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A CRITIQUE OF BEHAVIORAL PSYCHOTHERAPY: THE GROUNDWORK FOR AN INTEGRATED MODEL OF INTERVENTION*

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Abstract

Several strengths and weaknesses of the behavioral approach in psychotherapy are discussed. Possible remediation of some of the weaknesses are explored through integration of contributions from client-centered or psychodynamic approaches. Finally some of the risks associated with an integrated model of psychotherapy are considered.

Résumé

L'auteur discute plusieurs forces et faiblesses de l'application de l'approche behaviorale en psychothérapie. Il explore ensuite les possibilités de remédier à certaines des faiblesses de l'approche behaviorale par l'entremise d'une intégration des contributions offertes par l'approche Rogerienne ou psychodynamique. Pour conclure, certains des risques associés à une approche de modèles intégrés en psychothérapie sont discutés.

During the 1970's the behavioral model was embraced by many North American university training programs in counselling and clinical psychology. As a result client-centered and psychodynamic approaches received less attention than the behavioral approach. However, once graduates of monolithic programs began working in applied settings, they were rapidly exposed to the shortcomings of the behavioral model. As many clinicians began to

be acutely aware of the limits of the behavioral approach they pressured training program developers to search for a new approach to intervention.

The first purpose of this paper is to offer a perspective on the strengths and weaknesses of the behavioral approach to psychotherapy in order to encourage clinicians and training program developers not to throw out "the baby with the bath water". The second objective is to indicate how some of the weaknesses of the behavioral approach can be overcome by integrating with it contributions from client-centered and psychodynamic schools. Finally, some of the problems faced by those of us foolhardy enough to offer graduate training based on an integrated model of psychotherapy are considered.

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Definition of four distinct phases of psychotherapy: diagnosis, specification of objectives, intervention, and reevaluation

Proponents of the behavioral model, much more than either the dynamic, client-centered, or systemic approaches have recommended that the clinician be able to conduct four separable operations: a) diagnosis: the client and appropriate others participate in interviews, tests and observations to arrive at a clear definition of presenting problems and probable causality; b) specification of objectives: a clear definition is developed of the possible objectives that could be pursued in order to remediate the patient's complaints, for example reduce anxiety, raise social skill, increase self-esteem or increase insight; c) intervention: therapeutic procedures intended to achieve selected objectives are implemented; d) reevaluation: the functioning of the client is reevaluated to ascertain the presence of improvement, no change or deterioration.

The real and potential benefits of this approach are multiple and far reaching. For example, it allows the behavioral psychotherapist to administer the most modern and relevant diagnostic instruments in the interest of carefully matching intervention strategy to specific client needs. The obsessive could receive massed practice; the socially timid, social-skills training; and the depressed, cognitive restructuring, positive activity programs, and couple therapy. In theory, this type of approach also allows the behavioral clinician to reach the decision that certain patients are best referred to other types of psychotherapists or interventions. In brief, this four-phase approach permits (at least in theory) not only optimal pairing of behavioral technique to client problem, but selective pairing of overall therapeutic approach (e.g. psychodrama, hypnotherapy or behavior therapy) to be determined by a patient's needs, *not* the therapist's.

A careful isolation of a "specification-of-objectives" phase, many argue, reduces some of the risk that objectives pursued in therapy will be overly controlled by the therapist's values and preferences at the expense of the patient's (London, 1964). For example, a careful specification of all objectives can reduce chances that a given clinician will try to convince all troubled homosexuals to attempt to become happy heterosexuals instead of happy homosexuals, or will lead certain marital consultants to offer divorce counselling to certain distressed couples instead of pushing

all couples to attempt to preserve their marriage at all costs (Wright, 1984).

Finally, the reevaluation phase can allow the clinician to repeatedly adjust intervention procedures to optimize treatment gains and/or terminate interventions that are either ineffective or harmful. This final step can provide constant invaluable clinical information to the alert therapist permitting consistent improvement in clinical skills.

As well, if all therapeutic schools would adopt this four-phase model, two objectives Goldfried and Padawer (1982) have underlined could be achieved: greater public accountability and improved communication between schools.

Operationalization of therapeutic procedures

Relatively early in its development behavioral psychotherapy offered precise stepwise definitions of therapeutic interventions. Wolpe's early texts (1958) are remarkable models of precision when compared to publications available from other schools at that time. What the therapist did or said, how often, for how long, and with what anticipated response was clearly defined in particular for the desensitization of phobias.

The advantages of this drive to operationalization are multifold. Students can learn new procedures much more rapidly with precise stepwise manuals. With this type of open target, other schools can commence a very healthy debate on what the behaviorist is *doing* instead of mainly criticizing what he is *thinking*. As Goldfried and Padawer (1982) argue, the debate between schools will advance more rapidly if equal attention is focused on what therapists *do* with clients as well as concentrating on the theories of *why* therapists do what they do. The student or established clinician who desires to improve his repertoire can benefit from the explosion of precise therapist manuals on toilet training, assertion training, or couple problem solving. The reader of eminent contributors in this area is able to separate the personal style of a reputable clinician from his/her treatment procedure; this is essential for the optimal transmission of information between clinicians.

Finally, the operationalization of therapeutic procedures has permitted the highly sophisticated research required to separate the essential from the superfluous ingredients of psychotherapy. For example, the importance

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of relaxation training in systematic desensitization, of modeling in assertion training, or contracts in couple counseling have all been investigated in research designs characterized by enough internal and external validity to be relevant to the clinician of *any* theoretical persuasion.

The push for efficacy and accountability

Behavioral psychotherapies have now been the subject of more controlled outcome research than any other school. Commencing with the provocative and rather persistent publications of Hans Eysenck (1952), behaviorists have, more than any other school, subjected their intervention to evaluation research. One positive result is that the field of psychotherapy in general can now assert that certain precise target problems can be treated effectively (phobias, certain social performance difficulties, compulsions and reactive depression) and support this claim with scientific research that would be acceptable to other health professionals and even politicians. This is no small achievement given the state of the art in 1950 and pressure from governments in the '80s to improve the yield from each health-care dollar.

Clinical contribution: the notion of learning

As well, behaviorists have generated important new developments on *how to do therapy* and how therapists *construe* their activities. One of the most powerful notions has been that of learning. The idea that the development of a phobia, depression, a sexual dysfunction or social inhibition could be explained by the same laws as the development of normal speech, moral development or normal attraction has had revolutionary consequences. A wide range of problems that were previously ineffectively or incompletely treated by psychoanalysis or other available psychotherapies could now be treated successfully with relatively sophisticated but clearly defined procedures.

The notion that one of the main responsibilities of the therapist is to provide new learning experiences to help the patient to "unlearn" ineffective responses has also had positive repercussions. Undoubtedly learning plays important roles in the development of the theory and practice of psychodynamic and client-centered schools. However, behaviorists concentrated apparently limitless energy in analogue and clinical research on the role

of learning in the understanding and treatment of psychological problems.

The systematic study of cognitions

At the outset behaviorists allowed little room for the importance of the measurement, understanding or modification of cognitions. In fact, early behaviorists tended to ridicule or (even worse) ignore their dynamic or humanistic colleagues' fascination with the memories, thoughts, and self statements of their patients. However, in the last 14 years, an impressive array of theoretical, experimental, and clinical contributions on problem solving, self reinforcement and cognitive restructuring have appeared (Goldfried & Padawer, 1982).

The advantages of this new cognitive twist to the behavioral model are multifold. Although both dynamic and client-centered literature stressed the importance of the clinician's careful assessment of each patient's idiosyncratic cognitions, the behavioral approach has contributed a good deal more diagnostic precision through a variety of standardized interview, questionnaire, and self-observation instruments.

As well, the careful operationalization of cognitive procedures such as problem solving (D'Zurilla & Goldfried, 1971) allow for much more effective intervention with such diverse populations as hyperactive children, delinquents, alcoholics, and distressed couples. Undoubtedly neo-analytic therapists attempted to improve patient's problem solving. The contributions from behaviorists, however, allowed these procedures to be applied systematically to clinical populations with much more heterogeneous educational and psychological profiles.

The notion of competence and skill training

Until the advent of contributions from behaviorists, the blocked-potential model was used to explain ineffective patient functioning in social situations by many psychotherapists. For example, the psychodynamic approach to the socially withdrawn adolescent or to the low assertive adult would be to attempt to discover what painful emotional response blocked the ability of the patient to function "normally" in social situations. The assumption was that once the anxiety response was relived and understood, competent social performance would be possible. Similarly early client-centered contributions placed most emphasis

on providing the necessary conditions for the client to develop self-acceptance. It was assumed that once the client achieved this goal, overt social behavior would be relatively easy to change.

Well known behaviorists convincingly argued that many patients performed poorly in certain social situations because they had never learned what it takes to succeed. An explosion of clinical and experimental literature provided careful analyses of the relatively complicated social skills required to succeed in such heterogeneous situations as: simple assertion, dating, marital interaction, refusal of delinquent temptations, parenting, and teaching. The therapy programs that developed from this model allowed relatively short-term effective intervention with target populations that previously were often ignored or at best only treated partially. As well, the skill perspective is relevant for preventive behavioral or cognitive strategy acquisition programmes for high risk populations (Wright, 1985).

Distinction between client change during therapy and change in the natural environment

Behaviorists were the first to consistently underline the dangers of assuming that a patient was "cured" once he seemed to be functioning problem-free during therapy sessions. With a learning theory analysis, it was hypothesized that adaptive behavioral, emotional, or cognitive responses would generalize to the natural environment *only* to the extent that the stimuli in the two different settings were similar.

Directive psychotherapy: an important alternative

Before the advent of the behavioral influence the most popular therapy styles were characterized by a relatively slow-moving low profile for the therapist and a high work load on the patient. The client-centered model definitely increased the work load on the therapist but did not increase therapist directivity. The behavioral school offered a very different alternative in which from the beginning the clinician asked many questions, administered tests, offered alternatives, gave advice and in general directed the session.

Rapid evolution: overcoming weaknesses in the system

The rate at which a school of psychotherapy can evolve to effectively treat new

target populations has an impact on practitioner interest. To maintain constant evolution a school must continually attempt new intervention procedures, increase the power of established strategies and discard the ineffective. In addition, a school must tackle target populations that other change agents have either avoided or treat with less than optimal efficacy. The behavioral school rates a very high score on this criterion when the rapid evolution from 1950 to 1980 is noted.

This speed of evolution can be attributed to many factors such as: a) an obsession with measuring outcome (accountability); b) published operationalization of therapeutic procedures; c) a certain competitiveness between behaviorally oriented university departments to come up with discoveries similar to the interchange between research centers in the field of the physical health sciences; d) and finally this rapid evolution can be traced to a lively exchange between pure psychological theory, laboratory research, clinical theory, and clinical application. The behavioral school has profited more than other approaches from active exchanges between pure and applied researchers.

Possible improvements

This paper contends that the nine positive attributes considered above explain the high degree of impact the behavioral approach has had on graduate training programs. However, the eight dimensions discussed below partially account for the rise in disillusionment observed among practitioners.

An overly narrow theory of human functioning

Behaviorists pride themselves with having a theory of personality derived from "hard" laboratory research and testable theory. However, a clinician practising even for a few months rapidly encounters the limits of this theory of personality. Space does not permit a thorough and careful exploration of this question but several errors of omission in the behaviorists' theory of personality will be briefly considered.

Ironically, although a good deal of hard laboratory research exists on the development of cognitive, moral, or social behavior, most behavioral clinicians are ahistorical. They often spend little or no time exploring the patient's recent or distant past. Their psychodynamic colleagues do a far superior job in this area.

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Undoubtedly behaviorists shy away from an evaluation of the determinants of present behavior that are related to early childhood learning because of the problem of the testability of this type of hypothesis. However, psychodynamically oriented pragmatic clinicians can convincingly demonstrate how developmental problems *do* have a strong impact in the present of certain patients. Behaviorists (and logical positivists, generally) have been repulsed by the use of such terms as repression which are often necessary to explain how a patient's behavior could be controlled by responses that are beyond awareness. However, Dollard and Miller (1950) provided very convincing models as to how repeated punishment could lead to either thought avoidance ("repression") or overt behavioral avoidance. It is ironic that many modern behaviorists accept the importance of the role of punishment in suppressing overt behavior but have more difficulty accepting that punishment can suppress covert responses as well.

The explanatory model and treatment possibilities of the behavioral model have been increased greatly by attributing more importance to the role of cognitions. It is surprising that this school has been so slow to accept the importance of feelings. Ironically a good deal of hard psychological research does exist on the importance of feelings as determinants of behavior. However, behavioral clinicians have tended to approach feelings only as a dependent measure that will hopefully be modified by the end of therapy (the client is "happier", "less depressed" and "less anxious").

To summarize, many behavioral clinicians function with a theory of personality that is inadequate in describing and explaining the link between the patient's past and the present problems and the complex link between behaviors, cognitions and emotions. In addition most behavioral clinicians function with a model of dyadic interaction and individual-societal interaction that is much too narrow. The behaviorist who has attempted to treat highly distressed couples and then discovers contributions from Watzlawick, Beavin, and Jackson (1967), or Whitaker (1975), or Gurman (1978), cannot help but be in contact with certain limits of an overly microscopic model of human interaction. Similarly, the behaviorist attempting to help poverty stricken families with high frequencies of wife-or child-battering must start to look for models that

better explain the more macroscopic determinants of interpersonal behavior such as unemployment, lack of social support, and other social pathogens (Bouchard, 1983). This overly limited theory of personality has many negative repercussions as will be explored below.

Ignoring the importance of the therapeutic relationship

Most behavioral training programs offer heavy doses of clinical skill acquisition in such areas as behavioral analysis, anxiety management, operant contracting, and skill training but little is offered on relationship enhancement. Some interns pick up the latter skills in spite of their program, but many do not. Interestingly many of their more successful mentors already do offer high degrees of accurate empathy, warmth, or congruity, but unfortunately their mentors do not necessarily pass on these skills as easily as do their client centered colleagues. A frequent result is that the patient receiving behavior therapy from the colder clinician will be less motivated to work, feel less self-esteem, and be less creative in achieving self-change.

Naive about transference

Many behaviorists appear to have a phobia about thinking about a very frequently occurring series of phenomena which their psychodynamic colleagues have called transference. Transference can take several forms depending upon the particular situation. One example occurs when the patient starts to exhibit feelings, cognitions, and/or behavior towards his/her therapist that are not fully warranted by the present situation. Often these strong positive and/or negative reactions can be explained by the fact that the therapeutic relationship does in some important ways resemble early significant interpersonal relationships.

Many behavior therapists have avoided utilizing this phenomenon in the facilitations of client improvement because of an unfortunate association between transference and the hydraulic model of psychic functioning offered by psychodynamic colleagues. However, it takes little reading of Dollard and Miller (1950) or Yalom (1975) to realize just how much of the clinical phenomenon subsumed under the term "transference" could be explained and predicted by social learning theory provided the clinician is ready to use modern cognitive psychology, and

developmental psychology, and admit that certain autonomic reactions ("feelings") can be triggered without the patient being able to offer a rational "explanation".

The consequences of this omission of an important clinical phenomenon from the conscious awareness of the behavioral clinician can vary in intensity and importance depending upon the nature of the patient's overall functioning. For example, I have practiced principally with clients troubled by reactive depression, sexual deviance, sexual dysfunction, or marital discord. I have found that increased competence in the diagnosis and therapeutic management of transference can often lead to: a) an avoidance of premature termination; b) reduction of useless and exhausting power struggles over contracts and homework assignments; c) frequent discussions of meaningful cognitive, emotional, or behavioral material which patients generated through "irrational or inappropriate" gestures of either love or hate (or some other emotion), towards the clinician; and d) the maintenance of gains through heightened independence at termination of therapy.

Failure to measure the real environment and to assure generalization

As discussed above, the behavioral model, at least as originally developed, was intended to carefully assure that in-therapy changes generalized outside the therapy hour. However, in reality proportionally little clinical or research effort has been addressed to this question. For example, in the area of social skill training a recent review showed that few studies have both measured degree of transfer to the real life environment and also assured transfer through in vivo practice (Scott, Himadi, & Keame, 1983). In the area of couple and family therapy many behavioral practitioners seem to have forgotten early pioneering work in home-based family therapy (Patterson, 1971). The majority of behavioral clinicians seemed to have become, like their dynamic and client-centered colleagues, office bound.

Overestimating the average behavioral clinician's success rates

Behavior therapy owes a good deal of its rapid rise to fame to noisy claims that other schools yielded success rates no better than spontaneous remission rates but only behavior therapy was superior to no therapy or "placebo effects". Hundreds if not

thousands of outcome studies have been mustered to support this claim. However, two areas of outcome literature that I and my colleagues have reviewed, sex therapy (Wright, Perreault, & Mathieu, 1977) and marital therapy (Wright & Mathieu, 1977) lead to the conclusion that most claims probably erred in being overly optimistic because: a) unusually famous (placebo effects) and competent clinicians are often used in outcome studies; b) the client populations studied are often unrepresentative of clinical or hospital populations; c) cases included in the outcome study are handled with a good deal more energy and care than the run of the mill case. For example, where Masters and Johnson (1970) and Lopicollo and Lopicollo (1978) have claimed average success rates in excess of 80% for sex therapy our reviews indicate rates in the average psychiatric clinic to be often around 40%. Admittedly spontaneous or placebo influenced rates in these populations may be as low as 0% which could lead the clinician to feel very pleased with a 40% success rate.

Leaders in this field could avoid this problem if guidelines as to how success rates might vary with clinical population or setting were offered. However, this type of honest discussion (which is required by the food and drug laws in the U.S. for any new medication on the market), has to date seldom appeared. Admittedly no school of psychotherapy excels in modeling this type of honest admission of limits of applicability of their particular brand of therapy. In fact, most schools continue to publicly claim that their brand of intervention is good for any target problem no matter who the person or what the situation.

Underestimating the length of intervention required

Not only do behaviorists consistently claim to be able to "cure" some amazingly complicated problems where all others have failed but these impressive changes are often guaranteed in ten weekly one hour sessions. Perhaps this type of oral or written behavior (on the clinician's part) was warranted when the target problems were phobias or tics, however, alcoholism, reactive depression; marital discord, and many sexual dysfunctions can simply not be "cured" this rapidly.

Naivety about family systems, institutions, and social systems

Many behavioral psychotherapists like their dynamic and client-centered colleagues tend

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to underestimate the importance of the environment in the maintenance of target problems. Similarly the speed with which the environment can punish or sabotage "desired changes" is often seriously underestimated. A danger is that the new positive assertiveness of the delinquent, the alcoholic, or the previously depressed housewife will either be ignored or punished by significant others (fellow delinquent, drinking buddy or spouse).

Some very interesting possibilities of combining the behavioral approach with important systemic notions have been recommended (Gurman, 1978) with couples and families. In fact, one outcome study showed that only a combination of systemic and behavioral approaches to family therapy was better than regular institutional care in preventing relapse of young delinquents (Alexander, Barton, Schiano, & Parsons, 1976). The innovations of Bouchard (1983) and other ecologically oriented researchers indicate paths for intervention in child battering families that are more sensitive to the social network which must maintain the client's improvements once the consultant withdraws.

Inability to admit personal and technical limits

To come full circle, the behavioral model does allow for a careful assessment and specification-of-objective phase which is ideal for improving clinical judgment and reducing the influence of the clinician's personal biases. In fact, many practising behaviorists do not use this model consistently. As a result, many behavioral clinicians will accept patients who clearly have objectives or expectancies or personal preference that would be better suited to another type of therapy which concentrates, for example, on the client's concerns with the past, emotions, or more-difficult-to-define existential preoccupations.

Client-centered, psychodynamic, and gestalt training programs usually include significant experiences to heighten the trainee's awareness of his/her own thoughts, fantasies, feelings, needs, and values. Unfortunately, most behavioral training programs provide little in this area. This oversight leads to a variety of negative consequences: a) the behavioral clinician is less able to utilize his/her own reactions to the patient as valuable diagnostic material; b) by not being sensitive to his/her own counter-transference the behavioral clinician can at least miss important

clinical openings and at worst punish his/her patient inappropriately, for example, when the girl-shy male propositions his female therapist; or the depressed low-assertive patient does get angry with his/her therapist for "being just like my husband (or wife)"; or when the alcoholic lies to his therapist much as he lies to his spouse and colleagues; c) by being unaware of the influence of his/her own values the behavioral therapist is more vulnerable to forcing clients to choose objectives that are not necessarily in their own best interest (e.g. forcing the traditionally married couple to become more egalitarian even though neither spouse wants; or convincing a couple who has so far maintained an open marriage to separate because the multiple sexual partners is proof of "lack of motivation") (Wright, 1985).

The problems associated with the integration of various schools of psychotherapy

The position presented here is that many psychotherapists attempt to combine various ingredients from different schools of therapy in order to overcome weaknesses encountered in any given monolithic approach. The strengths and limits of the behavioral approach has been the example taken in this present paper. However, the same critical exercise could be repeated for the psychodynamic or client-centered model.

The clinician can clearly overcome some of the eight weaknesses of the behavioral approach by integrating specific contributions from the other major schools. In the masters program for counselling psychology at the University of Montréal an attempt at integration has been in effect since 1976 (Lecomte & Bernstein, 1976).

Training

In general graduate training programs that attempt to develop the intervention skills of several different schools (e.g. client-centered, behavioral and psychodynamic) will be lengthier and more sophisticated. The student in evaluating the strengths and weaknesses of alternate training programs could keep in mind that not all job situations require the more sophisticated model of intervention.

However, clinicians aspiring to function without supervision would be much better equipped for a wider range of employment after receiving courses and internships which integrated contributions from several schools of therapy.

Our physician colleagues think nothing of looking for specialized training in three or four post M.D. settings. It is a bit surprising that psychologists react so negatively to this possibility. Part of the problem is undoubtedly financial. However, the latter could be partially resolved if university psychology departments would become more actively involved in offering continuing education to professionals already on the job market, much as their medical colleagues involved in "pure" or "applied" research do not hesitate to communicate recent advances to eager clinicians already in the job market.

Problem of self-identity

Many clinicians and theoreticians (old and young) appear to become attached to a particular therapeutic school much by accident depending upon the orientation of the graduate school they happened to attend. From then on many answers to a variety of nagging questions fall into place: to what journals shall I subscribe? What books shall I buy? What annual meeting shall I attend? How do I advertise myself? How do I explain the chaotic world of human functioning? What intervention strategies should I employ? How shall I justify my therapeutic action? What label should be put on a postgraduate training program? And so forth. Obviously the decision to integrate several schools of therapy necessitates reexamination of some or all of the questions.

Combine what with what?

The clinician or theoretician interested in breaking down unnecessary barriers between schools of psychotherapy can choose from a myriad of alternative types of rapprochement. Inputs from various schools can be combined on at least *nine* dimensions: 1) diagnostic information; 2) descriptive labels; 3) hypotheses to explain the development of problematic functioning; 4) therapeutic objectives; 5) methods to select objectives; 6) intervention strategies; 7) justification of intervention strategies; 8) theories of change; and 9) outcome measures. In my opinion, rapprochement is most essential at the level of diagnosis. The clinician who completes a comprehensive diagnosis without too many theoretical blinders on can avoid a variety of risks described earlier in this paper. However, the other syntheses of school-specific modalities that can be pursued depend very much on the clinical setting of one's practice.

Theory, confusion, and cognitive complexity

Clinicians and theoreticians use concepts from a given school of psychotherapy because this cognitive operation helps establish order in a very complex and otherwise chaotic universe. Unfortunately there is a strong tendency for both clinicians and scientists to become irrationally attached to their cognitive constructs. These concepts continue to be employed in spite of questionable utility and/or contradictory evidence. One effective antidote to an irrational attachment to a theory is to read George Kelly's (1955) *Psychology of Personal Constructs*. Kelly suggests that cognitive constructs are tools used to describe, explain, and predict reality and have above all a utilitarian function. But the clinician, scientist, and/or patient runs into trouble when he/she starts to treat the concept or construct with more respect than the raw data coming in from existence. Each of the three popular schools of therapy commits the error of deforming the raw data produced by the patient to better fit pet theoretical notions. That is, each school has certain types of selective blindness that could be remediated if certain concepts were loosened up to better fit the raw data.

However, the cognitive responses of clinicians, researchers and patients often have anxiety reduction value. For example many clinicians *have to* arrive at a spot diagnosis within the first 5 minutes or at least the first hour of patient contact or they literally feel very uncomfortable. Fortunately, clinicians and researchers can be trained to tolerate lack of closure for increasingly long periods of time with modeling and gradual exposure during internships or research training.

The clinician who can tolerate entertaining a variety of hypotheses on a variety of levels simultaneously will find it much easier to avoid the adoption of an overly simple or ineffective cognitive construction of reality. Of course individuals in general, and psychologists in particular, vary greatly in terms of the number and diversity of cognitions they can manipulate simultaneously. It would be interesting to see whether there is a good deal of variability in cognitive complexity between clinicians and, in particular, whether higher cognitive complexity scores are associated with increased attempts at rapprochement.

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Eclecticism and improvement rates: is there really a positive correlation?

Little research has actually tested empirically whether the combined efforts from various schools actually enhance or hinder outcome statistics. It would be unwise to assume that the eclectic clinician would automatically be more effective than the purist especially during the early attempts at rapprochement. For example, as the clinician experiments with various types of combinations, conceivably he/she would be less decisive, less convincing, even more confused (and confusing) than his/her purist colleague. The result could be a lower placebo impact from the eclectic clinician and conceivably a much too complicated set of cognitions offered to the "lucky" patient. Clearly these types of questions urgently require investigation especially given various surveys indicate that over 50% of practitioners in the U.S. are already eclectic. It is quite possible that an integrated form of psychotherapy will lead to superior improvement rates only if practiced by some clinicians with some clients.

Wishy-washy eclecticism and premature switching

One of the more disquieting patterns of eclecticism was observed by the author during a clinical conference on the case of the treatment of a reactive depressive. The *very open* clinician who used to be the head of a large psychology department but started a successful private practice offered a good warm relationship in the first week, cognitive restructuring in the second, which when "unsuccessful" gave way to dynamic interpretation in the third to be replaced by confrontation in the fourth. When "nothing else worked", medication was started in the fifth. One of the advantages of maintaining rigid boundaries between schools is that this type of unthinking free-for-all is less likely to occur.

The problem with "dabbling" in a variety of therapeutic procedures is that the clinician can dabble superficially with many procedures but master none. This mastery is only possible through rather lengthy and well organized training. The pressure for admission to serious integrated training programs hopefully will increase as clinicians take the demands of an eclectic perspective seriously.

The problem of accountability

Another advantage associated with the rigid boundaries between schools was the facilitation of the already thankless task of the outcome researcher. Comparisons between behavior therapy and psychoanalysis in the treatment of reactive depression were thought feasible because purists in each school could be found. However, outcome researchers became quite chagrined when spot checks of sessions revealed that the "behaviorists" engaged in many transference interpretations and the "analysts" were doing cognitive restructuring and social skill training.

The task of studying "what school of psychotherapy is best suited for which target population" might at first glance seem to become more complicated with the rapprochement between schools. Uniformity myths that one given school is carrying out strategies that are totally different from all other schools are slowly disappearing. Perhaps one advantage of rapprochement will be that uniformity myths of the perfect homogeneity of therapist behavior within a school and heterogeneity between schools will be permanently buried.

Clearly outcome research methodology must increase in sophistication and precision to keep up with the increased complexity of the field that will inevitably result from the breakdown of barriers between schools. Many outcome researchers have already responded to the challenge by increasing design sophistication. However, an increase in precision of questions asked is also evident.

The real loser with rapprochement: healthy competition between paradigms

The field of psychotherapy has advanced by leaps and bounds. Amazing progress has occurred in the areas of theory, research and practice. Patients can more often expect efficient tailor-made types of consultations independent of the practitioner they should encounter. Clinicians are apparently much more willing to refer a patient after a relatively brief trial of unsuccessful intervention whereas earlier patients would often be encouraged to stay on for years without any important improvement.

A good deal of the advances can be directly or indirectly attributed to the healthy competition between schools, where debates about diagnosis, theory, objectives and interventions provoked increased reflection and effort. A

real danger of rapprochement is that this healthy competition will cease. One advantage of open competition for resources (whether for clients, students, research funds, or publication) is that it can potentially keep costs down and quality of services up. If all schools start to say "we're all playing the same game and offering identical services, of identical quality", is there not a risk that the consumer will suffer? It will be interesting to see whether schools of psychotherapy will be prosecuted for violation of antitrust laws in the next ten years.

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