
How Psychotherapy Integration Can Complement the Scientist-Practitioner Model



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This article aims to integrate the two separate bodies of literature in Psychotherapy Integration (PI) and the Scientist-Practitioner (S-P) model. Based on an examination and synthesis of the main ideas from the two fields, it illustrates that, although developed separately, these movements are compatible and they complement each other. After describing the historical, empirical, and conceptual relationship of the two movements, the implications of this relationship for psychotherapy are outlined and recommendations are offered. PI is conceptualized as a key ingredient in the optimal expression of the S-P model, which can address several difficulties in the actualization of the model. © 2002 Wiley Periodicals, Inc. *J Clin Psychol* 58: 1227–1240, 2002.

Keywords: scientist-practitioner model; psychotherapy integration; practice and training

An Introduction to Psychotherapy Integration and the Scientist-Practitioner Movements

Few issues have been as important, well-discussed, and controversial during the last 50 years in the field of therapeutic psychology as the psychotherapy integration movement and the scientist-practitioner model. Although they are naturally compatible, the potential of the relationship of these two fields remains underemphasized. After defining each of these movements, their historical, empirical, and conceptual connection is explored.

A different version of this article was the recipient of the 2000 Mathilda B. Canter Education and Training Student Award of the Psychotherapy Division of the American Psychological Association, and has been presented at the 108th Annual Convention of the APA, Washington, DC, August 2000.

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Definitions

Psychotherapy integration (PI) can be broadly defined as an attempt to go beyond the confines of single theories and explore issues of convergence and complementarity between different therapeutic approaches. The final aim is to create theories and practices that are superior to the existing pure-form models. However, PI is a diverse movement, with at least four distinct approaches, all of which are variations of the same integrative/eclectic philosophy. *Theoretical integration* aspires to synthesize many, if not all, different models on the theoretical level, in search of a superordinate metatheoretical integrative framework. *Technical eclecticism* attempts to combine effective interventions from different models, regardless of their theoretical origin. *The common factor approach* strives to identify and build on a common pathway that effective therapies share, hoping to minimize redundancy in developing new integrative approaches. *Assimilative integration* is a combination of technical eclecticism and theoretical integration, where techniques from various models are assimilated in a main theoretical framework in a theoretically coherent way (for reviews of PI approaches see Castonguay & Goldfried, 1994; Hawkins & Nestoros, 1997; Lampropoulos, 2000a, 2001a; Norcross & Goldfried, 1992; Stricker & Gold, 1993). Unless otherwise specified, the terms psychotherapy integration and eclecticism will be used interchangeably in this paper to refer to the PI movement in general.

The core intention of the Boulder Conference (Raimy, 1950) more than 50 years ago was that the clinician should be trained to be both a scientist and a practitioner. Still today the scientist-practitioner (S-P) model is broadly defined as an approach to clinical practice and training that integrates science and practice (see Benjamin & Baker, 2000; Beutler, 2000; Goldfried & Wolfe, 1996; Hayes, Barlow, & Nelson-Gray, 1999; Pepinsky & Pepinsky, 1954; Peterson, 1997; Raimy, 1950; Soldz & McCullough, 2000; Talley, Strupp, & Butler, 1994; Trierweiler & Stricker, 1998). Like PI, the S-P model is multicomponent and multifaceted. Some of the most important S-P functions and roles that will be emphasized in this article include (a) practitioners regularly consuming and applying research findings in their practice (Beutler, 2000); (b) practitioners following a scientific-methodological way of clinical thinking and practicing (Spengler, Strohmer, Dixon, & Shivy, 1995); and (c) practitioners regularly evaluating their practice (Ogles, Lambert, & Masters, 1996). Other aspects of the S-P model include practitioners conducting research and communicating their findings (Lampropoulos, Goldfried et al., 2000) and researchers collaborating with practitioners to conduct clinically meaningful research (Goldfried, Borkovec, Clarkin, Johnson, & Parry, 1999; Talley et al., 1994).

The Historical, Empirical, and Conceptual Relationship of PI and the S-P Model

PI Is a Movement Established on Research Findings. Unlike pure-form theories of therapy, PI historically has evolved based more on empirical research findings and clinical realities, and less on theories and historical figures. One major research finding that has fostered the development of PI is the phenomenon of outcome equivalence between different therapies (i.e., the Dodo bird verdict; Lambert & Bergin, 1994). This has further supported the notion that common factors exist in different therapies, some of which may heavily contribute to therapeutic outcome (Hubble, Duncan, & Miller, 1999; Orlinsky, Grawe, & Parks, 1994). In addition, the identification of specific differential effects produced by some interventions (Beutler, Clarkin, & Bongar, 2000; Roth & Fonagy, 1996) has also fostered a complementary approach to common factor research, eclecticism. The Dodo bird verdict, common factors, and prescriptive/eclectic findings have all stimulated PI to continue researching commonalities and differences between therapies, in order to improve clinical effectiveness. To this end, PI is the consummate example of S-P thinking.

PI Developed to Address Pressing Clinical Realities. Additional driving forces that fostered PI come from everyday clinical reality. These include pressures from both inside and outside the field of therapy (Castonguay & Goldfried, 1994). The former are (a) the confusing proliferation of competing therapies that currently numbers more than 400, the vast majority of which remain untested (Norcross, 1995); and (b) the inadequacy of single therapies to deal equally effectively with all problems and all clients (Norcross & Newman, 1992). Clients' real needs for integrative/eclectic treatment are confirmed by research that show that at least one third of clinicians identify with PI/eclecticism in their practice (Garfield, 1994), and even master therapists of single theoretical persuasions often practice eclectically (Gazzola & Stalikas, 1997; Goldfried, Raue, & Castonguay, 1998; Sollod, 2000). External pressures to therapeutic practice include the socioeconomic demands for cost-effectiveness and accountability (Berman, 1998) that favor the development of brief, prescriptive, and problem focused eclectic practices. All of the foregoing issues bear major implications for S-P clinical activity and support the utility of an integrative/eclectic approach to therapy.

PI Clinical, Empirical, and Theoretical Research. Several eclectic and integrative approaches have been developed and tested so far (for a review of empirical research see Glass, Arnkoff, & Rodriguez, 1998). These include but are not limited to Systematic Treatment Selection (Beutler & Clarkin, 1990; Beutler et al., 2000), the Transtheoretical approach (Prochaska & DiClemente, 1992), Cognitive-Analytic therapy (Ryle, 1995), and Dialectical Behavior therapy (Scheel, 2000). In addition, many more integrative approaches have been developed based on clinical observations and have received pre-experimental or quasi-experimental support, some of which hold great promise (see Glass et al., 1998). PI approaches are at least grounded in clinical experience (Norcross, 1996) and have great potential for efficacy and effectiveness research.

PI not only strives for empirical and clinical validation, but also reflects a high value placed on theoretical integration, consistency, and coherence (Lampropoulos, 2001a; Messer, 1992). This is accomplished either (a) by trying to integrate limited theories of therapy into more effective integrative systems, often including their epistemological and philosophical integration (theoretical integration models, e.g., Wachtel, 1997; and assimilative integration models, e.g., Stricker & Gold, 1996), or (b) by trying to develop data-based empirical theories of change (Beutler, 1995). Theoretical guidance and coherence is important in S-P clinical activity, as well as rational and theoretical ways of knowing.

The Potential of Infusing PI Into the S-P Model

Perhaps the most important components of the S-P model consist of the clinicians' activity of thinking and acting as scientists in their everyday practice (Meier, 1999; Pepinsky & Pepinsky, 1954; Peterson, 1991; Spengler et al., 1995). The major steps of clinicians' scientific role include the consumption of empirical literature, client assessment, hypothesis formation and hypothesis testing, generation of alternative hypotheses, case formulation, treatment selection and application, and continuous process and outcome evaluation (clinicians may go back and repeat these steps in treatment, if necessary). This article will next focus on the importance of an integrative philosophy in all of the foregoing S-P steps of clinical practice, in which integrative S-P functioning can offer solutions to common problems of S-P activity (e.g., availability bias in client assessment and case formulation). Implications and proposals for incorporating PI into the S-P model follow.

Transtheoretical Consumption of the Empirical Literature

The literature on the empirical effectiveness of different treatments for a variety of disorders has proliferated rapidly for the past two decades. Subsequently, one of the first and most important problems for clinicians and trainees alike is keeping up with current empirical literature and considering it in their clinical practice (Beutler, 2000; Cohen, Sargent, & Sechrest, 1986; Cullari, 1996; Morrow-Bradley & Elliott, 1986). Research journals are generally not perceived by clinicians as user-friendly vehicles to communicate new empirical knowledge in a clinically useful way (Beutler, Williams, Wakefield, & Entwistle, 1995). Thus, despite the greater availability of empirical research findings and empirical treatments, these are often not accessible to practitioners.

Efforts to systematize this knowledge in a consumer friendly, critically reviewed, and transtheoretically comprehensive way have been initiated by a group of seasoned researchers-practitioners. These scholars have been actively involved in the Society for the Exploration of Psychotherapy Integration (SEPI) and the Society for Psychotherapy Research (SPR) for a number of years. Over the last five years the results of these efforts have become available in common outlets. These findings can be found in a major psychological journal (*JCLP/In Session: Psychotherapy in Practice*), in textbooks on effective treatments (e.g., Roth & Fonagy, 1996), and in a series of guidebooks such as the one edited by Beutler on empirical treatment selection for major disorders (e.g., Beutler et al., 2000).

All the aforementioned efforts share the characteristic that they are transtheoretical in nature, and include every therapeutic orientation that has been supported empirically. In that way, the consumption of empirical literature can be a relatively manageable task for the informed reader of selected transtheoretical publications. Consuming the empirical literature in a transtheoretical/ integrative way is important because not all theories have demonstrated empirical results for all problems. However, the growing list of empirically supported treatments will gradually make a selection of different approaches possible for those interested in working from a specific theoretical orientation. Workgroups from APA divisions of Clinical Psychology (12), Counseling Psychology (17), Humanistic psychology (32), and Psychotherapy (29) continue to summarize the empirical literature on empirically supported treatments and practices (Division 12 Task Force, 1998; Lichtenberg & Wampold, 1998), alternative effective humanistic therapies (Bohart & Miller, 2000; Division 32 Task Force, 1997), and effective relationships (Division 29 Presidential Task Force; Norcross, 2000a), respectively. These outlets should remain the basic source of guidance for practitioners and psychotherapy educators. Furthermore, continuing education workshops and additional subscription to selected practice-oriented journals of high quality such as *Psychotherapy*, *Clinical Psychology: Science and Practice*, and *Journal of Psychotherapy Integration* can supplement an informed, transtheoretical, and manageable consumption of the empirical treatment literature.

Transtheoretical Diagnosis and Client Assessment

As with literature consumption, client assessment should be refined toward becoming transtheoretical and integrative/eclectic. Transtheoretical client assessment can include areas such as cognition (emphasized in cognitive theories), behavior (behavior theories), emotion (experiential theories), current relationships (interpersonal theories), early relationships, past experiences and unresolved conflicts (psychodynamic theories), existential beliefs and worries (existential theories), as well as strengths (humanistic and solution-focused theories and positive psychology) of client functioning. PI models have already

incorporated and used similar constructs for diagnostic and treatment purposes, such as the Transtheoretical model (client *levels of change*: symptom/situational problems, maladaptive cognitions, interpersonal, intrapersonal, and family conflicts; Prochaska & DiClemente, 1992) and Multimodal Therapy (client *BASIC I.D.*: behavior, affect, sensation, imagery, cognition, interpersonal relationships, and drugs/biology; Lazarus, 1992).

By assessing a multitude of areas, transtheoretical clinicians can get a full picture of client functioning that will allow them to capitalize on strengths and work on weaknesses by selecting the treatment most suitable for client needs. A transtheoretical assessment is very helpful in treatment selection, and can make the difference in choosing between a past-focused, a relationship-oriented, or a problem-focused approach (see also Beutler & Clarkin, 1990; Wolfe, 1992). In addition to clinician impressions, client reasons and beliefs about their problems also emerge as a promising eclectic variable (Addis & Jacobson, 1996; Duncan & Miller, 2000; Elkin et al., 1999; Jacobson, 1999; Zuber, 2000) and it should be measured and considered in treatment selection (see also relevant section below). After all, the provision of an acceptable (by the client) problem explanation and treatment rationale is important for therapeutic outcome (Frank & Frank, 1991; Ilardi & Craighead, 1994), and can be crucial for client adherence to interventions.

The informed clinician can employ the foregoing transtheoretical assessment (which capitalizes on knowledge from different theories of human nature, personality, psychopathology, and change) via the clinical interview, assisted also by global transtheoretical measures such as Lambert's Outcome Questionnaire and client assessment scheme (Lambert, Okiishi, Finch, & Johnson, 1998; Ogles et al., 1996; see also Strupp's [1996] tripartite assessment model). Although knowledge of different theories of psychopathology, human functioning, and change is assumed, the process of transtheoretical assessment itself need not be time consuming; rather, it can be performed and progress relatively fast through an elimination process used by the informed clinician. In addition, client (transtheoretical) nondiagnostic personality variables can also be measured and factored in treatment selection (Beutler et al., 2000; Halperin, Barber, Shoham, Clarkin, & Stiles, 2000).

Clinicians' transtheoretical background and attitude in client assessment have the benefits of (a) reducing biases in diagnosis stemming from specific theoretical orientations (and minimizing judgmental errors in diagnosis; Spengler et al., 1995; Wilson, 1996); and (b) offering greater flexibility in treatment selection (and thus improving chances for positive therapeutic outcome). Clinical training should include the study of different theories of psychopathology and change and general assessment issues in tandem with learning how to assess clients transtheoretically (both via the interview and the use of scales). An example of client assessment follows that will establish the context for further important therapeutic processes.

Integrative/Eclectic Hypothesis Formation/Testing and Case Formulation

This is probably the most complicated clinical activity. In addition to sufficient clinical and nonclinical information about the specific client discussed above, it also requires a broad knowledge base (e.g., of psychopathology and psychotherapy). Lacking this knowledge will limit clinicians' ability to generate different hypotheses, both inside and outside a given theory. That is, the true actualization of the S-P model requires a clinician to be not only a good theoretician, but to some extent an integrative/eclectic therapist. Knowledge of different theories of therapy and psychopathology is equally necessary with knowing how to function as a scientist-practitioner.

It should be noted that the process of hypothesis formation and testing is one that implicitly or explicitly happens constantly and in different levels of clinical activity (Spengler et al., 1995). That is, hypothesis-testing may involve clearly different theoretical constructs or formulations, or may just pertain to clarifying small information units in client behavior (which in turn may also be related and influence specific theoretical formulations). For example, consider the two case examples (one with interpersonal and one with vocational issues) of clients seen by supervisees of one of us (GL):

The first client described that she had been in a loveless and psychologically abusive marriage for 20 years. She stated that she hated her husband and she rejected any possibility of working things out in her marriage. Despite her decision that she did not want to live with him any longer, she felt that she could not do anything to get out of her marriage. Based on additional information given by the client, the therapist was faced with the following hypotheses about the client's difficulty to even consider taking action: (a) client is afraid to leave her husband for financial reasons; (b) client is afraid to leave her husband because she lacks social support; (c) client is afraid that society and her children will blame her for initiating the divorce; (d) client believes that a divorce would be against her parents' wishes, particularly since they insisted on this marriage; (e) client considers a divorce as a personal failure in her and society's eyes; (g) client is afraid to stand up for herself and ask for a divorce from her husband (or does not know how to do it); (h) client's reaction is part of a general maladaptive interpersonal pattern; (i) client is insecure about finding a new life partner; and (j) client doesn't really want to give up on the marriage.

The second case is a male client in his late 20s who presented with procrastination issues in the vocational domain of his life, accompanied with the strong desire to learn the causes of his procrastination. Using additional information given by the client, the therapist was faced with the following hypotheses: (a) client is simply and naturally overwhelmed by the geometrical growth of his Internet-based business and the lack of qualified personnel to deal with it; (b) client is in his first job and lacks relevant specific work experience and expertise in dealing with such problems; (c) client lacks organizational and problem-solving skills in general; (d) client enjoys only the interpersonal and enterprising aspects of his job, but dislikes the mechanical/technical responsibilities he is faced with due to the temporary lack of qualified personnel in his business; (e) client has general self-esteem issues or low professional self-efficacy in particular; (f) client is a perfectionist, using "all or nothing" thinking and catastrophizing; (g) client doesn't really enjoy his job, which is the result of his father's pressure and suggestion; (h) client likes his job, but he reacts to his father's pressure in a self-defeating pattern; (i) client is overworked and burned-out; and (j) client suffers from lack of adequate social support and personal time.

Although all these hypotheses are open and can be explored with additional client information in both cases, a single theory-driven counselor may prematurely favor one hypothesis/explanation without considering the others, based on assumptions closer to his or her theory of therapy (availability heuristic; see Wilson, 1996). A transtheoretical/integrative and open-minded clinician should be able to see and examine all these (and perhaps additional) hypotheses/possibilities (a combination of which may apply in the same case) and decide on the most applicable formulation and treatment planning, staying as close as possible to the data obtained by the client (Spengler et al., 1995).

Clinicians have usually selected a theory of therapy to operate from, and often also possess some knowledge of one or more additional theories. However, the process of forming clear hypotheses and explicit case formulations about clients is not an easy task (Meier, 1999; Spengler et al., 1995). Clinicians should be able implicitly or explicitly to (a) conceptualize a case in terms of two or more theory-based alternative ways, (b) put their conceptualizations in the form of alternative testable hypotheses, (c) know how they will test them, and (d) decide what will be the terms for accepting or rejecting them. In

deciding between the alternative/competing theoretical hypotheses, they should take into account empirical research and the fit with the specific client.

Multitheoretical clinical vignettes can be a valuable tool in training in the aforementioned process of a systematic hypothesis-formation and testing S-P strategy. Standardized multitheoretical vignettes or clinical exchanges on the same client cases can be found in the literature (e.g., Curtis, 1999; Dumont & Corsini, 2000; Luborsky & Barber, 1994; Messer, 1996; Norcross, 2000b) or on educational tapes (e.g., Shostrom, 1966), and are frequently presented in SEPI conferences (e.g., Fitzpatrick, Norcross, & Wolfe, 2000; Greenberg, Messer, Goldfried, & Watson, 2000).

In sum, the two necessary components for successful implementation of the foregoing S-P activity include (a) a methodical way of clinical thinking; and (b) assimilation and use of specific knowledge areas, such as the specific client's case; theories of human nature, personality, psychopathology, and change; and empirical research on the effectiveness of therapies. Again, the importance of a multitheoretical/integrative/eclectic case conceptualization lies exactly in the greater flexibility that it provides in the generation of alternative hypotheses, case formulations, and treatment planning. Although a single theory may be able to some extent to work with any given situation, there are times that "stretching" the theory forms a poor fit with the client data. These are the times that integration and eclecticism can be appreciated. Single-theory therapies, often dogmatic and monolithic, are obviously restricted by their limited flexibility. By contrast, the only limits set by the modes of theoretical-assimilative integration are those of theoretical coherence and compatibility (Lampropoulos, 2001a), while in eclecticism flexibility could be limitless.

Integrative/Eclectic Treatment Selection

After choosing the most fitting case conceptualization, clinicians should decide on the most appropriate treatment. Given the current status of psychotherapy effectiveness (where most of the 400 available treatments have not been empirically tested and some differential treatment effects have been demonstrated; Elliott, Stiles, & Shapiro, 1993; Lampropoulos, 2000b; Norcross, 1995), treatment selection has to include some form of eclectic choice. Moreover, some type of data-generated integration/eclecticism is needed to ensure the empirical basis of treatment. These data may be gleaned from (a) a rough eclectic approach that considers only client diagnosis (like the single-theory treatments for specific disorders included in the EST project); (b) an advanced empirically supported and technically eclectic approach that considers additional client variables (e.g., Beutler & Clarkin, 1990; Beutler & Harwood, 2000; Beutler et al., 2000); or (c) a theoretically integrative or assimilative integrative approach built on clinical experience and indirectly supported by research data (Lampropoulos, 2001a).

"Bona fide" treatments (Wampold et al., 1997) and similarly supported interventions constitute the pool upon which treatment selection should be based. The EST project is obviously a rough but helpful eclectic guide to what works in psychotherapy, as well as similar projects underway by divisions 17, 29, and 32, with two additions: (a) clinicians also need to be familiar with pharmacological treatments of choice for referral purposes; and (b) clinicians could benefit from considering client personality and other nonclinical characteristics along with clinical diagnosis in treatment selection (Beutler, 1999; Beutler et al., 2000).

Given that the existing empirical treatments (particularly manualized ESTs) have been validated in nonrepresentative clinical conditions, efforts should be made to apply

them flexibly enough to meet clinical realities (Shoham & Rohrbaugh, 1996) and in a way that they can be used in individualized case formulations (Lampropoulos, 2000b). In addition, the differential effectiveness of some ESTs with clients co-morbid problems (Barber & Muenz, 1996) and client personality characteristics (Beutler et al., 1991; Beutler, Goodrich, Fisher, & Williams, 1999) should be taken into account in treatment selection to maximize the treatment's potential to meet specific client needs.

Here is an example of data-based, manual-driven but flexible practice that used eclectic principles to meet client needs (Lampropoulos & Nicholas, 2001; Lampropoulos, Nicholas, Spengler, & Dixon, 2000):

A 50-year-old married female client reported moderately severe depression over the course of the last couple of years. The client clearly identified as the cause of depression her "unfinished business" (UFB) with three significant others in her past, while she failed to report any other problems. After extensive interviewing, the eclectic therapist was not able to identify any additional potentially contributing factors to the client's depression (such as current interpersonal difficulties, existential worries, irrational thoughts, or other coexisting problems or conditions). Based on the client's reasons for depression (Addis & Jacobson, 1996), the therapist's transtheoretical assessment, and the literature on the empirically supported treatments for depression, experiential empty-chair work for depression-related UFB emerged as the treatment of choice (Greenberg & Watson, 1998; Paivio & Greenberg, 1995). However, the client appeared somewhat unwilling to engage in, and unable to benefit from the insight-oriented and introspective self-exploration facilitated by the traditional empty-chair technique (Greenberg, Rice, & Elliott, 1993). Thus, continuing to follow the manual-based experiential UFB resolution model (Greenberg et al., 1993), the therapist modified the implementation of change processes to include mild interpretations and suggestions in an unobtrusive and theory compatible manner (see assimilative integration; Lampropoulos, 2001a; Messer, 1992) in order to adapt the intervention to client nonclinical personality characteristics (i.e., client's inability for introspection). That is, the informed eclectic therapist had to make two decisions (i.e., treatment selection and treatment adaptation) to successfully meet client clinical needs and personality characteristics and do so in a theoretically compatible way (for the use of interpretation in humanistic therapy, see Gazzola & Stalikas, 1977).

Assuming that a selected treatment is appropriate, empirically tested, and correctly applied, its effectiveness will also confirm or disconfirm the accuracy of the case conceptualization (Spengler et al., 1995). If any of the former three possibilities were not the case, remedial action should include changing the treatment or applying it more carefully. If treatment is still ineffective, this may mean that the initial conceptualization needs to be reexamined (i.e., the clinician may have to go back and generate alternative hypotheses). Benefits of integrative/eclectic treatment selection include (a) empirical guidance in the selection of treatments for specific clients and problems (eclecticism and prescriptive matching); (b) greater flexibility in treatment planning; and (c) resolution of emotional and cognitive dissonance between one's favorite therapy and its inability to address a specific problem.

Transtheoretical Process and Outcome Evaluation

The clinical use of multitheoretical/transtheoretical/eclectic/integrative process and outcome measures is also highly important. The eclectic use of outcome measurement requires the selection of those variables that are applicable for each client, and this may also include goal attainment and problem resolution scales (beyond the use of global measures). The transtheoretical/multitheoretical part suggest the measurement of variables, problems, or goals that may have been originated and developed in different theoretical

orientations (see also Strupp, Horowitz, & Lambert, 1997). The use of atheoretical/trans-theoretical/integrative measures may also include scales that cover a multitude of processes common or specific to various theoretical models (therapeutic alliance, common factor, and change event scales; e.g., Session Impacts Scale; Elliott & Wexler, 1994). The use of measures that assess newly developed integrative therapeutic constructs may also be necessary, particularly in the evaluation of integrative treatments (Arnkoff, Glass, Opazo, Caspar, & Lampropoulos, 2000). Last, trans-theoretical outcome measurement could consider measure selection according to phase models of therapeutic outcome (e.g., remoralization, remediation, and rehabilitation phases; Howard, Lueger, Maling, & Martinovich, 1993).

The major advantage of a multitheoretical/eclectic perspective in process and outcome assessment is again its limitless flexibility. This flexibility allows therapists to measure treatment in an ecologically valid and clinically meaningful way that meets individual client needs. Such a practice also holds part of the answer to the therapeutic equivalence phenomenon between different therapies (Norcross, 1995). Beyond measuring eclectically, of course, measure selection has to be appropriate and sensitive to capture meaningful but often difficult to measure client changes (Shoham & Rohrbaugh, 1996). An additional and also underemphasized issue is the inclusion of measures of client positive changes and gains in nonclinical areas of functioning. This practice may (a) further differentiate treatment effects and dispel the Dodo bird verdict, (b) reconcile pathology-oriented and positive-oriented treatments; and (c) facilitate the integration and transition from psychopathology to positive psychology (Lampropoulos, 2001b).

Concluding Thoughts

This article hopefully succeeds in highlighting the great potential of PI in relation to the S-P model. Our view of the S-P model is one of clinicians thinking methodically and practicing scientifically. We suggested that PI is an optimal expression of S-P clinical activity. We argued that the basic assumptions of the S-P model about methodological, open-minded, and evidence-based practice not only justify, but strongly suggest the use of integrative/eclectic therapies. In other words, S-P practice cannot be achieved without the willingness to consider alternative theoretical hypotheses, assessments, formulations, and treatments, whenever clinical reality and research findings dictate. Due to inherent flexibility and the availability of means for practicing differentially, PI can accurately reflect and actualize the S-P model. Despite the difficulty therapists face when attempting to overcome the limits of their training and their investments in specific theories (Lazarus, 1990), the benefits of PI are worth the additional effort to aspire to an integrative philosophy and practice. These benefits may include not only improved clinical effectiveness, but also a solution to therapist disillusionment with ineffective treatments.

This article provided the context and the foundation for how PI can complement and extend the S-P model. However, for a true fusion of these two movements additional empirical research is needed (including controlled outcome studies). Only those PI elements that are conceptually and clinically meaningful and receive empirical support should be retained as compatible with the S-P model. Thus, we encourage clinicians and researchers to get systematically involved in the empirical examination of tenets of psychotherapy integration as discussed in this article.

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