Which Therapeutic Modality of Treatment is Better?
The Elephant in the Room in Every Professional Discussion

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Clearly, psychotherapy is effective in the treatment of personality disorders. However, a troubling and persisting issue and challenge with modern psychotherapy is the seeming contradictions in its clinical practice wherein so many different and, alas, sometimes competing modalities of analysis and treatment are available and touted by practitioners as most or so very effective. This contradiction in the clinical practice of psychotherapy has been dealt with extensively by Hal Arkowitz in the APA history of the profession (Freedheim, 1992). There are many contradictions in the field of psychotherapy as reported by Arkowtiz and this particular one is rather disturbing. The two points of divergence in clinical practice are relevant to our discussion. On the one hand, many practitioners embrace an ideological, if not doctrinaire, commitment to a particular school of thought developed by one of the masters in the field such as Freud, Jung, Adler, Beck, etc. On the other hand and what makes for professional awkwardness in such differences is the fact that of the several hundred (some count upwards of 400!) differing (though not always and necessarily competing) schools of thought there is no incontrovertible empirical or clinical evidence that any one of these is consistently more effective than the others (Karasu, 1986; Beckham, 1990; Elkin et al., 1989; Lambert et al., 1986; Sloane et al., 1975).

If contrast in clinical practice was not enough to baffle the layman and arouse the professional, another disturbing reality is the fact that whereas most professional organizations, viz., societies, institutes, centers, and scholarly periodicals, have a strong allegiance to a particular theoretical construct promoting a theory and practice unique to a school of thought, that fact is that most practicing psychotherapists and clinicians rather choose not to side with one particular school of thought and practice but opt for what has become increasingly a public stance called “eclectic” psychotherapy (some even calling it “integrative” with a nuanced difference from eclectic) (Garfield and Kurtz, 1976; Norcross and Prochaska, 1982; Norcross and Prochaska, 1983; and Norcross and Prochaska, 1988).

Within the past three decades, the commonly held practice of selectivity in the employment of various modalities of analysis and treatment in psychotherapy has come out of the closet, so to speak, and has become a frequently used self-description of a clinical practice. Now, there is positive and even aggressive use of the concept of “eclectic psychotherapy” as a respected position of clinical practice within the profession. Its rise has been based upon a generally felt sense of dissatisfaction, says Arkowitz (1992), with a one-size-fits-all patients and an increasing desire to take advantage of the various schools of theory and practice which have something to offer to a diverse practice. There is more than one main dish on the table of psychotherapy say the eclectic psychotherapists and why then limit oneself to a doctrinaire allegiance to one when others might, in given situations, actually prove as or more effective. This “pragmatic” approach to clinical practice is, or was, initially a very American style of professional practice but is gaining recognition throughout the international community of psychotherapists.

To further explicate the significance of this subtle shift away from orthodoxy and towards pragmatic eclecticism, Strupp and Howard (1992) have offered an extended quote from Lambert, Shapiro, and Bergin (1986) as evidence of its growing popularity:

"Although there is little evidence of clinically meaningful superiority of one form of psychotherapy over another with respect to moderate outpatient disorders, behavioral and cognitive methods appear to add a significant increment of efficacy with respect to a number of difficult problems (e.g., phobias and compulsions) and to provide useful methods with a number of non-neurotic problems with which traditional therapies have shown little effectiveness (e.g., childhood aggression, psychotic behavior, stuttering). … Given the growing evidence that there are probably some specific technique effects, as well as large common effects across treatments, the vast majority of therapists have become eclectic in orientation."

A disturbing feature of research into the effectiveness of the competing schools of theory and practice within psychotherapy, explain Lambert and Gergin (1992), is the fact that the results across the spectrum of theories have been essentially the same. Even high profile theories and modalities of treatment, such as psychoanalysis and cognitive behavioral therapy, have failed to be unequivocally persuasive in their claim of effectiveness when evidence which can be replicated in a clinical setting is not forthcoming (Morgan, 2017). Verification of the actual effectiveness of particular techniques or modalities of treatment are simply (or at least not yet) unconvincing. This is not to say that there is reasonable dispute over the actual effectiveness of the therapeutic encounter but rather over whether or not any one modality of treatment has consistently proven more effective than another. Furthermore, and what raises grave concern within the training institutions in the field of psychotherapy, is the fact that (Sundland, 1977) there is no clear evidence that the differing approaches to the training of psychotherapists – whether psychiatry, social work, or clinical psychology -- makes any difference in the overall effectiveness of the therapy provided by one of these trained professionals for, as Sundland's research has shown, there is a commonality of practice among these various professions in the practice of psychotherapy with no measurable evidence of difference in the effectiveness of their practice.

Though not a designated school of psychotherapy nor merely a collage of loosely tangled theories and insights from established systems of theory and practice, eclectic psychotherapy over the past thirty or so years has become a highly respected "posture" for clinical practitioners to take in working with their clients. The use of more than one method of treatment of a mental health issue is not unlike a physician who tries more than one type of medication in attempting to alleviate the symptoms, if not the causes, of a health distress. In both instances, the psychotherapist and the physician, there is the expectation that the "practice" of health care is based on a substantial acquaintance with the whole *repertoire* of medicines and methods of treatment available to the trained professional (Zarbo, 2016; Norcross and Goldfried, 2005). The use of a variety of tools in the treatment of a client suffering from mental distress is always based on the therapist's acquaintance with the range of theories and methods within the practice of psychotherapy but, in the case of the eclectic psychotherapist, rather than the integrity of the theory it is the proven effectiveness of the methods from which he selects the treatment plan that is of utmost importance. The psychotherapist who uses one system only rather than drawing from a range of proven effective methods is not unlike the jaded physician who always prescribes an antibiotic whether the presenting illness calls for it not.

Each of the classical and modern schools of theory and practice in the field of psychotherapy which has been tried and proven effective over the years is available to the

therapist who is well trained. The therapist knowing only one system of clinical practice is, alas, not unlike the plumber who has only one wrench for all situations! Those schools of thought which have, over the years, been developed with an eye towards being comprehensive in all clinical situations are challenged by the data which, as we have pointed out earlier, suggests that no one system of assessment and treatment has consistently proven better than any other system developed and tested by the psychotherapeutic community. The one-size-fits-all approach or the stand-alone method of treatment has been proven both ineffective and professionally irresponsible in the face of such a wide range of other proven systems and methods of treatment. The psychotherapist who insists upon using only "the one" system to which he has committed himself exclusively is no more responsible than the physician who always prescribes an antibiotic regardless of the presenting symptoms. The naïve idea that there is a "correct" method for the treatment of every client rather than allowing the situation to dictate the range of available tools to be explored in the treatment of mental distress is professionally irresponsible according to the eclectic psychotherapist (Norcross and Goldfried, 2005).

The ideal training of a psychotherapist should consist of a substantial exposure to a range of clinical methods and theories rather than in just one system of practice regardless of the personal preferences of either the trainee or the training supervisor or institution. Many older therapists have been trained in one of the classical schools of psychotherapy, viz., psychoanalysis, analytical psychology, Adlerian psychology, logotherapy, interpersonal psychotherapy, cognitive behavioral therapy, gestalt, etc., but many have moved away from a singularity of practice to an embracing of other methods clinically proven effectiveness in treatment modalities. This "eclectic" shift has proven most effective in enhancing the successful treatment of a wider range of clients than the one-size-fits-all approach of an earlier era. Whereas in psychopathology, the profession relies heavily upon the DSM-5 and its cognates such as the ICD-10 for identifying a mental disorder but, while psychopathology is the science of identification and description, psychotherapy is the art of treatment, the human side of interpersonal interaction between therapist and client. Access to a range of treatment modalities provides the therapist with flexibility in the care of each client as that interpersonal relationship dictates.

If psychopathology appears somewhat rigid in its reliance upon the DSM-5 as a manual for identification and description, psychotherapy offers a balance in the mobility of the selection and even experimental options available to the clinical practitioner. Depending on the presenting symptoms of the client, the eclectic therapist may find that the use of one method for one symptom while the use of another method for a different symptom is both effective and practical. Furthermore, the use of Freud's psychoanalytic psychotherapy might work in dealing with one client whereas the use of Harry tack Sullivan's interpersonal psychotherapy works better with another client just as, in medicine, Prozac (fluoxetine) might work with one patient better than Ritalin (methylphenidate) for another patient. We think nothing of this practice in medicine and eclectic psychotherapists feel the same about therapeutic options of treatment.

There are a variety of psychotherapies, as has already been pointed out, and many eclectic psychotherapists think of the assortment they use in clinical practice as different types of eclectic psychotherapies. The use of the various forms is determined by the therapist in the clinical encounter with a client and usually the approach adopted constitutes a mutual agreement between the therapist and the client and the choice is always related to the mental distress being addressed in the counseling (Smid et al., 2015). For example, something called "brief eclectic psychotherapy" consists of a mutually agreed-upon limited number of therapy sessions using an

eclectic approach and this short-term approach usually consists of a combination of what is called cognitive behavioral therapy (CBT) and a psychodynamic approach (Jonas, 2013). Though the number of sessions is usually between twelve and sixteen (Nijdam, 2012; Jonas, 2013), the term itself "brief eclectic psychotherapy" has a range of definitions with an emphasis upon "short." It has proven particularly popular for the brief eclectic therapeutic treatment of traumatic grief (BET-TG) but also well practiced in the treatment of posttraumatic stress disorder (PTSD), major depressive disorder (MDD), and persistent complex bereavement disorder (PCBD) as well (Jonas, 2013).

Though informally a treatment modality for several generations, the formally developed and labeled eclectic psychotherapeutic approach developed by Larry E. Beutler and colleagues in the early 1990s consisted of four key factors in selecting this approach to the treatment of a client's mental stress, i.e., the client's personal characteristics as identified and assessed by the therapist, the clinical context of the treatment itself, a consideration of identified relationship variables, and, as Beutler explains, specific strategies and techniques "that will maximally focus on relevant problems, manage levels of client motivation, overcome obstacles to successful resolution of problems, achieve treatment objectives, consolidate treatment gains, and prevent or reduce relapse" (Beutler and Consoli,1993). Using these four factors, the Beutler approach to eclectic psychotherapy excludes the limitations on the number of sessions the therapist and client agree to having thereby, explains Beutler, the pressure is off in making specific progress within a tight time frame.

Another eclectic psychotherapy approach was developed earlier in the late 1970s by Richard E. Dimond and colleagues, called "prescriptive eclectic psychotherapy" which has its rationale in the creation of a very individualized treatment plan for each client and consists of a combination of various theories and modalities of treatment, known to the therapist and explained to the client, all the while adhering to a structured encounter which Diamond and colleagues based on actual clinical research data (Diamond, 1978; APA, 1994). Though employing a range of therapeutic techniques and tools for analysis, nevertheless, the prescriptive eclectic psychotherapist is bound to honor the existing research data linked to the formulated structured plan of treatment. Both the type of treatment to be employed as well as the identification and explication of a specified therapeutic relationship to be created between therapist and client must be articulated and agreed upon. Diamond and colleagues, unlike Beuler and colleagues, place their heaviest emphasis upon the identification and utilization of clinical data and empirically validated success rates in establishing a therapeutic treatment plan with the client.

A much simpler and much more commonly used technique or modality of treatment in the eclectic psychotherapeutic tradition is known simply as "technical eclectic psychotherapy" owing to the singularity of focus upon the use of a variety of available modalities of treatment drawn from a range of psychotherapeutic schools of thought and practice but with the specific characteristic of disregarding the theoretical foundations of those various treatment modalities (Short and Thomas, 2015). Extremely pragmatic, this technique is focused exclusively upon what the therapist believes to be the most promising of treatment modalities for each individual patient drawn from the full range of treatment plans known by the therapist. The therapist, therefore, is limited in the exercise of mental health treatment only by the range of his own knowledge of the variety of psychotherapeutic tools which have been created over the years by both the classical and modern schools of theory and practice. Knowledge of these schools of thought is crucial but the therapist is in no way under obligation to adhere to the "theory" of each

school of thought but only the promise of effectiveness in dealing with specific clients (Morgan, 2017). What matters is results. Nothing else matters for if the therapist adheres religiously to the specified assessment and treatment of a particular school but the results are negative, what has been gained? One variation on this rather loosely conceived perspective is that developed by Arnold Lazarus in the early 1960s called "multimodal therapy" and its claim to importance is the earliness with which this eclectic approach was developed by Lazarus (Short and Thomas, 2015; Lazarus, 1967).

A closing note should be made here distinguishing "eclectic psychotherapy" from what eventually became known as "integrative psychotherapy." The distinction, though subtle, is important for often laypersons use the two terms interchangeably and this, of course, is incorrect. The APA (2017) is keen to make a distinction by listing these two types of therapies as unique and, though similar, different types of psychotherapies. While both eclectic and integrative psychotherapies practice the use of a variety of theories and treatment modalities, integrative psychotherapy places more emphasis upon the theories being employed by the therapist while the eclectic therapist is focused more upon the actual outcome (Zarbo et al., 2016).

REFERENCES

"Approaches Featured in PsycTHERAPY". apa.org. Retrieved 2017-03-31.

Arkowitz, H. (1992). "Integrative Theories of Therapy," Chapter 8, in Donald K. Freedham, Editor, *History of Psychotherapy: A Century of Change,* Washington, DC: American Psychological Association.

Beckham, E. E. (1990). "Psychotherapy of Depression at the Crossroads: Directions for the 1990s," *Clinical Psychology Review,* 10, 207-228.

Beutler, Larry E.; Consoli, Andrés J. (1993). "Matching the therapist's interpersonal stance to clients' characteristics: Contributions from systematic eclectic psychotherapy". *Psychotherapy: Theory, Research, Practice, Training. 30 (3): 417–422.*

Dimond, Richard E.; Havens, Ronald A.; Jones, Arthur C. (1978). "A conceptual framework for the practice of prescriptive eclecticism in psychotherapy". *American Psychologist. 33 (3): 239–248.*

Donald K. Freedheim, Editor, (1992). *History of Psychotherapy: A Century of Change,* Washington, DC: American Psychological Association.

Elkin, I., Shea, M. T., Watkins, J. T., Imber, S.D., Sotsky, S. M., Collins, J. J., and Parloff, M. B. (1989). "National Institute of Mental Health Treatment of Depression Collaborative Research Program: General Effectiveness of treatments," *Archives of General Psychiatry, 46, 971-982.*

Garfield, S. L. and Kurtz, R. (1976). "Clinical Psychologists in the 70s," *American Psychologist,* 31, 1-9.

Jonas, Daniel E.; Cusack, Karen; Forneris, Catherine A.; Wilkins, Tania M.; Sonis, Jeffrey; Middleton, Jennifer Cook; Feltner, Cynthia; Meredith, Dane; Cavanaugh, Jamie (April 2013). *Psychological and Pharmacological Treatments for Adults With Posttraumatic Stress Disorder (PTSD). AHRQ Comparative Effectiveness Reviews. Rockville (MD): Agency for Healthcare Research and Quality (US).*

Karasu, T.B. (1986) "The Specificity Versus Non-specificity Dilemma: Towards Identifying therapeutic change agents," *American Journal of Psychiatry,* 143, 687-695.

Lambert, M. J., Shapiro, D.A., and A. E. Bergin (1986). "The Effectiveness of Psychotherapy," in S. L. Garfield and A. E. Bergin, eds., *Handbook of Psychotherapy and Behavior Change*, 34d ed., pp. 157-211, NY: Wiley.

Lambert, Michael J. and Allen E. Gergin (1992). "Achievements and Limitations of Psychotherapy Research," Chapter 11 in Donald K. Freedham, Editor, *History of Psychotherapy: A Century of Change,* Washington, DC: American Psychological Association.

Lazarus, Arnold A. (October 1967). "In support of technical eclecticism". *Psychological Reports. 21 (2): 415–416.*

Morgan, John H. (2017). *Clinical Psychotherapy: A History of Theory and Practice (from Sigmund Freud to Aaron Beck).* South Bend, IN: GTF Books.

Nijdam, Mirjam J.; Gersons, Berthold P. R.; Reitsma, Johannes B.; Jongh, Ad de; Olff, Miranda (March 2012). "Brief eclectic psychotherapy v. eye movement desensitisation and reprocessing therapy for post-traumatic stress disorder: randomised controlled trial". *The British Journal of Psychiatry. 200 (3): 224–231.*

Norcross, J. C. and Prochaska, J. O. (1982). "A National Survey of clinical Psychologists: Affiliations and Orientations," *The Clinical Psychologist,* 35, 1-2, 4-6.

Norcross, J. C. and Prochaska, J. O. (1983). "Clinicians' Theoretical Orientations; Selections, Utilization, and Efficacy," *Professional Psychology: Research and Practice,* 14, 197-208.

Norcross, J. C. and Prochaska, J. O. (1988). "A Study of Eclectic (and Integrative) Views Revisited," *Professional Psychology: Research and Practice,* 19, 170-174).

Norcross, John C. and Goldfried, Marvin R. (2005). *Handbook of psychotherapy integration.* New York: Oxford University Press.

"Prescriptive Eclectic Therapy". apa.org. 1994. Retrieved 2017-03-31.

Short, Fay; Thomas, Phil (2015). *Core approaches in counselling and psychotherapy.* New York: Routledge. pp. 65–67.

Sloane, R. B., Staples, F.R., Cristol, A. H., Yorkston, N. J., and Whipple, K. (1975). *Psychotherapy Versus Behavior Theory,* Cambridge, MA: Harvard University Press.

Smid, Geert E.; Kleber, Rolf J.; Rie, Simone M. de la; Bos, Jannetta B. A.; Gersons, Berthold P. R.; Boelen, Paul A. (2015-06-06). "Brief Eclectic Psychotherapy for Traumatic Grief (BEP-TG): toward integrated treatment of symptoms related to traumatic loss". *European Journal of Psychotraumatology. 6 (1): 27324.*

Strupp, H. H. and Kenneth I. Howard, (1992). "A Brief History of Psychotherapy Research," Chapter 9 in Donald K. Freedham, Editor, *History of Psychotherapy: A Century of Change,* Washington, DC: American Psychological Association.

Sundland, D. M. (1977). "Theoretical Orientations of Psychotheraptists: in A. S. Gurman and A.M. Rzin, eds., *Effective Psychotherapy: A Handbook of Research,* pp. 189-219, NY: Pergamon Press.

Zarbo, Cristina; Tasca, Giorgio A.; Cattafi, Francesco; Compare, Angelo (2016-01-11). "Opinion article: Integrative psychotherapy works". *Frontiers in Psychology. 6.*