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psychology will abandon the natural science framework for this human science alternative. Rather, I am suggesting that, as this approach continues to grow, it becomes increasingly inaccurate to presuppose an essential dichotomy between "human" and "science" and increasingly misleading to neglect the possibility of psychology as a genuinely human science.

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Retrieving German Psychological Literature: Services Available to U.S. Psychologists

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In response to Rosenzweig's (August 1984) valuable contribution on the relation between U.S. psychology and world psychology, I would like to call attention to a number of information services provided by the Zentralstelle für Psychologische Information und Dokumentation [ZPID; Center for Psychological Information and Documentation] in Trier, Federal Republic of Germany (Postfach 38 25, 5500 Trier, Federal Republic of Germany; tel. (0651) 201-2869).

The ZPID (pronounded zet-pit) provides the most comprehensive documentation of German-language psychological literature in the world. Its services include PSYNDEX, a German-English database of German-language psychological literature (i.e., literature from the Federal Republic of Germany, Austria, Switzerland, and the German Democratic Republic); Psychologischer Index (PI), a quarterly abstract periodical corresponding to PSYNDEX; Bibliographie deutschsprachiger psychologischer Dissertationen, an annual abstract journal of doctoral dissertations; and customized searches in PSYNDEX and other databases, insofar as these pertain to psychological topics.

The database PSYNDEX totals over 20,000 references since 1977. The yearly increase is 4,500 at present. PSYNDEX documents journals (approximately 160), books and book chapters in edited volumes, doctoral dissertations, and reports. In addition, the ZPID provides assistance to users in securing copies of full-length articles—a helpful service in these days of funding cutbacks for libraries. A special feature of PSYNDEX is its complete compatibility with PsycINFO, which documents only about 10% of this literature. Subject areas, descriptors, and classification codes are exactly the same in both databases so that a search in PsycINFO can be directly transferred to PSYNDEX. Another special feature of PSYNDEX is that it provides informative abstracts in German (100% of the references) and English (at present, 60% of the journal article references). PSYNDEX, which is available through Deutsches Institut für Medizinische Information und Dokumentation (DIMDI) in Cologne, Federal Republic of Germany, can be accessed from any country. For more information about establishing online contact, DIMDI can be reached at the following address: Postfach 420 580, 5000 Cologne, Federal Republic of Germany. The PI and Bibliographie deutschsprachiger psychologischer Dissertationen (both in German language only) each have an author/editor index as well as a subject index in German and English and are available at a discount for American Psychological Association (APA) members through C. J. Hogrefe, Inc., 525 Eglinton Avenue East, Toronto, Ontario, M4P 1N5, Canada. For fast and inexpensive literature searches, the ZPID may be contacted at the above address.

These services enable American colleagues to easily find out who is publishing what in the German-speaking countries and thus constitute a valuable asset to the already known services of the APA, especially for those who feel stuck in a monocultural psychology bog and would like to discover more of world psychology.

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Setting the Record Straight

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Wolpe (November, 1984) took me severely to task for watering down the efficacy of "pure" behavior therapy with my eclectic mixture. He insisted that my "exceptionally unstable" outcomes—a 36% relapse rate in 112 clients treated by behavior therapy (Lazarus, 1971, p. 18)—contrasted markedly with his own 3% relapse rate (Wolpe, 1958, p. 216), and he cited Paul (1969), who attested to the absence of relapse following systematic desensitization. Moreover, Wolpe contended that I had been practicing "multimodal therapy" (Lazarus, 1981) and not "behavior therapy" when conducting my initial (1971) follow-up inquiries. It is necessary to rebut these points because they have far-reaching significance for both theory and practice.

What is remarkable is not that I obtained a high relapse rate in the early 1970s, but that Wolpe claimed to have achieved such unprecedented and unequaled outcomes and follow-ups in the 1950s. During the past decade, behavior therapy has undergone several significant procedural and conceptual shifts (see Franks, 1984; Lazarus & Fay, 1984). For example, the behavioral treatment of obsessive–compulsive disorders no longer relies on "avoidance conditioning" by means of "a severe shock passed into (the subject's) forearm" (Wolpe, 1958, p. 182), but employs totally different methods such as response prevention, flooding, and participant modeling (e.g., Rachman & Hodgson, 1980; Steketee, Foa, & Grayson, 1982). In many respects, behavior therapy as practiced in the mid-1980s is considerably different from Wolpe's (1958, 1969) pioneering contributions (see Wilson, Franks, Brownell, & Kendall, 1984). Thus, had I administered in the 1960s those procedures I developed or learned about in the 1970s and early 1980s, my 36% relapse rate would probably have decreased significantly, although it would still not have approximated Wolpe's alleged 3%.

Perhaps the foregoing statistic is due to differences in sampling, and is not, as Wolpe implied, a function of my inadequate "stimulus–response analysis" (p. 1327). Thus, Paul's (1969) survey, which Wolpe considered so "compelling," was confined to " 'phobic stimuli,' such as snakes, rats, spiders, heights, and enclosures" (p. 146). Paul also included social anxieties (i.e., phobic responses to interviews, exams, and public performance), but found "evidence of poorer differential success . . . with problems described as 'panic' and 'pervasive anxiety' " (p. 146). My "systematic follow-up inquiry of 112 cases, randomly selected" (Lazarus, 1971, p. 16) was not confined to phobic disorders but included clients with panic, pervasive anxiety, depression, obsessions, compulsions, addictions, eating disorders, and complex family and marital problems. Wolpe has provided no information about the composition of his caseload, how his follow-up data were obtained, and what measures were used. We were informed only that: "Although no systematic follow-up study has been made, follow-up information has been obtained on 45 'apparently cured' and 'much improved' patients two to seven years after the end of treatment" (Wolpe, 1958, p. 216). Selective sampling can easily yield a 100% remission rate and a 0% relapse rate!

By insisting that I practiced "multimodal therapy" prior to 1971, Wolpe lumped this approach together with all other eclectic, multifaceted, or multidimensional orientations, whereas "multimodal therapy" has a well-defined history, a systematic theoretical base, a coherent framework, and several unique assessment–therapy procedures (Lazarus, 1976, 1981, 1984, 1985). My earliest writings (e.g., Lazarus, 1956) favor multidisciplinary, multiform, and multidimensional assessment and therapy, but the first report on "multimodal therapy" (Lazarus, 1973) underscored that, although all multimodal therapists are eclectic, not all eclectic therapists are multimodal.

Wolpe emphasized that, out of my 39 most-used techniques, 33 are "the standard fare of routine behavior therapy" (p. 1326). This is because multimodal practitioners select techniques that are demonstrably effective, and the evidence (e.g., Rachman & Wilson, 1980) points to the efficacy of behavioral and cognitive behavioral procedures over most (but not all) other interventions. But from Wolpe's perspective, the addition of a half dozen of "nonbehavioral" techniques is sufficient to pollute the controlling discipline and render adequate intervention unlikely!

One of the "nonbehavior therapy techniques" to which Wolpe objected is self-disclosure. As Fay and Lazarus (1982) have pointed out, unlike psychoanalysts who eschew self-disclosure because their theory demands detachment and distance for the facilitation of transference, behavior therapists have no such proscriptions. Selective self-disclosure often enhances the therapeutic relationship and proves valuable when using modeling and behavior rehearsal techniques (see Rimm & Masters, 1979, pp. 119–120). Wolpe did not explain why he considered self-disclosure "not a behavior therapy technique" (p. 1326). When a therapist tells a claustrophobic client, "I used to experience great anxiety in closed places until I learned to do X, Y, and Z," we have the hallmarks of good behavior therapy—rapport, empathy, identification, specificity, and practice. It seems capricious to define behavior therapy only as those methods that Wolpe deems acceptable.

Despite our points of departure, however, the theories and methods to which Wolpe and I subscribe, when compared to the views held by psychodynamic practitioners, Gestalt therapists, phenomenologists, person-centered therapists, and so on amount to a just noticeable difference. A dispassionate accounting of technique effectiveness would be greatly facilitated if Wolpe concurred.

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