CHAPTER 3

Psychotherapy Outcome Research: Implications for Integrative and Eclectic Therapists

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RESEARCH INTO THE EFFECTS of therapy now spans over six decades and has typically been aimed at examining the efficacy of school-based approaches to helping people change. The results of this research, as well as the process of engaging in research, have had a modest impact on the practice of psychotherapy. This impact ranges from the dramatic increase in behavior therapies due to the success of some behavioral interventions to the identification of particular treatment methods that are harmful to particular clients.

Although considerable effort has been expended on specific school-based therapies, far less has been devoted to the study of eclectic and integrative approaches. Despite the fact that the plurality of therapists subscribe to an eclectic approach (Jensen, Bergin, & Greaves, 1990; Norcross & Newman, 1992) there is not sufficient outcome research on eclectic psychotherapies to base a chapter on these data. Nevertheless, the decades of past research have many implications for the practice of eclectic therapy. This chapter focuses on the implications of psychotherapy research for the practice of eclectic psychotherapy. First, several controversial issues, such as the general effects of therapy, are addressed. Then the factors that have been identified as causing therapeutic improvement are discussed. Finally, directions for future research are suggested.

Eclectic Therapies and Research

This *Handbook*, the many systems highlighted herein, and other compendiums appearing before it (e.g., Norcross, 1986) are evidence of the growth and sophistication of eclectic practice. For many reasons, this is an exciting development in the field of psychological interventions. In the first place, eclectic therapies, in general, are very friendly toward research. Eclectic therapy, like psychotherapy research, is preoccupied with practical results—with what is most helpful. Thus many eclectic therapists, like psychotherapy researchers, maintain a commitment to the pursuit of data wherever they lead, unencumbered by conceptual, doctrinal, or prior professional commitments. Perhaps eclecticism will be the broad base needed for the integration of research findings that will facilitate reliably effective treatments. Psychotherapy research may make its strongest contribution to practice in eclectic approaches that combine diverse techniques and concepts into a comprehensive and pragmatic approach to treatment; one that avoids strong allegiances to narrow theories or schools of thought.

Many authors (e.g., Goldfried & Wachtel, 1987; Norcross & Grencavage, 1989) have discussed the proper conception of eclectic and integrative therapy. Eclectic therapies are relatively atheoretical, pragmatic, and empirical, made up from a collection of divergent techniques (Norcross & Grencavage, 1989). Integration-based therapies, on the other hand, are invested in a conceptual and theoretical creation beyond a technical blend of methods, so that higher order constructs are offered to account for change and to direct interventions. It appears from these definitions that it would be easier for the eclectic approach than the integrative one to use research findings readily. Some who take the integrative position may be as uninterested in research results as single-school practitioners, their primary interest being in theoretical elegance.

Despite the seemingly natural compatibility and affinity for research that is obvious in systematic, eclectic approaches, there is clear evidence that many eclectic approaches are developed and advocated without reference to studies of efficacy. So the desired consequence of the research-practice compatibility (i.e., reliably effective, empirically based approaches) is more of a fantasy than a reality. It has not proved easy to identify a limited set of salient techniques from across schools. Thus, not much agreement has been reached with regard to which treatment techniques are most effective and which should be chosen for incorporation in eclectic practice. Many of the reviews of eclectic therapy have supported this conclusion (Garfield & Kurtz, 1977; Larson, 1980; Norcross & Prochaska, 1982; Mahalik, 1990). All of these studies suggest that there are many

kinds of eclectic combinations and great diversity in the techniques selected as "most beneficial" by eclectic therapists.

Jensen, Bergin, and Greaves (1990), for example, conducted a study that attempted to discover how many therapists claim to be eclectic therapists, and of those, what forms of therapy they most often used. In order to accomplish these goals, the authors sent questionnaires about theoretical orientation to 800 therapists from within the fields of clinical psychology, marriage and family therapy, social work, and psychiatry. They found that 68 percent of the therapists who responded claimed to be eclectic in orientation. They further discovered that eclectic therapists most often claimed their theoretical orientation to be primarily dynamic, cognitive, or behavioral. The authors determined that, within the sample, eclectic therapists used 4.4 different theories in their practices. The most common combination of theoretical approaches was found to be the use of dynamic theories, cognitive-behavioral techniques, humanistic, and systems approaches. (See Norcross & Newman, 1992, for a review of similar studies.)

Because of the wide variability of techniques used by eclectic therapists, it is extremely difficult to assess the effectiveness of standard eclectic therapies. In order to improve the ability to assess the effectiveness of therapy, several researchers have discussed the need to develop more systematic approaches to incorporating eclectic techniques into general practice (Held, 1984; Duncan, Parks, & Rusk, 1990; Mahalik, 1990). It appears, however, that new eclectic approaches are being invented and advocated just as rapidly as new school-based approaches. Despite this, it seems that the most commonly applied eclectic approaches are based on traditional theories with at least a modicum of empirical support.

It is hoped that the emergence and impact of eclectic treatments will continue to be enhanced through synthesis of empirical findings. But just what findings should be focused on and integrated into eclectic therapies? What are the implications of outcome research for eclectic and integrative psychotherapies?

Conclusions and Implications of Outcome Research

Based on reviews of psychotherapy outcome research (Lambert, Shapiro, & Bergin, 1986), figure 3.1 is an illustration of what empirical studies suggest about psychotherapy outcome. This research literature is extensive, covering decades, and diverse in that it deals with a large range of adult disorders and a variety of research designs, including naturalistic observations, epidemiological studies, comparative clinical trials, and

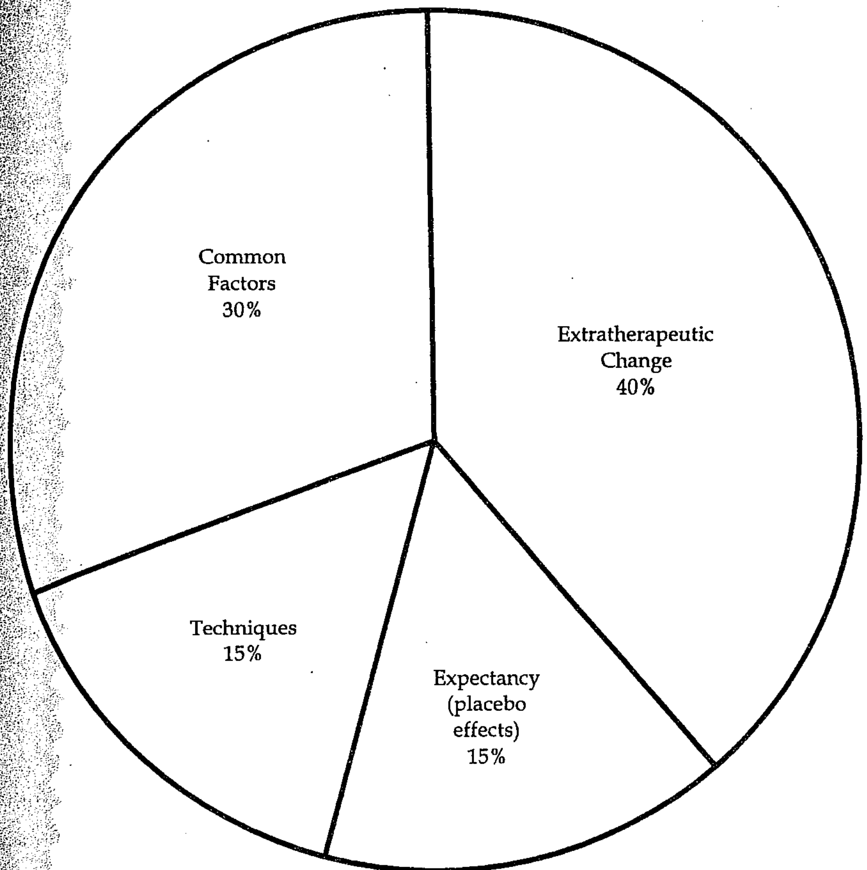

FIGURE 3.1
Percent of Improvement in Psychotherapy Patients as a Function of Therapeutic Factors.

a. Extratherapeutic Change: Those factors that are a part of the client (such as ego strength and other homeostatic mechanisms) and part of the environment (such as fortuitous events, social support) that aid in recovery regardless of participation in therapy.
b. Expectancy (placebo effects): That portion of improvement that results from the client's knowledge that he/she is being treated and from the differential credibility of specific treatment techniques and rationale.
c. Techniques: Those factors unique to specific therapies (such as biofeedback, hypnosis, or systematic desensitization).
d. Common Factors: Include a host of variables that are found in a variety of therapies regardless of the therapist's theoretical orientation: such as empathy, warmth, acceptance, encouragement of risk taking, et cetera.

experimental analogues. However, no statistical procedures were used to derive the percentages that appear in figure 3.1, which appears somewhat more precise than is perhaps warranted. The figure, nevertheless, conveys several of the conclusions to be drawn in this chapter.

Conclusion 1: A substantial number of outpatients improve without formal psychological intervention. The first conclusion apparent from psychotherapy research is that a portion of patients improve "spontaneously" without the benefit of psychotherapy. The available literature on extratherapeutic improvement, using any of the research methods currently available to us, has been summarized elsewhere (Lambert, 1976; Bergin & Lambert, 1978). The studies reviewed are the best this area has to offer in answer to the question of spontaneous-remission rates. The data include subjects who had minimal treatment, but not extensive psychotherapy, as well as subjects who were, for the most part, untreated. The median rate for extratherapeutic improvement for all available studies was 43 percent, with a range of 18 percent to 67 percent. This figure is far from the original estimate of two-thirds suggested by Eysenck (1952) and more recently supported by Rachman and Wilson (1980). The figure of 43 percent represents a rough estimate of spontaneous remission; however, it is an average figure that obscures considerable variation. The evidence reviewed suggests that rates vary from 0 percent to 90 percent at follow-up, and that very low rates of extratherapeutic improvement do not necessarily mean that the course of treatment will be long and difficult. Thus, low rates do not invariably lead to low predictions of success with treatment. Also, high spontaneous recovery rates for a particular disorder do not always imply that patients referred for treatment will recover quickly or at all.

In general, it seems that several factors have a marked effect on spontaneous improvement, such as the number of organ systems involved in a disorder; the length of time the disorder has persisted; the presence of an underlying personality disorder; and the nature, strength, and quality of social supports—especially the marital relationship (Lambert, 1976; Andrews & Tennant, 1978; Mann, Jenkins, & Belsey, 1981). There would also appear to be differential rates of improvement within the general category of neurosis. There is some evidence to suggest that these rates vary as a function of diagnosis, with depression having the highest remission rates, followed by anxiety and hysterical, phobic, obsessive-compulsive, and hypochondriacal disorders (Schapira, Roth, Kerr, & Gurney, 1972).

The substantial limitations of the research on spontaneous remission have been elaborated on elsewhere (Lambert, 1976; Rachman & Wilson, 1980). Despite these limitations, it is apparent that a number of patients improve without formal treatment. Unfortunately, many persons with psychological disorders, especially those referred for treatment, will not improve over a short period of time without professionally guided interventions. The extratherapeutic improvement rate for most disorders is not so high as to make it impossible to demonstrate the efficacy of psychotherapy.

The existing large number of controlled research studies permits a more exact comparison of treated and untreated cases; as a result, comparing treated persons with baseline or "spontaneous remission" estimates is no longer as important as it once was. Nevertheless, these data should remind us that a significant proportion of patients improve without undergoing formal therapy. It is important, therefore, not only to examine the effective ingredients of psychotherapy, but to examine the supportive aspects of the natural environment. Both areas contain useful information about psychological health and adjustment. Not only do we find that significant numbers of people are helped by friends, family, and the clergy, who employ a variety of supportive acts, but people with disorders are also helped by the indirect influence of psychological techniques.

For example, in the United States people readily have available to them a wide variety of self-help literature and self-help groups. These resources often employ behavioral, cognitive, and insight-oriented material from a variety of formal psychotherapy systems. Some of this material, such as self-help books, has been shown to reduce symptomatology (cf. Ogles, Lambert, & Craig, 1991). Thus, some of what appears to be helpful—independent of psychotherapy techniques and theory—may, in fact, derive specifically from psychological theory and technique. This contamination or confusion is even more apparent in the realm of self-help groups for specific disorders, because the structured material used in these groups is often developed by psychologists and applied by people with some training and supervision (e.g., Lewinsohn, Antonuccio, Breckenridge, & Teri, 1984).

Implication 1: While many patients improve without formal therapy, extratherapeutic events are not so powerful that formal therapies are unnecessary. Eclectic therapists can draw upon the natural helping systems that are abundant in the environment to assist them in their efforts to improve psychological therapies.

Conclusion 2: Psychological treatments are in general beneficial. A wide variety of treatment methods have been empirically tested in controlled outcome studies, usually undertaken by advocates of a particular school of therapy. Ordinarily, however, particular systems of therapy are developed and advocated long before empirical evidence supports their use. This is, unfortunately, true for eclectic and integrationist systems as well. As a result, we have today perhaps as many as 250 different therapies (Herink, 1980), most of which have not been tested. Nevertheless, most of the major therapeutic systems have been tested empirically in controlled research.

The available research has led to one basic conclusion: Psychotherapy,

in general, has been shown to be effective. Positive outcomes have been reported for a wide variety of theoretical positions and technical interventions. Much of this research has been summarized in past reviews (Lambert, Shapiro, & Bergin, 1986; Lambert, 1982; Bergin, 1971; Bergin & Lambert, 1978; Meltzoff & Kornreich, 1970) and in meta-analytic summaries (Smith, Glass, & Miller, 1980; Andrews & Harvey, 1981; Shapiro & Shapiro, 1982). These reviews represent outcome literature on literally thousands of patients and hundreds of therapists across the Western world. The reviews represent data on mildly disturbed persons with specific limited symptoms, as well as on severely impaired patients whose disorders are both personally intolerable and socially dysfunctional. These data average changes in patients across diverse and comprehensive measures of improvement. The measures of improvement that are employed include a variety of perspectives of importance to patients, patients' families, mental health professionals, and society in general.

A summary of meta-analytic studies of psychotherapy outcome research comparing, for the most part, untreated to treated patients is presented in table 3.1.

As can be seen from the table, the average effect associated with psychological treatment approaches one standard deviation unit. The first application of meta-analysis to psychotherapy outcome (Smith & Glass, 1977; Smith, Glass, & Miller, 1980) addressed the general question of the extent of benefit associated with psychotherapy and found an average effect size of 0.85 standard deviation units over 475 studies comparing treated and untreated groups. This implies that, at the end of treatment, the average treated person is better off than 80 percent of the untreated sample. By the standards developed by Cohen (1977) for the quantitative evaluation of empirical relations in behavioral science, this is a large effect. The results of this meta-analysis suggest that the assignment to treatment versus control conditions accounts for some 10 percent of the variation among individuals assessed in a typical study. As Rosenthal (1983) has pointed out, this is equivalent to changing the success rate from 34 percent of the cases to 66 percent. Smith, Glass, and Miller (1980) illustrated the clinical meaning of this effect size by contrasting effect sizes derived from therapy outcome studies to those achieved in other situations. For example, in elementary schools the effects of nine months of instruction in reading is about 0.67 standard deviation units. The increments in mathematics achievement resulting from the use of computer-based instruction is 0.40 standard deviation units.

The effect sizes produced in psychotherapy can also be compared to those derived from the use of psychoactive medication. For example, Andrews (1982, 1983) found that treatments of agoraphobics involving graded exposure produced a median effect size of 1.30, whereas antidepres-

TABLE 3.1

Meta-Analytic Reviews and the Effects of Therapy

	Patient Diagnosis/Treatment	Number of Studies	Effect Size
Smith, Glass, & Miller (1980)	Mixed	475	.85
Andrews & Harvey (1981)	Neurotic	81	.72
Landman & Dawes (1982)	Mixed	42	.90
Prioleau et al. (1983)	Mixed	32	.42[a]
Shapiro & Shapiro (1982)	Mixed	143	1.03
Nicholson & Berman (1983)	Neurotic	47[b]	.70
Andrews, Guitar, & Howie (1980)	Stuttering	29	1.53-1.65[c]
Blanchard et al. (1980)	Headache	35	% improved
Quality Assurance Project (1982)	Agoraphobia	25	1.20[c]
Quality Assurance Project (1983)	Depression	200	.65
Steinbrueck, Maxwell, & Howard (1983)	Depression	56	1.22
Dush, Hirt, & Schroeder (1983)	Self-statement modification	69	.74
Miller & Berman (1983)	Cognitive-behavior therapy	38	.83
Stein & Lambert (1984)	Professional vs. paraprofessional	28	.00
Wampler (1982)	Marital communication	20	.43
Asay et al. (1984)	Mixed mental health	9[e]	.82[c]
Robinson, Berman, & Neimeyer (1990)	Depression	37	.73[e]
Hahlweg & Markman (1988)	Behavioral marital therapy	17	.95[c]
Dobson (1989)	Depression	10	2.15[c]
Benton & Schroeder (1990)	Social skills training with schizophrenics	23	.76[c]
Hazelrigg, Cooper, & Borduin (1987)	Family therapy Behavioral therapy	7 6	.45 .50

TABLE 3.1 *(continued)*

	Patient Diagnosis/Treatment	Number of Studies	Effect Size
Christensen et al. (1987)	OCD/Exposure based treatment[f]	5	1.37
	Nonspecific treatments	5	-.14
	Behavioral treatments	5	1.19
Jore (1989)	Trait anxiety & neuroticism	63	.53
Quality Assurance Project (1985)	Anxiety/behavioral treatments	81	.98
Quality Assurance Project (1985)	Obsessive-compulsive/ exposure therapies	38	1.37
Scogin et al. (1990)	Self-administered treatments	40	.96
	Therapies		1.19

a = Psychotherapy vs. placebo
b = Number of comparison groups
c = Based on pre-post gains rather than control group comparison
d = Improved 40–80% in psychological treatments and 20–40% in placebo controls
e = Number of mental health centers studied
f = Obsessive-compulsive disorder

sant medication produced an average effect size of 1.10. With depression, the effect sizes produced for antidepressants ranged from 0.81 to 0.40, depending on the type of antidepressant and on patient population. Thus, the effect sizes produced through the application of psychotherapies are generally as large as or larger than those produced by a variety of methods typically employed during educational and medical interventions.

It is important to reiterate that the changes occurring in patients as a result of therapy are neither trivial nor just cold statistics; rather, they are substantial. A considerable number of people who might be classified as "cases" before treatment would be considered enough improved to no longer be so classified following treatment, although the exact proportion who leave the ranks of the dysfunctional is open to interpretation (Jacobson, Follette, & Revenstorf, 1984; Tingey, Burlingame, Lambert, & Barlow, 1990). Research on psychotherapy outcome suggests that patients with a variety of problems are helped by many methods that may have been put to the empirical test. The results of psychotherapy outcome research by no means suggest, however, that every participant gains to a clinically meaningful extent. The results are also compatible with the suggestion that some clients may deteriorate during therapy (Lambert, Bergin, & Collins, 1977).

Implication 2: To the extent that eclectic therapies provide treatment that includes substantial overlap with traditional methods that have been developed and tested, they rest on a firm empirical base, and they should prove to be at least as effective as traditional school-based therapies and certainly more effective than no-treatment controls.

Conclusion 3: Although there are a large number of therapies, each containing its own rationale and specific techniques, there is little evidence to suggest the superiority of one school or technique over another.

Evidence for this conclusion has been summarized elsewhere (Lambert, Shapiro, & Bergin, 1986; Luborsky, Singer, & Luborsky, 1975; Smith, Glass, & Miller, 1980). And while there are exceptions, the equivalence among seemingly highly diverse therapies has numerous implications for eclectic practice. The general findings of no-difference in the outcome of therapy for clients who have participated in highly diverse therapies has a number of alternative explanations: (a) different therapies can achieve similar goals through different processes; (b) different outcomes do occur but are not detected by past research strategies; and (c) different therapies embody *common factors* that are curative although not emphasized by the theory of change central to a particular school. At this time, any of the above interpretations can be advocated and defended, since there is not enough evidence available to rule out alternative explanations.

Clearly, different therapies require the client to undergo different experiences and engage in different behaviors. Diverse therapies could be effective for different reasons. But we do not yet know enough about the boundaries of effectiveness for each therapy to discuss alternative (a) and its merits. Alternative (b), the inadequacy of past research, will not be fully discussed here. Suffice it to say that there are many methodological reasons for failing to reject the null hypothesis. Kazdin and Bass (1989), for example, have questioned the value of the majority of past comparative studies on the basis of a "lack of statistical power." There are also as yet serious problems in accurately measuring behavioral change (Lambert, Christensen, & DeJulio, 1983). Any of a host of methodological problems could result in a failure to detect differences between therapies. The third alternative (c), emphasizing common factors in different therapies, is the possibility that has received the most research attention and the one that has the clearest implications for practice. It is not only an interpretation of the comparative outcome literature, but is based on *other* research aimed at discovering the active ingredients of psychotherapy. This interpretation also has a relationship to the placebo literature alluded to in figure 3.1.

A variety of factors common across therapies account for a substantial amount of improvement found in psychotherapy patients (see figure 3.1).

These so-called common factors may account for most of the gains that result from psychological interventions. It is important, therefore, for eclectic therapies to intentionally incorporate them. What are these common factors, and what empirical support has been found to suggest their contribution to therapeutic outcome?

Common factors can be conceptualized in a variety of ways (see Grencavage & Norcross, 1990). To clarify the differences between them, they have been grouped into Support, Learning, and Action categories in table 3.2. These categories were chosen to represent a possible developmental sequence that is presumed to operate in many psychotherapies. The developmental sequence is at least partially mediated through factors common across therapies. The developmental nature of this sequence presumes that the supportive functions precede changes in beliefs and attitudes, which precede attempts by the therapist to encourage patient action.

A variety of common factors attributable to the therapist, therapy procedures, and the client are listed in this table. As already mentioned, these factors would seem to operate most potently during the process of therapy. Together they provide for a cooperative working endeavor in which the patient's increased sense of trust, security, and safety, along with decreases in tension, threat, and anxiety, lead to changes in conceptualizing his or her problems and ultimately in acting differently by refacing fears, taking risks, and working through problems in interpersonal relationships.

Several studies emphasize the importance of many of these common factors. Among the common factors most frequently studied have been those identified by the client-centered school as "necessary and sufficient conditions" for patient personality change: accurate empathy, positive regard, nonpossessive warmth, and congruence or genuineness. Virtually all schools of therapy accept the notion that these or related therapist relationship variables are important for significant progress in psychotherapy and, in fact, fundamental in the formation of a working alliance (Lambert, 1983).

Studies showing both positive and equivocal support for the hypothesized relationship have been reviewed elsewhere (cf. Levant & Shlien, 1984; Patterson, 1984; Gurman, 1977; Lambert, DeJülio, & Stein, 1978; Mitchell, Bozarth, & Krauft, 1977). Reviewers are virtually unanimous in their opinion that the therapist-patient relationship is critical; however, they point out that research support for this position is more ambiguous than was once thought. Studies using ratings of client-perceived relationship factors, rather than objective raters' perceptions, obtain consistently more positive results, and the larger correlations with outcome are often between client process ratings and client self-reports of outcome. Nevertheless, there is considerable support for the positive effect of therapist attitudes on clients and their posttherapy adjustment.

TABLE 3.2

Sequential Listing of Factors Common Across Therapies That Are Associated with Positive Outcomes

Support Factors	Learning Factors	Action Factors
Catharsis	Advice	Behavioral regulation
Identification with therapist	Affective experiencing	Cognitive mastery
Mitigation of isolation	Assimilation of problematic experiences	Encouragement of facing fears, taking risks, mastery efforts
Positive relationship	Changing expectations for personal effectiveness	Modeling
Reassurance	Cognitive learning	
Release of tension	Corrective emotional experience	Practice
Structure	Exploration of internal frame of reference	Reality testing
Therapeutic alliance	Feedback	Success experience
Therapist-client active participation	Insight	Working through
Therapist expertness	Rationale	
Therapist warmth, respect, empathy, acceptance, genuineness		
Trust		

For example, Miller, Taylor, and West (1980) investigated the comparative effectiveness of various behavioral approaches aimed at helping problem drinkers control their alcohol consumption. Although the focus of the study was on the comparative effects of focused versus broad-spectrum behavior therapy, the authors also collected data on the contribution of therapist empathy to patient outcome. One finding—surprising to the authors and important for our discussion—was the discovery of a strong relationship between empathy and patient outcome obtained from the six- to eight-months follow-up interviews used to assess drinking behavior. Therapist rank on empathy correlated ($r = 0.82$) with patient outcome, thus accounting for 67 percent of the variance on the criteria. These results argue for the importance of therapist communicative skills even with behavioral interventions. They were also presented in a context where

variations in specific techniques did not prove to have a similar powerful effect on outcome.

The importance of the therapeutic relationship has been bolstered in recent years by investigations of the therapeutic alliance (Frieswyk et al., 1986). This construct has been conceptualized and defined differently by a host of interested investigators. And like the client-centered dimensions, it has been measured by client ratings, therapist ratings, and judges' ratings. Ratings of the alliance have been undertaken with a wide variety of adult patients who have been diagnosed with a broad spectrum of disorders.

There is more disagreement about the therapeutic alliance construct than there was with the client-centered conditions. This may prove to be a hindrance in drawing conclusions in this area because there are now several popular methods for measuring this construct, rather than the limited number of scales evidenced in the client-centered literature. In addition, the alliance is seen as a necessary, but not sufficient, condition for personality change, and so assumes a less important theoretical position in dynamic therapies and certainly other therapies than the facilitative conditions did in client-centered therapy. In addition, ratings of the therapeutic alliance contain a heavy emphasis on patient variables, mainly their ability to participate in therapy. They go well beyond measuring therapist behavior and should correlate more highly with outcome because they take into account important patient variables as well as therapist behavior.

Gaston (1990), in trying to integrate the various constructs that have been offered to describe the therapeutic alliance, has suggested that some of the following components of the alliance are measured by some but not all current rating scales: (a) the patient's affective relationship to the therapist, (b) the patient's capacity to purposefully work in therapy, (c) the therapist's empathic understanding and involvement, and (d) patient-therapist agreement on the goals and tasks of therapy.

That therapeutic alliance is not the same as the facilitative conditions hypothesized by Rogers is clear from the above definition, the operationalization of the constructs in rating scales, and some empirical research. For example, Johnson (1988) correlated relationship inventory ratings (based on Rogers's conception of the relationship) with two alliance scales and found no significant association.

A sample of studies on the alliance is presented in table 3.3, reflecting the current status of research in this area. Clearly the alliance is related to therapy outcome although there are instances where it fails to predict outcome and related instances where only a few associations are found and others are rather small.

The work of Windholz and Silberschatz (1988) is typical of research in this area. These authors attempted to replicate the findings of the Vanderbilt research group as reported by O'Malley, Suh, and Strupp

TABLE 3.3

Percentage of Outcome Variance Accounted For by Therapeutic Alliance Ratings

Author	Scale Used	Outcome	% of Outcome Accounted For
Gomes-Schwartz (1978)	VPPS[a]	Global ratings of gains	27%–38%
Morgan et al. (1982)	PHAS[b]	Composite residualized gain scores	20%
Luborsky et al. (1985)	PHAS[b]	Indices of social functioning	25%–51%
Marziali (1984)	TARS[b]	Symptomatic change Patient-therapist evaluations	9%–14% 9%–35%
Eaton et al. (1988)	TARS[b]	Improvement in symptoms of bereavement	19%–35%
Marmar et al. (1989)	CALPAS[bcd]	Symptomatic change, interpersonal functioning	9%–16%
Horvarth & Greenberg (1989)	WAI[bc]	Variety of outcome measures[e]	18%–27%
Tichenor & Hill (1989)	VTAS[a] WAI[a] CALPAS[a] PHAS[a]	Variety of outcome[f]	0%–50%
Johnson (1988)	VPPS[a] PHAS[a]	Symptom levels at termination	No association
Gaston et al. (in press)	CALPAS[a]	Symptomatic improvement	36%–57%

Key Terms Defined: VPPS = Vanderbilt Psychotherapy Process Scale; VTAS = Vanderbilt Therapeutic Alliance Scale; TARS = Therapeutic Alliance Rating Scale; CALPAS = California Psychotherapy Alliance Scale; PHAS = Penn Helping Alliance Scale; WAI = Working Alliance Inventory.

[a] = Rated by clinical judges
[b] = Rated by patient
[c] = Rated by therapist
[d] = Patient working capacity subscale only, rated by patient and therapist
[e] = When outcome was based on residual gain scores (initial levels of disturbance accounted for), no significant relation was found
[f] = Initial levels of symptoms not accounted for

1983). The Vanderbilt researchers had reported that two process variables, 'patient involvement" and "therapist-offered relationship," predicted out-:ome in an outpatient college population. Using a larger sample of thera-)ists, and a more typical adult outpatient sample, the authors replicated the /anderbilt findings. Ratings on 10 minutes of therapy from a single session :orrelated with the outcome of 16 weeks of brief dynamic psychotherapy)ased on therapist ratings of change (but not client ratings).

Using the Vanderbilt Psychotherapy Process Scale (VPPS) to study he active ingredients of therapy, the Vanderbilt group found differences n behavior between therapists from different orientations. The analytic herapists were observed to use more exploratory techniques, the Rogerian herapists were warmer and more empathetic, and the nonprofessionals ;ave more advice and engaged in more informal conversations (Gomes-ichwartz, 1978). Despite these differences in behavior and theory, no ubstantive differences in outcome were found between therapies. Drawing ın the same database, O'Malley et al. (1983) examined the active ingredi-nts of therapy in the first three sessions. In this study they revised the 'PPS and still found that it correlated mainly with therapist ratings of ·sychotherapy outcome. The predictive variables were patient involve-ıent and therapist-offered relationship.

Both the Vanderbilt group and Windholz and Silberschatz (1988) /ere puzzled over the failure of the process variables to correlate more ighly with patient ratings of change. And these failures weaken the onclusions from both sets of studies. Neither group found much in the /ay of specific techniques that were unique to particular theories of hange, strengthening the conclusion that common factors are central.

Research on the therapeutic alliance has, as yet, generated far less esearch than that generated by client-centered theory. Still, it has ad-anced to the stage of trying to show that the alliance is actually some-ıing that not only *precedes* therapeutic change but is also an active ingredi-nt of psychotherapy. Gaston, Marmar, Thompson, and Gallagher (in ress), for example, used hierarchical regression analysis to examine the lliance in elderly depressed patients who received dynamic, cognitive, or ehavioral therapy. Initial symptomatology, symptomatic improvement up ͻ time of alliance measurement, and patient and therapist CALPAS (Cali-ͻrnia Psychotherapy Alliance Scale) scores were used to predict symptoms : termination. The alliance assessed near termination accounted for 36 ercent to 57 percent of outcome variance over and above initial symp-ͻmatology and in-treatment symptomatology change.

Another approach to understanding the contribution of the therapist ͻ effective outcome has involved the use of behavioral and adjective ıecklists filled out by clients following their therapeutic contacts. Lorr 1965), for example, had 523 psychotherapy patients describe their therapists on 65 different statements. A subsequent factor analysis identified five factors: understanding, accepting, authoritarian (directive), independence-encouraging, and critical-hostile. Scores on these descriptive factors were correlated with improvement ratings, with the result that client ratings of understanding and accepting correlated most highly with client- and therapist-rated improvement.

In a more recent study, Cooley and Lajoy (1980) attempted to replicate the Lorr study. In addition, they studied the relationship between therapist ratings of themselves and of outcome, as well as the relationship of discrepancies between patient and therapist ratings and outcome ratings. The patients were 56 adult community mental health outpatients who had been treated by one of eight therapists at the clinic. As with the Lorr study, patient ratings of therapist understanding and acceptance correlated most highly with client-rated outcome. On the other hand, when self-ratings of therapists attributes were compared to therapist-rated patient outcome, the correlations were insignificant, suggesting that therapists did not perceive their personal attributes as a factor influencing therapeutic outcome.

Similar findings have been reported in group treatment. Glass and Arnkoff (1988) examined common and specific factors in client descriptions and explanations of change. The clients were shy and consequently treated in one of three structured group therapies for shyness or in an unstructured therapy group. Each group was based upon a different theory of change and differed in its content and focus. Nevertheless, content analysis revealed that in addition to specific treatment factors, all groups contained considerable emphasis on group process and common factors such as support. They suggest that "the role of common group process factors appeared to be at least as important to subjects as the specific therapy program content" (p. 437).

Murphy, Cramer, and Lillie (1984) studied common factors by having outpatients generate a list of curative factors that they believed to be associated with their cognitive behavioral therapy. Those factors suggested by a significant portion of patients were advice (79 percent), talking to someone interested in my problems (75 percent), encouragement and reassurance (67 percent), talking to someone who understands (58 percent), and installation of hope (58 percent). The two factors that correlated most highly with outcome, as assessed by both therapist and patient, were talking to someone who understands, and receiving advice. It is interesting to note that the patients in this study were predominantly from the lower socioeconomic class, and past research has shown that these patients expect advice (Goin, Yamamoto, & Silverman, 1965).

Patients frequently attribute their success in treatment to personal qualities of the therapist. That these personal qualities bear a striking resemblance to each other across studies and methodologies is evidence

that they are highly important in psychotherapy outcome. This notion was also emphasized by Lazarus (1971) in an uncontrolled follow-up study of 112 patients whom he had seen in therapy. These patients were asked to provide information about the effects of their treatment and the durability of improvement, and their perceptions of the therapeutic process and characteristics of the therapist. With regard to therapist characteristics, those adjectives most often used to describe Lazarus were sensitive, gentle, and honest. Patients clearly felt the personal qualities of the therapist were more important than specific technical factors, about which there was little agreement.

In their study comparing behavioral and more traditional insight-oriented therapy, Sloane, Staples, Cristol, Yorkston, and Whipple (1975) reported a similar finding and elaborated upon the place of therapist variables in positive outcome. Although they failed to find a relationship between judges' ratings of therapists' behavior during the third therapy session (on empathy) and later outcome, they did find that patients tended to emphasize the personal qualities of their therapists as causing personality change.

The notion that common factors are important in producing positive outcomes is also supported by the failure to find differential outcomes in studies comparing therapies that use highly divergent techniques. This finding has been documented in several reviews (Bergin & Lambert, 1978; Luborsky, Singer, & Luborsky, 1975), and has been dramatically illustrated in the NIMH multisite collaborative study of depression (Elkin et al., 1989), which compared a standard reference treatment (imipramine plus clinical management) with two psychotherapies (cognitive-behavior therapy and interpersonal psychotherapy, a kind of dynamic therapy). These three treatments were contrasted with a drug placebo plus clinical management control group. The study was the first head-to-head comparison of these two psychotherapies that had been shown in previous research to be specifically effective with depression. Both these therapies had been extensively tested by their developers, but less was known about the degree to which their effectiveness could be replicated by therapists outside of the groups that developed these treatments.

The 250 patients seen in this study were randomly assigned to the four treatments that were offered in Pittsburgh, Oklahoma City, and Washington, D.C. They met research diagnostic criteria for a major depressive episode and a score of 14 or more on the 17-item Hamilton Rating Scale for Depression. A host of exclusion criteria were also applied so as to leave the sample who were treated as free from other disorders as possible.

The therapists were 28 psychiatrists and psychologists who were carefully selected, trained, and monitored in the specific treatment they offered. Each therapist saw between one and eleven patients. The treatments were carefully defined and intended to reflect a manual that spelled out theoretical issues, general strategies, major techniques, and methods of managing typical problems. Those who completed therapy averaged 16.2 sessions. The battery of outcome measures included symptomatic and adjustment ratings from multiple perspectives.

Numerous comparisons were made and the results of this study are very complex. Among the more interesting findings were comparisons of the two psychotherapies with the medication placebo plus clinical management (PLA-CM). This latter condition was intended to control for the effects of regular contact with an experienced and supportive therapist, the general support of the research setting, and the effects of receiving a drug that was thought to be helpful. Did the psychotherapies have any effects beyond what could be achieved through this rather extensive placebo?

There was limited evidence of the specific effectiveness of the interpersonal psychotherapy (IPT) and no evidence for the specific effectiveness of cognitive-behavioral therapy (CBT). In general there was little evidence for superiority of the therapies in contrast to the placebo. The therapies were effective, but the patients who received the placebo also improved. Interpersonal psychotherapy, however, was more impressive with the more severely disturbed patients.

In head-to-head comparisons of IPT and CBT, no significant differences were found in any of the major analyses or in comparisons with more and less severely disturbed patients. This similarity held up even on measures that were thought to be differentially sensitive to the two therapies. The authors conclude: "The general lack of differences between the two psychotherapies, together with the good results for the PLA-CM condition, suggests once again the importance of common factors in different types of psychologically mediated treatment" (Elkin et al., 1989, p. 979).

Similar conclusions were reached by Zeiss, Lewinsohn, and Munoz (1979). These authors compared (a) interpersonal-skills training, (b) a reinforcement-theory program to increase pleasant activities (and the enjoyment of potentially pleasant activities), and (c) a cognitive approach to the modification of depressive thoughts. They found that all treatments were associated with reduction in depression, without any differential changes specific to aspects of the patient's problems targeted by the three treatments. Zeiss et al. (1979) note the improvements also recorded by the waiting list group and cite Frank's (1974) demoralization hypothesis as the most parsimonious explanation for the results. These researchers suggest that the impact of treatment was due to the enhancement of self-efficacy via training self-help skills, thus increasing expectations of mastery and perception of greater positive reinforcement as a function of the patient's greater skillfulness. Therefore, the common components of therapy for depression emerge as important. On the other hand, it should be noted that

the experience level of the therapists was not high (counseling psychology graduate students and M.A.'s), and there was no monitoring of the therapists' contributions to therapy; thus treatment delivery according to the design is not assured. In addition, patients' and therapists' perceptions of curative factors were not studied, so that the attribution of causality to them is purely hypothetical.

Implication 3: In general, eclectic therapies should stress commonalities, including the therapist's contribution to outcome, by emphasizing those factors common across therapies highlighted in empirical research. To the extent that they are present in therapy positive personality change is likely.

What Techniques Can Be Chosen on the Basis of Demonstrated Superiority?

Given the improvement that results from homeostatic mechanisms, fortuitous events, social supports, expectations, and common factors, there has not been any general, clear demonstration of the power and differential impact of specific techniques on patient functioning. Nevertheless, technique effects sometimes show themselves in particular studies; unfortunately, replication of technique effects has proved difficult.

COMPARATIVE OUTCOME STUDIES

Traditional reviewing procedures of the earliest comparative studies have not resulted in conclusions that favor the superiority of a particular therapy across the broad categories of anxiety, depression, and interpersonal problems to which they have been applied (Meltzoff & Kornreich, 1970; Luborsky, Singer, & Luborsky, 1975; Bergin & Lambert, 1978). The newer quantitative reviews (see table 3.1) based on meta-analysis have been more likely to reflect small differential outcomes, albeit with little consistency.

Data from several meta-analytical reviews (Dush et al., 1983; Nicholson & Berman, 1983; Shapiro & Shapiro, 1982; Smith, Glass, & Miller, 1980; Quality Assurance Project, 1983) tend to yield a small but consistent advantage for cognitive and behavioral methods over traditional verbal and relationship-oriented therapies. The most reliable data coming from within-study comparisons suggest some advantage for cognitive and behavioral therapies over dynamic-humanistic ones.

To examine this issue more carefully, let us consider Shapiro and Shapiro's (1982) extensive meta-analysis, which focused exclusively on studies comparing two or more active treatments with control conditions. In consequence, their data contained more replicated comparisons between treatment methods than found in the Smith et al. (1980) review, and permitted more definitive statements concerning the comparative efficacy of treatments. Based on an examination of 143 studies, Shapiro and Shapiro (1982) found that cognitive and various behavioral treatments yielded more favorable outcomes (1.00 and 1.06 effect sizes, respectively) than other treatments with which they were compared, whereas dynamic and humanistic therapies tended to yield inferior outcomes (effect size 0.40). Like Smith, Glass, and Miller (1980), however, Shapiro and Shapiro (1982), also attributed the larger effect sizes to strong biases in the behavioral and cognitive literature toward analog studies, mild cases, and highly reactive criteria. They stated that the treatments and cases studied were unrepresentative of clinical practice but very representative of the simple experiments on those techniques that are frequently conducted in university settings.

An interesting sidelight of the Shapiro and Shapiro report was the finding of a significantly larger effect size for cognitive-behavior therapy over systematic desensitization. This conclusion has, however, been challenged by another meta-analysis. Berman, Miller, and Massman (1984), using a larger, but overlapping, sample of studies, showed no difference between cognitive-behavior and desensitization therapies (effective size difference 0.06). It also revealed that the larger effect sizes for cognitive-behavior therapy occurred in studies conducted by investigators having an allegiance to that method. Also of interest was the finding that the combination of desensitization with a cognitive-behavior method did not increase effects beyond that obtainable by either treatment alone.

Dobson (1989) reported a meta-analysis of 28 studies that compared Beck's cognitive therapy with no treatment, other behavior therapy, drug treatment, or other psychotherapy with depressed patients. In each study the Beck Depression Inventory was used as the outcome measure. Cognitive therapy was two standard deviations better than no treatment, and half a standard deviation was better than drug treatment, behavior therapy, or other psychotherapy.

Robinson, Berman, and Neimeyer (1990) in a broader and more diverse sampling of the literature found cognitive, cognitive-behavioral, and behavioral psychotherapies to be a half standard deviation superior to general verbal therapies (which appeared to be no more effective than placebo controls). However, when allegiance of the experimenter was taken into account, the differential effects of treatments washed out.

The foregoing meta-analyses reveal a mixed picture. There is a strong trend toward no differences between techniques in amount of change produced, with occasional superiority for a particular method.

A variety of psychotherapy research strategies have confirmed the powerful and superior effects of some behavior therapies with certain specific problems. The most clear superiority for a particular treatment is with phobic disorders. Research has suggested the necessary steps to facilitate rapid reduction of anxiety to phobic situations. These procedures involved selecting patients with clearly identified fears that are evoked by specific stimuli. In addition to identifying the evoking stimuli, the patient must be motivated to seek and complete treatment. Early reports indicated that as many as 25 percent of patients may refuse or drop out of treatment (Marks, 1978), although this is not a high figure for a research protocol. In order for the treatment to work, clients must be willing to "make contact" with the evoking stimuli until their discomfort subsides.

Numerous behavioral approaches are based on this "exposure" paradigm. Desensitization involves repeated brief exposure in fantasy or in vivo with a counteracting response, such as relaxation, during and between exposure. Flooding involves rapid, prolonged approach into the phobic situation in fantasy or in vivo. Operant approaches have been used via systematic rewards for moving toward or staying in the feared situation. Modeling follows a similar paradigm in which the therapist models approach behaviors and then encourages the patient to do the same. Even in cognitive rehearsal and self-regulation approaches, the patient is encouraged to face feared situations and attain mastery of those situations through the use of effective coping strategies. Therapies for some other anxiety-based disorders such as sexual dysfunctions and compulsive rituals are dealt with through the use of similar exposure techniques. These include gradual practice in sexual situations, and response prevention following exposure to the anxiety that precedes and accompanies rituals.

Although the exposure principle does not explain the reasons for improvement, it does suggest the necessary conditions for improvement and the therapeutic strategy that is to be used: identify the provoking stimuli, encourage exposure, help the patient remain exposed until the anxiety subsides, and assist in mastering thoughts and feelings linked with the disordered responses. Given enough contact with the feared situation, patients cease to respond with avoidance, anxiety, or rituals. Contrary to the expectations of some professionals and the patients themselves, increased sensitization to the anxiety-provoking situation is rare. Marks (1978) suggests such sensitization occurred in only 3 percent of the cases that were expected to be successful (i.e., had adequate motivation, absence of serious depression, no attempts to escape exposure in fantasy or reality, and completed a reasonable amount of treatment).

Numerous studies have tried to sort out the specific procedures necessary for successful treatment. Is deep muscle relaxation necessary? Is gradual exposure through a hierarchy required? Is high arousal necessary (as in implosion)? Should exposure be in vivo or through mental images? Does modeling enhance other exposure methods? Should exposure be prolonged or brief? Will the addition of cognitive coping strategies enhance the effects of exposure treatments? The bulk of evidence on these and similar questions suggests that achieving lasting reductions in fears and rituals is a function of exposure. Time spent with deep muscle relaxation, the use of tranquilizers, and high levels of arousal, add little or nothing to treatments that focus on any effective means of encouraging exposure until anxiety reduction occurs (Marks, 1978; Emmelkamp, 1986). Likewise, interactional exposure without modeling produces fear reduction, but modeling without interactional exposure does not (Marks, 1978, p. 505).

Exposure-based therapies play a major role in the treatment of panic disorder with agoraphobia (Barlow, 1988; Michelson & Marchione, 1991). Clearly they are superior to alternative techniques, with conservative estimates of clinically significant improvement approximating 50 percent and full recovery occurring in less than a third of patients (Jacobson, Wilson, & Tupper, 1988).

Cognitive-behavioral treatments for panic with agoraphobia have also received considerable research attention in recent years. It is a bit early to draw definitive conclusions, but evidence is accumulating that combining cognitive therapy (aimed at cognitive restructuring and changing core beliefs, misperceptions, and misattributions related to the disorder) with gradual, therapist-guided exposure produces results superior to gradual exposure alone or in combination with other treatments (Michelson, Marchione, & Greenwald, 1989). This seemingly synergistic combination is especially interesting for eclectic practice because it strongly supports the basic premise of eclectic practice.

Conclusion 4: Although the earliest studies on anxiety reduction were undertaken with simple phobias and nonclinical populations such as speech phobics, there is now an abundance of studies on clinical populations that substantiate the specific effects of exposure treatments when contrasted with other therapeutic modalities and specific techniques that don't include an exposure component. Still, research has identified boundaries to these effects; exposure treatments, although effective with agoraphobia, simple phobias, and compulsions, are not as effective nor as uniquely effective with social phobias, generalized anxiety disorders, or combinations of the above. The exposure principle seems to have more limited specific applicability with sexual dysfunctions, where the short-term effects are not followed with the same long-term effects as exposure for agoraphobics (Emmelkamp, 1986).

The specific importance of cognitive therapy for panic and agoraphobia with panic appears promising but is in need of further investigation (Michelson & Marchione, 1991).

Implication 4: Eclectic therapies that capitalize on the contributions of specific techniques are likely to be especially effective and should be recommended for practice. Since there is some evidence for the usefulness of particular techniques, eclectic therapies may be effective either because clinicians with this orientation are flexible enough to use techniques that directly address a problem or because eclectics are more open to the value of referral to clinicians skilled in the use of a particular technique. In either case, because of its flexibility in use of technique, eclectic therapy may be less likely to produce negative outcomes in patients.

Overall Conclusions and Future Research

Although most eclectic therapies are based on empirically tested therapies, their foundation has been borrowed from research work on specific therapy schools. Very little research has been produced by the emerging systematic eclectic approaches.

Garfield (1986), in reference to his own theory, states: "Unfortunately, no systematic research has been conducted on the approach. . . . The only evidence that exists to support the efficacy of this approach are clinical observations and anecdotes, and this is not really adequate" (pp. 157–158).

Mahalik (1990) has reviewed the status of four distinct (systematic) eclectic approaches on five dimensions ranging from theoretical adequacy to empirical support. By evaluating the approaches of Beutler, Howard, Lazarus, and Prochaska, Mahalik has focused on four of the most fully developed and described representatives of eclecticism. His review clearly reflects the status of research in this area:

> None of the models have been well evaluated and none have received more than the beginnings of empirical support. Additionally, the great majority of research on the models has been conducted by the authors. If the systematic eclectic field is going to attain greater credibility, research outside the labs of the model's advocates must replicate and extend these findings. (p. 675)

In my view the picture is, if anything, more bleak than Mahalik points out. With the exception of the Beutler and Prochaska models, Mahalik's review showed that only two outcome studies had been conducted on the other models, and no comparative or control group studies were among these.

For example, Lazarus (1992) has suggested that his approach is not intended to be added to the hundreds in existence but rather is an attempt to be at the cutting edge of clinical effectiveness by incorporating the findings of current research and practice. Despite his commendable efforts to be empirical, it is disappointing to see so little systematic effort directed toward a controlled investigation of the effects of a multimodal therapy that purports to be at the "cutting-edge" of therapy. What kind of improvement rate can one expect as a result of this application of technical eclecticism? Are there patients for whom this approach is more appropriate? Would this eclectic approach offer clients anything more than the cognitive-behavioral therapy to which it is most indebted? These and a host of similar questions remain unanswered at this time. But it would be surprising if the unsubstantiated reports of superiority held up in a comparative outcome study!

The Beutler model (Beutler & Consoli, 1992) has generated considerably more outcome research as he has initiated several studies of his matching hypothesis and has begun to study interventions according to his theory of systematic eclecticism. Despite this, he has encountered significant difficulty in applying his matching scheme successfully, leaving important aspects of his theory without confirmation (e.g., Calvert, Beutler, & Crago, 1988). Matching patients, therapists, and therapies is no small achievement, and it continues to elude those who have the confidence to attempt it.

Prochaska and DiClemente's (1992) model, the transtheoretical approach, has also generated considerable research. As compared with other eclectic systems, it rests on a more substantial base of empirical research, a good deal of which is based on a narrow sample of clients who were attempting to give up smoking. Nevertheless, empirical support for some of the most important postulates of this model (e.g., how the needs of clients change over time as they improve, how this interacts with interventions) is slowly being accumulated. The outcome research has used manuals aimed at facilitating self-change, finding that with and without a therapist present, it proved more effective at helping people quit smoking than a traditional self-change approach not based on the principles and assumptions of the transtheoretical approach. These initial steps toward evaluation of the transtheoretical approach must be followed by systematic research aimed at sorting out the advantages, if any, of this approach over single-school or other eclectic procedures.

Recent research conducted in England by Stiles et al. (1990) may be of special interest to eclectic practitioners and theoreticians. This research also has implications for eclectic, stage-model of change (e.g., Beitman, 1992; Prochaska & DiClemente, 1992). Stiles and his associates have proposed an assimilation model of change, which proposes that an important

common change mechanism across therapies is the assimilation of problematic experiences. Eight stages of problem solution are proposed. These include (1) warded off, (2) unwanted thoughts, (3) vague awareness, (4) problem recognition, (5) insight/understanding, (6) application of understanding, (7) problem solution, and (8) mastery. As with the Beitman and with the Prochaska and DiClemente's models, the assimilation model suggests that dynamic-humanistic therapies are most suitable at the early stages of therapy, while cognitive-behavioral therapies are best suited for the issues that arise in the latter stages of problem solution and assimilation, such as mastery.

Results of other research conducted in the Sheffield University project (Shapiro & Firth, 1987), similarly, have several implications for eclectic practice. These researchers, who undertook a comparative outcome study, employed an unusual research design to maximize sensitivity to technique effects. They used a crossover design in which 40 outpatients received eight sessions of cognitive-behavioral therapy and eight sessions of humanistic-dynamically oriented psychotherapy. These therapies were offered by the same therapists, but the order of exposure was varied. This procedure allowed for a comparison of the effectiveness of both therapies while reducing the variance in outcome as a result of different therapies offered by different therapists. It also allowed for the examination of order effects; does combining therapy in a set order enhance the effects of therapy? This design thus tests the assimilation model and has implications for the transtheoretical model as well.

Results of the analysis showed few differences between the two treatments, although a slight superiority for the cognitive-behavioral treatment was noted. Of greater importance in the present analysis was their study of sequencing of treatments. In view of the models just presented, and the widespread belief in establishing a relationship prior to requiring activities outside of therapy (as required in many behavior therapies), it is surprising to see no differences in outcome due to the order of receiving treatment. Although Stiles et al. (1990) have proposed the importance of sequencing interventions, it would not appear that starting therapy with a method that emphasizes reducing defenses, increasing awareness of feelings, and facilitating insight, was any more helpful than beginning therapy with cognitive-behavioral procedures that focus more on active problem solving and mastery of problems.

In many ways the Sheffield Psychotherapy Research Project reflects the conclusions of meta-analytic reviews and summaries of comparative studies: slight superiority for cognitive-behavioral psychotherapies in contrast to dynamic-humanistic ones. The methodological issues noted in past reviews tended to balance out in this study. On the one hand, the dynamic therapy was offered in only eight sessions, a decision that could be seen as favoring the cognitive-behavioral therapy. At the same time, the allegiance of the researchers, if any, favored the dynamic-humanistic intervention. On balance, one would have to conclude that if therapists were choosing a therapy on the basis of efficacy, they have grounds, from this study, to consider adapting the cognitive-behavioral techniques, but in so doing they cannot expect to show much superiority over dynamic-humanistic practitioners.

Also of considerable interest to eclectic therapists is a report on "therapist effects" arising out of this same research. Could therapists offer both therapies equally well? Shapiro, Firth-Cozens, and Stiles (1989) examined the effects of specific therapists on the outcome of therapy in the Sheffield project. The 40 patients were seen by four therapists who offered both a cognitive-behavioral and dynamic therapy to patients. Although the project used manuals and supervision to minimize the effect of individual therapists on treatment outcome, the authors discovered that the two therapists who saw the majority of patients had different outcomes. One of the therapists was more effective than the other in cognitive-behavioral therapy and less effective in the dynamic. The results of this study suggest that even with intensive supervision and training, therapists can still show differential effectiveness under the most controlled of circumstances. This appears to be true even when the therapists have an interest and a commitment to both modalities. There may well be limits to the variety of techniques that some clinicians can employ.

One implication of this research is the serious demands that can be put on eclectic practitioners. The effective use of any given therapy, of course, requires considerable skill. But the effective use of many methods, the timing of their use, and the continued updating on techniques is especially challenging for the eclectic. This book responds in part to the need to organize and systemize the demanding task of the eclectic therapist.

Despite the openness of eclectic theorists to knowledge derived from clinical practice and basic research, the eclectic approach has not yet produced a distinguishable body of research that supports its claims of superior efficacy. In the short run, therefore, projects aimed at demonstrating the effectiveness of eclectic approaches are sorely needed. Since eclectic theorists' most persuasive argument for effectiveness lies in their claim for flexibility in dealing with a variety of patient problems, an initial study would call for the random assignment of patients to practitioners who advocate treatment within the confines of a single-school approach and to practitioners of an eclectic approach (cf. Wolfe & Goldfried, 1988). Such a study would need to make recordings of the therapies offered in order to clarify the nature of therapeutic interventions. The patients in such a study should not be homogeneous with regard to their disorder. Instead, they

should represent a cross section of patients typical of outpatient clinical practice.

The central disadvantage of such research is that it repeats the competitive polarizing pattern that has characterized past comparative research. Unfortunately, this research may lead to the solidification of yet another therapy school rather than to agreement about the most effective intervention practices. Thus, the consequences of such research may go against the basic values of an eclectic approach, but at least it could illustrate the advantages of systematically combining treatments.

One attempt to focus future research on psychotherapy integration was forged by the participants of a National Institute of Mental Health workshop reported by Wolfe and Goldfried (1988). The workshop participants developed a list of 23 recommendations, which fell into four domains: (1) conceptual clarification, (2) psychotherapy process research, (3) efficacy studies on integrative and systematic eclecticism, and (4) the training and supervision of integrative therapists. The two issues of greatest relevance to this chapter are efficacy research and process research. The need for more studies of efficacy have already been addressed. There is also an urgent need for process studies that link therapist and patient actions to positive change. Two studies will be highlighted to provide the reader with intriguing strategies that illuminate the process-outcome connection.

Jones, Cumming, and Horowitz (1988) attempted to demonstrate that there are, indeed, specific factors (not common across therapies) that lead to therapeutic change. They studied the effects of therapist actions and techniques, as well as patient attitudes and behaviors, on psychotherapy outcome. They examined Psychotherapy Process Q-Sort ratings of brief (12-session) psychodynamic psychotherapy with patients suffering stress response syndromes following traumatic events or bereavement. The authors found that different factors predicted success with more and less disturbed patients. Those patients who were initially more seriously disturbed seemed to respond better to supportive interventions such as direct reassurance, avoidance of threatening interpretations, directing the dialogue, and support of defenses (rather than analysis of defenses). Those patients who were less disturbed tended to do better with the aggressive approaches. These patients were more aware of conflicts surrounding their dependency needs, were more clear in their ability to express problems, and were more organized. The therapists more often drew connections between the patients' current relationships and their past relationships and experiences. The here and now was also more emphasized within therapy sessions.

Although Jones and colleagues emphasize the importance of their results for highlighting specific techniques in contrast to common factors, the implications for eclectic therapy are limited. First, the divergence of effective techniques is easily handled within a pure-school approach. Thus, this process research does not suggest the need for techniques outside of a dynamic theory of change. Second, the nature of the report makes it impossible to assess the accuracy of their interpretation of results, since the items that did not correlate with outcome in either group were not reported and their analysis was post hoc. It remains to be seen if more or less disturbed clients can be systematically identified before treatment and then assigned to ideal and unideal matches. Nevertheless, this research strategy allows for a complex analysis of therapy process and it can be recommended for further use in studies that investigate the active ingredients of psychotherapy.

A second illustrative study was reported by Richards, Burlingame, Barlow, and Lambert (1990). These authors examined the interpersonal style of a select set of six patients who manifested clinically significant improvement or deterioration following 16 weeks of group psychotherapy. All group interactions that involved the patient, the therapist, and group members were selected from three sessions: early, middle, and late in the therapy. In all, nearly 4,000 interaction units were analyzed using the Structured Analysis of Social Behavior (SASB) developed by Benjamin (1982). A stable pattern emerged for patients regardless of who in the group they were speaking to, and who was speaking to them. Those who improved were self-reflective and self-accepting, and their therapists related to them in an accepting manner. Those who deteriorated tended to avoid self-reflection, were warded off and closed up, had many more hostile interactions, and often had interactions in which they were hostilely compliant. In addition, therapists related to them in more parental ways. The patients tried to befriend their therapist, and therapists were friendly in return. Thus, it was not therapist hostility that was related to deterioration but rather that therapists failed to draw patients out of their defensive and placating style.

These results are similar to those of Henry, Schacht, and Strupp (1986), who found that nonimprovers in individual therapy had approximately the same high levels of hostile behaviors. Both process studies identify patient styles that suggest the need for interventions that were not offered, and both suggest ways of increasing the effectiveness of psychotherapy quite apart from a single-school approach. In this sense they illustrate the natural affinity between process research and psychotherapy integration (Goldfried, Castonguay, & Safran, 1992).

Despite the seeming compatibility of psychotherapy research and eclectic psychotherapy, there is little evidence that eclectic therapies are being carefully researched. Before claims of superiority based on integration of the best from single-school approaches can be supported, empirical investigations will need to be conducted. Until such investigations have

been conducted, eclectic practitioners would do well to be more modest in their claims for superiority. It may be that eclectics are far too eager to integrate the least important aspects of treatment (techniques) while neglecting the central facilitating forces within treatments (common factors). In so doing they may even produce therapies that are less efficacious than the single-school approaches from which they are often derived.

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