship, and their interactions. These variables, according to Beutler, are more important than specific techniques (Beutler, 1989). In terms of theory, Beutler (1986) advocated the development of a functional theory. The main theoretical bases for his current position were social psychological theories of persuasion, since he views psychotherapy as a process of persuasion (Beutler, 1978).

Arkowitz (1992), in his evaluation of Lazarus and Beutler, wrote:

> At the very heart of modern eclecticism is an actuarial approach that uses data from pas cases to predict what will work best for new cases. This actuarial approach requires a search for relations among variables, rather than for an overall theory to

> fit these data.... One problem is the enormous number of possible variables that may correlate with the enormous number of outcome variables.... If the number of variables is limitless, the number of interactions among them is also limitless.... The task seems overwhelming unless we have some coherent framework to guide the selection of relevant variables and to help in understanding the interactions among variables. (pp. 288-289)

Lazarus, Beutler, and Norcross (I992) joined in a prediction of the future of technical eclecticism. Some of their predictions included the following: *(1) "Technical eclecticism will represent the psychotherapeutic Zeitgeist well into the 2Ist century"; (2) "Limitations of theoretical integration will be more fully realized"; (3) "Treatments of choice for selected clinical disorders will become standard practice";* (5) *"The meaning of technical eclecticism will be broadened to denote ... therapist relationship stances";* (6) *"Common therapeutic factory will be concretely operationalized and prescriptively employed";* (10) *"Technical eclecticism, as one thrust of the psychotherapy integration movement, will become 'institutionalized'"* (pp. 13-17).

Paradoxically, eclecticism as an integrating force, based on the specific treatment paradigm, actually appears to be fostering divergence. But Norcross (1986) wrote that "a truly eclectic psychotherapy may begin with and be based on an operationalization of common variables that play an important role in most therapies (Garfield, 1973, 1980; Goldfried, 1980, 1982; Prochaska & DiClementi, 1984)" (p. 15).

THE COMMON ELEMENTS SOLUTION

For nearly sixty years (Rosenzweig, 1936) it has been recognized that there are basic common elements or factors in the diverse approaches to psychotherapy. Following RosenZweig, other writers include Oberndorf (1946), Hathaway (1948), Wyatt (1948), Ziskind (1949), Collier (1950), Rioch (1951), Black (1952), Cottle (1953), and Patterson (1959, Chapter 13). As Arkowitz (1992, p. 278) noted, there was a drop in "common factors" publications in the 1960s and 1970s. Exceptions were Goldstein (1962), Hobbs (1962), Garfield (1980), and especially Frank (1961, 1971, 1973, 1974, 1982), and Marmor (1976).

The common factors suggested have been numerous and varied, from the general to the specific. All therapies, at a very general level, involve an interaction or communication between therapist and client (Rioch, 195 1). Rapport and transference are other general factors (Black, 1952; Hathaway, 1948; Ziskind, 1949). Rosenzweig (1936) listed three factors: (1) therapist personality; (2) interpretations (whether right or wrong they provide explanations of client behavior); and (3) theoretical orientation (though different, they have a synergistic effect on various areas of functioning). More specific factors have included advice, encouragement, explanations, therapist attention, warmth, persuasiveness, support, reassurance, and suggestion (see Lambert & Bergin, 1994).

Implicit Commonalities

Frank, who has been writing about common elements for over 30 years, has focused on a group of components more specific than those considered above (Frank, 1959, 1961, 1971, 1973 1974, 1976, 1982; Frank & Frank, 1991). They center on his concept of therapy as "a means of directly or indirectly combating demoralization" (1982, p. 10), which is the source of emotional disturbances. His first component is "an emotionally charged confiding relationship with a helping person," involving the therapist's status or reputation but also including the communication of caring, competence, and the absence of ulterior motives (p. 19). Second, is a healing setting that heightens the client's expectation of help from a healer and that provides safety. Third, is "a rational, conceptual scheme or myth that provides a plausible explanation for the patient's symptoms and prescribes a ritual or procedure for resolving them" (p. 20). The fourth is "a ritual that requires active participation of both patient and therapist and that is believed by both to be the means of restoring the patient's health" (p. 20). Though developed in detail over a period of time, Frank's elements are abstract and not operationalized. Yet they have apparently had wide acceptance. They bear a striking resemblance to Fish's (1973) delineation of placebo therapy.

A number of characteristics of psychotherapy appear to be present in all theories or approaches but are seldom explicitly noted.

1. All approaches and all therapists agree that human beings are capable of change or of being changed; disagreement is on how best to bring about change. Human beings are not predetermined; at any stage of development, they are still pliable. Learning theory approaches are based on this assumption. Skinner (1958) expressed it as follows:

> It is dangerous to assert that an organism of a given species or age can not solve a given problem. As a result of careful scheduling, pigeons, rats, and monkeys have done things in the last five years which members of their species have never done before. It is not that their forebears were incapable of such behavior; nature had simply never arranged effective sequences of schedules. (p. 96)

Other approaches may not be so optimistic about the changeability of personality or of behavior, but they clearly assume the possibility of change; otherwise there would be no point to engaging in psychotherapy.

2. There is agreement that some kinds of behavior are undesirable, inadequate, and harmful or result in dissatisfaction, unhappiness, or limitation of a person's potential and, therefore, warrant attempts at change. These behaviors may include cognitive or emotional disturbances or disorders, conflicts, unresolved problems, or behaviors designated as neurotic or psychotic.

3. All therapies and therapists expect their clients or patients to change as a result of their particular techniques. This expectation may vary in its degree; in some instances, it approaches a highly optimistic or even enthusiastic expectation, while in others, it may be minimal, or minimal changes may be expected.

4. Every therapist believes in or has confidence in the theory and method that he/she uses. If the therapist did not believe that this approach was the best method, it would not be used; some other method would replace it. As in the case of belief in the ability of clients to change, therapists would not be engaged in the practice of therapy if they did not expect their clients to change and did not believe that their methods would lead to change. It might be hypothesized that success (or at least therapists' and perhaps clients' reports of success) bears a strong relationship to the degree of confidence that the therapist has in his/her approach. A common aspect of therapy thus appears to be the therapist's commitment to a particular theory or at least a particular method or set of techniques. The effect of this commitment, or the interaction of commitment and effectiveness of a method, is one of the problems in attempting to evaluate the effectiveness as a method apart from the therapist who uses it.

5. Individuals who enter and continue in therapy feel the need for help. They "hurt," they are suffering or are unhappy because of conflicts, symptoms, negative feelings or emotions, interpersonal problems or conflicts, inadequate or unsatisfying behaviors, and so on. Therefore, they are motivated to change. Therapists are not particularly interested in working with unmotivated or "involuntary" clients, even though such clients may obviously have problems. Persons who do not recognize their problems or do not feet any need for help do not often enter therapy, or if they do, they usually do not continue.

6. Clients also believe that change is possible and expect to change. Frank (1959, 1961) has emphasized the universality of this factor in clients. Cartwright and Cartwright (1958) indicated that this is a complex factor: there may be a belief that improvement will occur, a belief in the therapist as the major source of help, or a belief in himself/herself as the major source of help. Cartwright and Cartwright felt that it is only the last belief that leads to improvement in a positive, linear manner. The other beliefs are probably present to some extent in all clients, however. If the client did not feel that he/she would improve and that the therapist and the therapist's methods could effect such improvement, the client would not enter or continue in treatment.

7. All therapists appear to expect and insist that the client be an active participant in the process. The client is not a passive recipient, as is the physically ill patient who is being treated by a physician, even in the approaches that are most directive and active. All learning (behavior change) appears to require some activity, whether motor, verbal, or intellectual, on the part of the client.

These characteristics of a therapy relationship form the background for therapy itself. They are accepted as given by all approaches.

The Therapist in the Relationship

A set of elements even more specific deal with therapist variables in the therapy relationship.

In 1967 Truax and Carkhuff, after reviewing the major theoretical approaches to psychotherapy, in a chapter titled "Central Therapeutic Ingredients: Theoretic Convergence," found three sets of characteristics: (1) "the therapist's ability to be integrated, mature, genuine or congruent," (2) "the therapist's ability to provide a non-threatening, trusting, safe or secure atmosphere by his acceptance, nonpossessive warmth, unconditional positive regard, or love," and (3) "the therapist's ability to be accurately empathic, be with the client, be understanding, or grasp the patient's meaning" (Truax & Carkhuff, 1967, p. 25). Accurate empathy, respect or nonpossessive warmth, and genuineness are "aspects of the therapist's behavior that cut across virtually all theories of psychotherapy and appear to be common necessary and sufficient therapist conditions for therapeutic personality change.

1. All therapists manifest a real concern for their clients. They are interested in their clients, care for them, and want to help them. Rogers used the phrase *unconditional positive regard.* Others have referred to warmth or nonpossessive warmth, respect, prizing, valuing, and accepting. While client-centered therapists would include a respect for the client's potential to take responsibility for self and to resolve his/her own problems, some therapists would not include this. The client-centered nonevaluative, nonjudgmental attitudes also might not be shared by others, but a basic interest, concern, and desire to help another human being are common to all therapists and are a powerful aspect of the therapeutic relationship.

2. A second characteristic of all effective therapists is honesty, or a genuineness and openness. Rogers referred to it as therapist congruence-a consistency between the thoughts and feelings of the therapist and the therapist's expressions to the client. Therapists are sincere, authentic, transparent, and real persons. They are not engaged in trickery or deceit in their relations with their clients.

3. Empathic understanding is a third aspect of a therapeutic relationship. In some form or other, although it varies in terminology, all the major writers on psychotherapy refer to this characteristic of therapists as being important. Theorists vary in the degree of emphasis they place on empathic understanding, and therapists of different persuasions vary in the degree to which they provide it, but no one seems to deny its desirability, if not its importance. There appears to be general agreement on the importance, even the necessity of a good relationship fostered by the therapist.

The most widely known studies on the nature of the relationship as viewed by therapists are those of Fiedler (1950a, 1950b, 1951), who found that therapists from different schools of psychotherapy agreed on the nature of the ideal therapeutic relationship. Factor analysis yielded one common factor of "goodness," whose items were concerned with empathy or understanding. Fiedler also concluded that a good

therapeutic relationship as viewed by these therapists is similar to a good interpersonal relationship.

There is currently widespread, if not universal, agreement among theorists and therapists on the influence of the relationship in therapy or behavior change. Goldstein (1962), reviewing the literature on therapist and patient expectations in psychotherapy, concluded: "There can no longer be any doubt as to the primary status which must be accorded the therapeutic transaction" (p. 12).

Menninger and Holzman (1973), in the second edition of *Theory of Psychoanalytic Techniques,* viewed the relationship as the "central focus of the therapeutic process." Goodstein (1977), reviewing a collection of papers published under the title *What Makes Behavior Change Possible?,* stated that "among virtually all of the contributors there is an awareness of and attention to the therapeutic relationship as an essential ingredient of behavior change." The fourteen contributors included Frank, Strupp, Burton, Ellis, Raimy, the Polsters, Bandura, and Wolpe.

There is an extensive literature on the therapeutic relationship, now frequently called the "therapeutic alliance" including research studies and reviews. Beutler, Crago, and Arizmendi (1986) writing in the third edition of Garfield and Bergin's *Handbook of Psychotherapy and Behavior Change*, stated: "The importance of such [therapist] qualities have subsequently been almost universally accepted by all psychotherapies, with varying levels of emphasis" (p. 276). Lambert and Bergin (1994) stated that

> Virtually all schools of psychotherapy accept the notion that these [accurate empathy, positive regard, nonpossessive warmth, and congruence or genuineness] or related therapist relationship variables are important for significant progress in psychotherapy and, in fact, fundamental in the formation of a working alliance. (p. 164)

"These and related factors common across therapies seem to make up a significant portion of the effective ingredients of psychotherapy" (Lambert, Shapiro, & Bergin, 1986, p. 171). And Emmelkamp (1994), reviewing behavior therapy, concluded that "it is ... becoming increasingly clear that the quality of the therapeutic relationship may be influential in determining success or failure of the behavior therapies." (p. 417, cf. Emmelkamp, 1986).

The Client in the Relationship

The literature on the therapeutic relationship has focused almost entirely on the therapist's contribution, but the client must also be considered. The therapy relationship cannot exist without the participation of the client. In fact, the client's contribution is considered more important than that of the therapist in determining the outcome of therapy. Frank (1974), after twenty-five years of research, concluded that "the most important determinants of long-term improvement lie in the patient" (p. 39). Norcross (1986) wrote that "experts estimate that about one-third of treatment outcome is due to

the therapist, and two-thirds to the client. Less than 10% of outcome variance is generally added for techniques" (p. *15).*

These experts presumably include Strupp (in Bergin & Strupp, 1972): "In my judgment, by far the greatest proportion of variance in therapeutic outcomes is accounted for by patient variables" (p. 410), and Bergin and Lambert (1978) who wrote: "We believe ... that the largest variation in therapy outcome is accounted for by preexisting client factors such as motivation for change, and the like. Therapist personal factors account for the second largest proportion of change, with techniques coming in a distant third" (p. 180). Bergin still held this belief when he and his associates (Lambert, Shapiro, & Bergin, 1986) wrote: "It is becoming increasingly clear that the attributes of the patient, as well as the therapist, play an important part in creating the quality of the relationship and the outcome of psychotherapy" (p. 171). These views have been more recently echoed in Lambert (1991), in Lambert and Bergin (1992), as well as in Bergin and Garfield's (1994) most recent *Handbook of Psychotherapy and Behavior Change.*

It is not clear what client variables other than motivation are involved-they are not specified. Research on client demographic and personal variables provides no basis for predicting outcome from these client variables (Garfield, 1986a).

Rogers, in his 1957 article, listed two client conditions as being necessary, and sufficient, for positive therapy outcome:

> 1. [T]he client is in a state of incongruence, being vulnerable and anxious (p. 96). [Incongruence] refers to a discrepancy between the actual experience of the organism and the self-picture of the individual insofar as it represents that experience.... [T]here is a fundamental discrepancy between the expressed meaning of the situation as it registers in his organism and the symbolic representation of that experience in awareness in such a way that it does not conflict with the picture he has of himself.... When the individual has no awareness of such incongruence, then he is merely vulnerable to the possibility of anxiety and disorganization.... If the individual dimly perceives such an incongruence in himself, then a tension state occurs which is known as anxiety. (pp. 96-97)

Simply put, the individual is anxious, confused, in conflict-he/she hurts and needs and wants help. In other words he/she is motivated. It is objective evidence of motivation that clients present for and continue in therapy.

> 2. The second condition states that "the communication to the client of the therapist's empathic understanding and unconditional positive regard is to a minimal degree achieved" (Rogers, 1957, p. 96). "Unless some communication of these attitudes has been achieved, then such attitudes do not exist in the relationship as far as the client is concerned, and the therapeutic process could not ... be initiated. Since attitudes cannot be directly perceived it might be somewhat more accurate to state that the therapist behaviors and words are perceived by the client as meaning that to some degree the therapist accepts and understands him. (Rogers, 1957, p. 99)

The research evidence (Orlinsky & Howard, 1986) indicates that, in relating therapist qualities and outcome, "the proportion of positive findings is highest across all outcome categories when therapist warmth and acceptance are observed from the client's perspective. Here, again, the most decisive aspect of therapeutic process seems to be the patient's experience of it" (p. 348; cf. Orlinsky, Grawe, & Parks, 1994, pp. 326, 339, 360-361).

There is an additional client condition that Rogers does not include, though it is necessary. That is that the client must be able to engage in the process of self-exploration, including self-disclosure-the verbal expression of feelings, attitudes, thoughts and experiences. In Rogers' conditions, it is assumed that when the therapist and the other client conditions are present, at least to a minimal degree, then the client is enabled to engage in the process of self-exploration.

THE RELATIONSHIP AS A NONSPECIFIC ELEMENT

Many writers of diverse theoretical orientations view the total psychotherapeutic relationship as nonspecific. Frank (1973, 1982) has long maintained this position. Bergin and Lambert (1978) and Strupp (1978, 1986b) also have emphasized the nonspecific nature of the relationship, repeatedly emphasizing the necessity of specific techniques in addition to the nonspecific relationship.

Behaviorists view the therapeutic relationship as nonspecific, in contrast to the specific techniques of behavior therapy. Wolpe, for example, has claimed that his method of reciprocal inhibition, as well as other behavioristic techniques, increases the improvement rate over that of the relationship alone, stating that "the procedures of behavior therapy have effects additional to those relational effects that are common to all forms of psychotherapy" (Wolpe, 1973, p. 9). Such claims have been disputed and are not supported by any research that has controlled for the relationship. Those who regard the relationship as nonspecific hold that it is not related directly to the treatment of any of the client's specific problems. It is the substrate from which the therapist operates, the setting or environment in which specific methods are used; some therapists view it as rapport or as the basis of the client's trust in the therapist, providing a power base for influencing the client in some way.

There are two arguments against this view. First, if it is assumed that the source of many, if not most, of the problems of clients involves disturbed interpersonal relationships, then a therapeutic relationship that includes the characteristics of a good human relationship is a relevant, and specific, method of treatment. The therapist is a model for the client from whom the client can learn how to maintain a good relationship with others, and, at the same time, the client is helped by experiencing the relationship offered by the therapist. It is being increasingly recognized that good interpersonal relationships are characterized by understanding, honesty, openness, sincerity, and spontaneity. Psychotherapy is an interpersonal relationship that includes these characteristics. Indeed, therapy would be limited if it attempted to help the client develop better interpersonal relationships in the context of a different kind of relationship.

It is pervasive and generally acknowledged that the evidence that the source of much, if not most, emotional disturbance is the absence of good human relationships. Ford and Urban (1963) in evaluating the theories or systems of psychotherapy presented in their book, stated that "all of these theorists seem to agree that the situational conditions necessary for the development of behavior disorder are the ways other people behave toward the growing person" (p. 649). Spitz's (1945) classic studies of institutionalized infants indicate that deprivation of attention, handling, and personal contact is deleterious not only psychologically, but also physiologically. Love, which is the essence of a good human relationship, is necessary for survival. Burton (1972) wrote that "the basic pathogen is, for me, a disordered maternal or care-taking environment rather than any specific trauma as such" (p. 14). Many other writers and therapists have suggested that emotional disturbances or neuroses and psychoses are the result of lack of or inadequate love and acceptance (or unconditional positive regard) in childhood (Glasser, 1965; Patterson, 1985a; Walsh, 1991). Burton (1967) noted that "after all research in psychotherapy is accounted for, psychotherapy still resolves itself into a relationship best subsumed by the word 'love'" (p. 102-103).

The second argument against the view that the relationship is nonspecific is the research on relationship (nonspecific) variables. There is evidence that the providing of the relationship as defined here, without any additional techniques, is effective with many clients who have many kinds of social-psychological or interpersonal problems (see references to this research in Chapter 13).

THE UBIQUITOUS PLACEBO

Related to the argument that relationship factors are nonspecific is the contention that such factors are placebos. Rosenthal and Frank (I 956) took this position, as did Krasner and Ullmann (1965) and Wolpe (1973).

Shapiro (who probably has engaged in more intensive study of placebos than anyone else) and Morris (1978) gave the following definitions:

> *A placebo* is defined as any therapy or component of therapy that is deliberately used for its nonspecific, psychologic, or psychophysiological, effect, or that is used for its presumed specific effect, but is without specific activity for the condition being treated.
>
> The *placebo effect* is defined as the nonspecific, psychologic, or physiologic effect produced by placebos.
>
> *A placebo,* when used as a control in experimental studies, is defined as a substance or procedure that is without specific activity for the condition being evaluated.
>
> The *placebo effect* is defined as the psychological or psychophysiological effect produced by placebos. (p. 369)

Shapiro and Morris (1978) considered placebo effects in both medical treatment and psychotherapy, which are quite different situations. They noted that "the placebo effect may have greater implications for psychotherapy than any other form of treatment because both psychotherapy and the placebo effect function primarily through psychological mechanisms.... *The placebo effect is an important component and perhaps the entire basis for the existence, popularity, and effectiveness of numerous methods of psychotherapy" (p.* 369).

The placebo as an inert substance does not exist in psychotherapy. All the variables in the therapeutic relationship are psychological and active, having some specific or direct effects on the client (see Patterson, 1985b).

In an earlier discussion of the placebo effect, Shapiro (I 97 1) stated that he was presenting "an examination of psychotherapy as a placebo effect," thus suggesting that psychotherapy is nothing more than a placebo. However, Shapiro and Morris (1978) viewed the total psychotherapy *relationship* as a placebo. They referred to a review by Luborsky, Singer, and Luborsky (1975) (see also Smith & Glass, 1977, and Smith, Glass, & Miller, 1980) that found several types of psychotherapy to be about equally effective. Shapiro and Morris concluded that this equal effectiveness was related to the common therapist-patient relationship and pointed to this relationship as a demonstration of the placebo effect.

Rosenthal and Frank (1956) much earlier came to the same conclusion. Referring to the placebo effect as a nonspecific form of psychotherapy, they wrote, "The similarity of the forces operating in psychotherapy and the placebo effect may account for the high consistency of improvement rates found with various therapies, from that conducted by physicians to intensive psychoanalysis" (p. 298). More recently, Pentony (1981) in his extensive analysis of the placebo as a model of psychotherapy, suggests that "the placebo effect constitutes the most parsimonious explanation that would account for the apparently equal success achieved by each of the diverse collection of therapies practiced" (p. 56).

This statement assumes that the total therapeutic relationship is a placebo. It is proposed here, however, that the relationship consists of two major classes of variables: specific variables and nonspecific, or placebo variables. We have already enumerated the major specific variables: empathic understanding, respect or warmth, and genuineness.
The nonspecific, or placebo, variables are the social-influence variables (Strong, 1978)-perceived therapist expertness or credibility, trustworthiness, attractiveness, and therapist expectations. These variables are among those listed by Shapiro and Morris (1978) as variables through which the placebo operates. Indeed, they are the essence of what Fish (1973) boldly called "placebo therapy."

Recognizing that "the social influence process has been considered the active ingredient in the placebo," Fish stated that placebo therapy "denotes a broad frame of reference for considering all forms of human interaction, especially psychotherapy, in terms of social influence process" (Fish, 1973, p. xi). The therapist does everything

possible to establish himself/herself as an expert and an authority in the eyes of the client. The client's susceptibility to influence and persuasion is assessed. The impression is created that "once I know what is wrong with you I can cure you."

A treatment strategy is then formulated and communicated to the client in a plausible manner, tailored to the client's belief system. The major techniques used are those of behavior modification, together with suggestion and hypnosis. "Placebo therapy is a strategy for getting the maximum impact from such techniques regardless of their validity" (Fish, 1973, p. vii). Placebo communications are used not because they are true, but because of their effects. The validity of the techniques, or the "therapeutic ritual," to use Fish's term, is important only as it enhances the patient's faith-that is, how believable, impressive, or persuasive the technique is to the patient. The therapist "says things for the effect they will have rather than for his belief that they are true. Instead of speaking empathically because he believes that empathy cures, he does so because he sees that such statements add to credibility in the patient's eyes" (Fish, 1973, p. 32). Further, "lying to a patient is desirable if the lie furthers the therapeutic goals, is unlikely to be discovered (and hence backfire) and is likely to be more effective than any other strategy" (Fish, 1973, p. 39).

Pentony provided a critical evaluation of Fish's placebo therapy. He stated that "it seems questionable whether a treatment based on suggestion [or persuasion] alone will be universally applicable," given the existence of strong resistance to change. He raised three other questions about placebo therapy:

> 1. Is it ethical to mislead the client in regard to the therapeutic strategy? 2. Will the therapist be convincing when he is not a true believer in the ritual he is carrying through? 3. If placebo therapy becomes general and clients become aware of its nature, will they lose faith in the healing rituals and hence render these ineffective? (Pentony, 1981, pp. 63-64)

Fish's attempts to answer these questions are less than convincing. No attention is given to the problem of therapist genuineness and the client's detection of its absence in the therapist.

There are other problems with placebo therapy. Fish, who claimed that it works, urged that the reasons be researched. There is probably no question that placebo therapy works with some clients some of the time. It is the basis for the success of charlatans and charismatics, who produce satisfied clients and testimonials.

There are three problems with the placebo as therapy, however. First, it is uncertain, or unreliable. Not all subjects are placebo reactors, and it is not possible to identify those who will respond positively to placebos. Fish attempted to determine who among his clients will be positive reactors. Although he noted that many are called but few are chosen, he did not tell how many or what proportion are chosen. He referred to the problem client who expects and desires a different relationship with the therapist. Second, placebo effects are not dependable; that is, when they do exist, they usually are not durable, but tend to be transitory. None of the research on the social-influence variables

has included long-term, or even short-term, follow-up of results. Third, the possible side effects of placebo therapy are undesirable, including the fostering of dependence.

The social-influence variables and the specific-relationship variables probably are not completely independent. LaCrosse (1977) found significant correlations between the Counselor Rating Form, which measures client perceptions of counselor expertness, attractiveness, and trustworthiness, and the Barrett-Lennard Relationship Inventory, which measures client perceptions of counselor empathic understanding, congruence, level of regard, and unconditional positive regard. Observer ratings were also highly correlated, although ratings by the counselors themselves were not, which raises some question about the presence of an artifact, such as the halo effect, in the client and observer ratings.

The presence of correlations between these two sets of relationship variables poses the question of which is primary, or which causes or leads to the others. That the core conditions are primary is suggested by studies that have shown them to be related to various therapy outcomes, while this has not been shown for the social-influence variables. Krumboltz, Becker-Haven, and Burnett (1979) have indicated the direction of the relationship when they suggested, after reviewing the research, that therapists "who want to be seen as attractive should be empathic, warm and active." It also would appear, from LaCrosse's research, that therapists who want to be regarded as experts also should be empathic, respectful, warm, and genuine. Similarly, it might be suggested that therapists who want to be perceived as trustworthy should demonstrate the same qualities.

It appears that the complex therapeutic relationship cannot be prevented from being "contaminated" by placebo elements. Clients perceive therapists, to some extent at least, as authoritative and expert-regardless of the therapists' behavior. Clients normally trust their therapists. Therapists' belief in their theory is inextricable from their methods. If they did not have confidence in them, they would use other methods in which they did have confidence.

If placebo elements cannot be entirely eliminated from psychotherapy, they can be either maximized or minimized. If they are maximized, the therapist is engaging in placebo therapy, with the possibility that results may be limited, superficial, or temporary. Research on the social-influence variables has attempted to maximize the placebo effect in various ways, including favorable introductions of therapists to clients, display of degrees and diplomas and of professional books and journals, wearing of a white coat by the therapist, luxurious office furnishings, and cultivation of a self-confident, charismatic manner by the therapist. In spite of this, the research does not demonstrate the effectiveness of the variables. If, on the contrary, placebo elements are minimized and specific-relationship variables are maximized, therapy is effective.

Continued in Part 2, with references.