Psychotherapy Volume 37/Winter 2000/Number 4

EVOLVING PSYCHOTHERAPY INTEGRATION: ECLECTIC SELECTION AND PRESCRIPTIVE APPLICATIONS OF COMMON FACTORS IN THERAPY

GEORGIOS K. LAMPROPOULOS
Ball State University

Since its inception 65 years ago, the psychotherapy integration movement has undergone much development along its major thrusts: technical eclecticism, common factors, and theoretical integration. Based on findings from decades of exploration of psychotherapy integration, this article attempts to advance the movement one step further by (a) reviewing the pros and cons of eclecticism and common factors, and (b) integrating the two approaches into a new conceptual scheme. The new integrative scheme aspires to improve treatment selection and application, as well as facilitate integrative training and research.

Introduction: Celebrating the Evolution of the Psychotherapy Integration Movement

The psychotherapy integration movement has an unofficial history of more than 65 years, and an official presence since 1983. The Society for the Exploration of Psychotherapy Integration (SEPI) presently numbers hundreds of members in several countries (SEPI, 1999) and has generated more than 150 training programs, courses, and workshops in psychotherapy integration worldwide (Norcross & Kaplan, 1995). A general satisfaction with the movement has been reported in a recent survey of its membership (Figured & Norcross, 1996), and a proposal to replace "Exploration" with "Evolution" in the society's title was recently considered.

What exactly has been explored so far? In sum, major areas of attention have been (a) the theoretical integration route; (b) the technical eclecticism route; (c) the common factors approach; (d) the assimilative integration route; (e) the empirically supported (manualized) treatments (ESTs) movement (as a form of eclecticism); (f) the development of integrative treatments for specific disorders and specific populations; (g) the development of integrative-eclectic systems of treatment selection, and the integrative exploration of psychotherapy case formulation methods; and (h) training and supervision in eclectic and integrative therapies (all reviewed in Gold, 1996; Hawkins & Nestoros, 1997; Lampropoulos, in press-a; Norcross & Goldfried, 1992; Stricker & Gold, 1993; see also Nestoros & Vallianatou, 1990).

Initial explorations have been conducted in all these areas of integrative focus. While developments in integrative theory, practice, and research are clearly evident, definitive answers are not available for most integrative questions. Fourteen years after the 1986 National Institute of Mental Health (NIMH) conference issued research recommendations for the society (Wolfe & Goldfried, 1988), many of the designated areas of research have not yet received appropriate attention. Obviously, the end of the exploration era is more distant than integrationists might wish. Nevertheless, a period of evaluation, redefinition, and empirical research in the application of integ-

An earlier version of this article was the recipient of the Psychotherapy Division of the American Psychological Association's Freedheim Student Development Award.

The author is thankful to the anonymous reviewers for their comments, as well as to Carol Chalk for her assistance with the English language.

Correspondence regarding this article should be addressed to Georgios K. Lampropoulos, Department of Counseling Psychology and Guidance Services, Teachers College 622, Ball State University, Muncie, IN 47306. E-mail: G_lamp@hotmail.com

rative therapies and ideas is necessary for the movement to evolve (Beitman, 1994; Norcross, 1997). This author, along with others in the field, believes that future efforts of the society should focus on (a) theory-driven programmatic aptitude by treatment interaction (ATI)[1] research focusing on small intervention packages rather than whole therapies (Beutler, 1991; Shoham & Rohrbaugh, 1995); (b) the development and empirical testing of integrative models of psychotherapy for specific populations, preferably against theoretically pure ESTs (Goldfried & Wolfe, 1998); (c) the development, evaluation, and dissemination of integrative-eclectic psychotherapy training; and (d) the development of integrative-eclectic systematic treatment-selection methods.

The improvement of integrative treatment-selection systems is the focus of this article. The plethora and diversity of integrative developments and findings mentioned above raises a need for an organizational scheme to guide integrative clinicians. This organization is necessary, considering that the integration movement is experiencing a problem that it meant to address in the first place: the proliferation of different therapeutic models, now in the form of various integrative-eclectic approaches (Lazarus, in Lazarus & Messer, 1991). To organize the existing integrative clinical findings, integration within the integration movement is attempted here. Specifically, an effort to integrate two of the major thrusts of psychotherapy integration (i.e., common factors and eclecticism) follows. The proposed integration is also fueled by the need to compensate for existing weaknesses of eclecticism and the common factors approach (reviewed below).

Common Factors and Eclecticism as Guiding Systems in Therapy

The Common Factors Approach: Pros and Cons

The common factors approach has been proposed as a guiding model to describe clinical practice in terms of ingredients common in all therapies, despite the varying terminology that is used. It has been identified as one of the major routes to psychotherapy integration and one of the most important trends in psychotherapy in the last few decades (Grencavage & Norcross, 1990). The major advantage of this approach is that it focuses on the "heart and soul of change," that is, the most important factors associated with positive outcomes in various therapies (for detailed descriptions see the edition by Hubble, Duncan, & Miller, 1999a). Lambert (1992; Asay & Lambert, 1999) estimates that only 15% of change can be attributed to specific techniques used by various therapies (with some exceptions); the other 85% of clients' improvement can be attributed to factors such as the therapeutic relationship, placebo effects, and other client factors.

Proponents of this thrust have offered different lists of common factors to be followed in clinical practice. Among them are common factors models proposed by Garfield (1986), Beitman (1992), Frank and Frank (1991), Arkowitz (1992), Orlinsky and Howard (1987), and Weinberger (1993). Commonly cited common factors include the therapeutic alliance, empathy and support, positive expectations about therapy, emotional catharsis, problem exploration and insight, exposure and confrontation of the problem, and learning of new behaviors (Grencavage & Norcross, 1990). This author counts at least a dozen psychotherapy research programs that continue to provide data on common factors worldwide (for more on research issues see Castonguay, 1993; Goldfried, 1991; Norcross, 1993a, 1995a). In addition, authors who review common factors in therapy usually conclude that therapists should incorporate and emphasize those common factors in their practice, in order to enhance clinical effectiveness (e.g., Asay & Lambert, 1999; Fischer, Jome, & Atkinson, 1998; Hubble, Duncan, & Miller, 1999b). Examples of how common factors can be employed in therapy are also available (e.g., Hubble et al., 1999b). Other authors add that a combination of common and specific factors might be necessary for optimal therapeutic effects (e.g., Beitman, 1992; Lambert, 1992). Clearly, common factors do exist and are important contributors to therapeutic outcome. They also appear to be the major explanation for the *Dodo bird verdict* (i.e., that all therapies produce equivalent outcomes; Lambert & Bergin, 1994; Luborsky, 1995; Luborsky, Singer, & Luborsky, 1975).

Despite the obvious importance of common factors in therapy, several weaknesses exist in this approach. In sum, (a) common factors are obscurely defined; (b) common factors in different theories are not as similar as they are claimed

[1] Aptitude by treatment interactions can be found when different interventions are matched to client variables according to a clinically meaningful hypothesis.

to be; (c) common factors provide only a minimal description of change (least common denominator) that may overlook valuable clinical information; (d) common factors proposals are insensitive to client, problem, and therapist individual differences; (e) the proposed common factors are too general and abstract to guide clinical practice (because of the aforementioned two weaknesses, i.e., *c* and *d*); and (f) common factors are often erroneously considered sufficient change agents; some specific factors and effects also exist (see Emmelkamp, 1994; Ogles, Anderson, & Lunnen, 1999). The final point is further supported by literature that reveals several additional explanations besides common factors for the outcome equivalence phenomenon (Lampropoulos, 2000; Luborsky, 1995; Norcross, 1995b). Such explanations include the lack of adequate statistical power to reveal differences between therapies, inappropriate research designs, the use of insensitive outcome measures, and the lack of psychologically meaningful hypotheses in ATI research. For additional discussion on common factors issues, the reader is referred to relevant roundtables (Norcross, 1993a, 1995a), a monograph (Weinberger, 1995), and other publications (e.g., Arkowitz, 1995; Butler & Strupp, 1986; Castonguay, 1993; Goldfried, 1991; Grencavage & Norcross, 1990; Hubble et al., 1999a; Lampropoulos, 2000; Messer & Winokur, 1981; Omer & London, 1989).

It is obvious that the common factors approach alone cannot be used as an adequate treatment plan at this point in its development. To further illustrate the foregoing six weaknesses and the need to eclectically choose and prescriptively match common factors in therapy, the example of "support" is used: How exactly is support being defined in different therapies? Do we define it as a process, or do we include the content of what is being supported as well (Arkowitz, 1997)? Is support in psychoanalytic psychotherapy (Wallerstein & DeWitt, 1997) the same thing as support in cognitive therapy (Alford & Beck, 1997) and support in existential-humanistic therapy (Yalom & Bugental, 1997)? Can we define it at a commonly accepted level without omitting important aspects that are unique to various theories? Is support as necessary and important for the treatment of depression (where support is considered to be the cornerstone of therapy; Arkowitz, 1992) as it is for the treatment of other problems? Is support therapeutic or equally important in all phases of therapy, such as the phase of client vague awareness of the problem and the phase where clients are attempting a new solution? Should support have the same form and intensity in all phases of change? When should it be alternated with challenge, interpretation, confrontation, and insight-oriented, exploratory interventions? Is support equally necessary for all types of clients (e.g., clients with strong vs. poor social support systems, constrictive and internalizing vs. impulsive and externalizing clients, highly distressed vs. low distressed and unmotivated clients; Beutler, Goodrich, Fisher, & Williams, 1999)? In order to answer those kinds of questions, an eclectic approach to therapy is needed. Next, the pros and cons of eclecticism are discussed followed by a specific proposal as to how common factors and eclecticism can complement each other.

The Eclectic Approach: Pros and Cons

Technical eclecticism has been described as the Zeitgeist of counseling and psychotherapy in the 21st century (Lazarus, Beutler, & Norcross, 1992). Technical eclecticism advocates the selective combination of the most efficient techniques, regardless of their theoretical origin, in order to achieve optimal therapeutic results for a specific client. It is largely guided by Paul's (1967) question "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under *which* set of circumstances?" Indeed, eclecticism by definition covers major variables pertaining to clients (175 variables), therapists (40 variables), and therapies (50 variables), and its final aim is to match them with the appropriate intervention (Beutler, 1991). Eclecticism has the potential to describe optimal change in exhaustive detail; however, this task will take decades of intense effort to be completed, if ever. Furthermore, the eclectic movement has experienced both successes (e.g., Beutler, Engle et al., 1991; Beutler et al., 1999; for a review see Dance & Neufeld, 1988) and failures (e.g., Project MATCH Research Group, 1997) in demonstrating differential therapeutic effectiveness. Failures occasionally include research that has utilized prospective ATI designs and evidence-generated hypotheses. Thus, the use of robust theory-driven hypotheses has been suggested for future ATI research (Beutler, 1991; Shoham & Rohrbaugh, 1995). Such examples have been discussed in Henry (1996), and Piper, Joyce, McCallum, and Azim (1998).

A closer look at the major types of eclecticism suggests the following pros and cons: *"Stages of change" eclecticism* suggests that clients (a) change by progressing through continuous stages, and (b) respond optimally to treatment if their stage of change is matched to the appropriate intervention. The best example of this type of eclecticism is the transtheoretical model, which has been modestly supported by research (Prochaska & DiClemente, 1984, 1992). For example, in Matching Alcoholism Treatments to Client Heterogeneity (project MATCH), the expected aptitude-treatment interaction between client stage of change and type of treatment was confirmed for clients at the earlier stages of change but not at the later stages (Project MATCH Research Group, 1997). Along with modest research support, this type of eclecticism is also somewhat insensitive to personality and problem differences. However, sensitivity to client clinical problems in the transtheoretical approach has increased with the consideration of client levels of change (symptom-situational problems, maladaptive cognitions, interpersonal, intrapersonal, and family conflicts; Prochaska & DiClemente, 1992).

"Level of problem assimilation" eclecticism is similar to the transtheoretical approach with regard to conceptualization of client change. Developed and researched by Stiles and associates (1990, 1997a, 1997b), the assimilation model proposes that (a) client problems progress through seven levels until they become assimilated into client schemata (i.e., problem is solved), and (b) clients respond differentially to treatments based on their level of problem assimilation. It has also received modest research support. For instance, the expected differential effectiveness of psychodynamic-interpersonal treatment in the first three levels of assimilation was not confirmed in a recent study (Stiles, Shankland, Wright, & Field, 1997a). The assessment of problem-assimilation level takes into consideration some client and problem variables (as measured by the Early Assimilation Research Scale; Stiles, Shankland, Wright, & Field, 1997b). However, this kind of eclectic practice can also be considered insensitive to other important personality and problem differences (i.e., it differentiates clients only by grouping them in one of the seven assimilation levels). Further, it has been researched mainly in two types of treatments: cognitive-behavioral and psychodynamic-interpersonal therapies.

Psychopathology-matched eclecticism is simply the empirically supported treatment movement. Although some might argue against its inclusion in eclecticism (since complete treatments and pure theoretical models are tested for specific problems), this movement can be included in a broader definition of eclectic practice. Furthermore, if we consider using empirically supported techniques for specific problems (e.g., empty-chair dialogue for unfinished business; Paivio & Greenberg, 1995) as portable interventions to be incorporated and used eclectically in larger treatment packages (Lampropoulos, in press-a), psychopathology-matched eclecticism gets its own place in the integration movement. Needless to say, its major disadvantage is that it too neglects client personality differences as well as other diagnostic variables (e.g., disorder subtypes and comorbidity). For example, in terms of personality differences, not all clients are suitable or willing to participate in the empty-chair technique; further, clients with greater need for therapists' direction and advice will probably benefit more from a different type of treatment for unfinished business (Greenberg, Rice, & Elliott, 1993). For these clients, an expressive-interpretive approach to the resolution of unfinished business has been proposed as an integrative-eclectic alternative to the empty-chair intervention (Lampropoulos, 1999).

Personality-matched eclecticism has been the focus of attention of Beutler and his associates for more than 30 years (Beutler, 1983; Beutler & Clarkin, 1990; Beutler et al., 1999; Beutler & Williams, in press). Their work has resulted in the development of an eclectic model called Systematic Treatment Selection (STS). One of its major advantages is empirical support for its major dimensions. Second, it has the goal of developing a data-based theory of psychotherapy and change, due to the inadequacy of the existing theories of personality and psychopathology in that domain (Beutler, 1995). Next, it considers both nondiagnostic client personality variables (e.g., resistance, coping style) and diagnostic variables, such as functional impairment, subjective distress, and problem complexity (Beutler et al., 1999; Beutler & Williams, in press; Fisher, Beutler, & Williams, 1999); thus, it has become an advanced eclectic approach to systematic, empirically-based treatment selection. Finally, it has been significantly developed to allow specific eclectic recommendations for specific disorders,

such as depression (Beutler, Clarkin, & Bongar, 2000) and alcoholism. It is worth noting that in the Couples Alcoholism Treatment (CAT) project (where four of the seven dimensions of Beutler's model were tested together for the first time), three of the matching dimensions alone were able to predict collectively 76% of the variance in change (Beutler et al., 1999). Nevertheless, STS's weaknesses are that (a) only a small number of client variables are used from many potentially important ones, and (b) some assumptions have not always been supported by research (e.g., client coping style or impulsivity in the CAT project; Beutler et al., 1999).

A general weakness of eclecticism as an approach to treatment is the lack of a basic guiding structure to the essence of psychotherapy. Eclecticism focuses on meaningful details and specific differences, while neglecting common factors. Eclectic therapists may be aware of differential effects and guidelines, but they also have to make sure that all important common factors have been applied in their therapy. Clinicians should not lose sight of the "forest" (common factors) by paying attention to the "tree" (individual differences and eclecticism). The common factors approach, both referring to important relationship variables (i.e., alliance, support, empathy) and important therapeutic structure variables (i.e., catharsis, remoralization, exploration, insight, problem confrontation, learning, test and mastery of new behavior), can be a guiding map for eclectic therapists. This common-factors map will allow them to see the important therapeutic qualities and processes they need to include in therapy. The eclectic map will allow them to match these qualities and processes to individual clients and situations in order to maximize therapeutic results. A detailed description of the proposed integration of common factors and eclecticism follows.

Some Factors Are More Common (and Necessary) Than Others: Eclectic Selection

More than two decades after the Dodo bird verdict first announced the equivalence of therapeutic outcomes (Luborsky et al., 1975), this finding continues to receive empirical support (Shapiro et al., 1994; Wampold et al., 1997). However, research supporting this equivalence has been strongly criticized (e.g., Crits-Christoph, 1997; Kazdin & Bass, 1989; Norcross, 1995b; Norcross & Rossi, 1994; Shadish & Sweeney, 1991). Although most researchers agree about the contribution of common factors to the equivalent outcomes phenomenon, the presence of additional explanations for this phenomenon (Luborsky, 1995; Norcross, 1995b) suggests that (a) therapies may not be as equal as they appear, and (b) common factors may not be sufficient or the only change agents (Lampropoulos, 2000). Specific factors exist and account for some demonstrated differential outcomes among therapies (see also Asay & Lambert, 1999; Ogles et al., 1999).

It should, therefore, be expected that future research findings will include (a) some widely common and therapeutic elements (e.g., an effective working alliance), (b) additional therapeutic elements that are common only in some (but not all) of these therapies (e.g., the rehearsal and test of new behaviors), and (c) a few unique elements in some treatments, particularly with specific problems (Lampropoulos, 2000). The last two types of therapeutic agents will be responsible for specific effects and should be researched among therapies that have already demonstrated differential outcomes with specific clients and problems (i.e., empirically supported treatments and other eclectic therapies). Consistent with these expectations is the observation that certain common factors might be more relevant and important for some problems than others (i.e., social support for depression; Arkowitz, 1995; see also Garfield, 1986).

Some therapeutic factors are common and necessary. For instance, therapists should always target a good working alliance. However, as it concerns the treatment of some specific problems, the therapist might consider an eclectic use of common factors. For instance, learning, testing, and performing new behaviors are not necessary in the treatment of unfinished business with a deceased significant other. Therefore, it is appropriate to choose common factors to include in therapy according to each individual case. Employing lists of common factors should not become the Procrustean bed either, as is the case with many inflexible pure-form therapies. In sum, a selective combination of common and specific factors should be employed in the treatment of each client.

Common Factors Are Not (and Should Not Always Be) the Same: Prescriptive Applications

Some researchers have suggested exploring different functions of hypothesized common fac-

tors in various therapies, as well as studying their interactions with specific factors and in certain contexts (Elkin, 1995; Glass & Arnkoff, 1993; Shoham, 1993; see also Arkowitz, 1997; Castonguay, 1997). The view that common factors exist and operate in different forms in various therapies dictates a flexible conceptualization of the common factors approach. Thus, a recommendation for prescriptive application of specific forms of common factors is in order. At this point, it should be noted that recommendations for both eclectic selection and prescriptive application are based on (a) observations of what actually happens in various therapies, and (b) predictions of why and how the integration of common factors and eclectic models will enhance clinical practice. The rationale of why this will happen has already been presented in reviewing the strengths and weaknesses of the two approaches. Following are specific suggestions of how this will happen in clinical practice. Several available categories of therapy variables can be identified as common factors (e.g., client variables, therapist variables, techniques, change events; Lampropoulos, 2000). Due to space limitations, discussion is limited to common factors from two major combined categories: relational variables and therapeutic structure variables (phases of change).

Relational Variables as Common Factors: Prescriptive Applications

Therapeutic Relationships of Choice

The therapeutic relationship and the working alliance have been unanimously accepted as the most important common factors in therapy, and they make a major contribution to the therapeutic outcome (Horvath & Greenberg, 1994; Sexton & Whiston, 1994). As the single most important factor in therapy, the therapeutic relationship deserves at least as much attention as other therapeutic variables. Thus, eclectic applications and prescriptive matching in treatment (Norcross, 1991) have now been extended to include the therapeutic relationship. Expert therapists have recently discussed issues pertaining to tailoring relationship styles to client variables (Norcross, 1993b). There are several questions to ask regarding prescriptive applications of the therapeutic relationship (see also Mahoney & Norcross, 1993).

How should therapists choose the appropriate relational style? The first concern for eclectic therapists is to identify the client variables for which they need to tailor their relational style. Considering that a great number of client variables could be considered for that purpose (Garfield, 1994), clinical attention should focus on those that have received some empirical support and have been proposed by expert integrative therapists. The following are some of the most important variables to consider:

1. Client expectations about therapist behavior and relational style (Lazarus, 1993). When there are no serious therapeutic considerations for not doing so, the therapist should honor client expectations about, for instance, the level of formality, activity, and structure, and the degree of personal disclosure, directiveness, warmth, and emotional depth. This author's experience in watching other therapists has convinced him that therapists can even adjust the way they empathize, either being more emotional and warm or intellectual and formal, according to client style or situational needs. That is, the therapist should take both client expectations and real characteristics and needs into account when adopting a relational style.

2. Client reactance and coping style (introspective vs. externalizing) (Beutler et al., 1999; Lazarus, 1993). These client variables should not only dictate the choice of the appropriate intervention, but also constantly inform the therapist's way of relating to the client. For example, the employment of a paradoxical or a self-change technique with a highly resistant client will not be as effective if the therapist's relational style remains directive, controlling, instructional, or confrontational. The entire therapeutic style, including techniques selected, should be matched to the individual client.

3. Other important variables might include (a) client attachment style (in which therapists match their stance in order to disconfirm client maladaptive patterns; Dolan, Arnkoff, & Glass, 1993); (b) client motivational arousal and readiness for change (Beutler et al., 1999); and (c) client intellectual and educational level (i.e., use of client's language and frames of reference to communicate). However, a couple of cautionary notes should be made. First, all basic microcounseling skills and qualities are necessary in some form in the relationship, regardless of whether or not they will be prescriptively applied. Second, because the therapeutic relationship is not a static phenomenon, therapist relational style may also change throughout therapy.

How similar should the client and therapist be? A certain degree of difference and dissimilarity in the therapist-client relationship in variables such as problem-solving experience (Mahoney & Norcross, 1993) or attitudes about attachment and intimacy (Beutler, Zetzer, & Williams, 1996) might be necessary for therapeutic change. It seems that a complex pattern of initial similarities and differences exists in the optimally matched therapeutic relationship (see Beutler, Clarkin, Crago, & Bergan, 1991; Beutler, Machado, & Neufeldt, 1994). In sum, in successful therapy, the client and therapist should be initially similar in some variables (e.g., demographics) and dissimilar in others (e.g., attitudes), while some convergence in the latter should appear at the end of treatment.

How flexible can the therapist be? Although master therapists seem to have a more flexible repertoire than novices, an ability to control themselves, and a talent to improvise when necessary to fit different clients, this variability has its limits. Even when therapists are aware that a different stance is needed, their personality may limit their flexibility. This author recalls an experienced therapist (with a natural client-centered style) admitting how difficult and awkward it was for him to be strategically nonsupportive at times to a client he treated with a manualized empirically supported treatment for obsessive-compulsive disorder, even though both therapist and client knew that this stance was required by the treatment.

To conclude, although there are certain limits in therapists' flexibility in relating to different clients, the following training recommendations seem helpful: (a) educate therapists to identify and be aware of their relationship styles; (b) train therapists to explore and attempt varying therapeutic styles, when necessary; (c) train therapists to recognize important criteria for adopting different relationship styles; (d) educate them to identify and maintain an optimal level of fit or difference in the relationship; and (e) train them to make appropriate referrals when there is a clear incompatibility and mismatch in the relationship that cannot be fixed. Empirical research is also needed to clarify and guide clinical practice in these areas.

Support

Issues regarding the complexities and varieties of support have already been raised (see also Castonguay, 1997). With a conventional Rogerian definition of support in mind, some of the dilemmas of an informed eclectic therapist include the following:

Support versus challenge. This is the most important decision the therapist has to make according to a variety of client variables. For example, high distress indicates an increased level of support. Usually the average talented therapist will respond instinctively in the right direction when the client arrives at the first session tearful or anxious. More difficult but equally important is to challenge the low distressed, unmotivated client. A similar client variable that requires a decision regarding the support versus challenge dilemma is client readiness for change.

Supportive versus exploratory (insight-oriented) treatment. Client functional impairment and ego strength may also dictate the treatment of choice. Supportive interventions are required in severe situations and when few client resources are available. Exploratory behavior is feasible, useful, and recommended to the degree that the client is strong and able to benefit from it. The clients' internal versus external attributions of their problems may also dictate the treatment of choice.

Amount and duration of support. This depends on client objective and subjective (perceived) levels of social support (Beutler et al., 1999), both currently and in the past, as well as the type of the client's presenting problem (e.g., a great deal of support for long periods of time might be necessary for the chronically depressed client). The amount of support might also depend on the client's perceived self-efficacy to perform a specific behavior in therapy.

Type and content of support. This should also be determined by client problem or disorder. Different kinds of support might be necessary for the depressed client, the client with various anxiety disorders, and the client with personality disorders. Pure therapies also differ in the content of their support (Arkowitz, 1997). For example, cognitive therapy supports client efforts to correct maladaptive cognitions (Alford & Beck, 1997). It is argued that this seems optimal only when maladaptive cognitions are the main causal reason for the psychological dysfunction (e.g., depression). Similarly, the existential-humanistic emphasis is on supporting client self-exploration (Yalom & Bugental, 1997). However, support should not only be available where theory says it

is necessary, but also in areas where particular clients need that support. Psychopathology and its etiology, rather than theoretical orientation per se, should decide the content of support in therapy.

Timing and conditions of support. Progress in therapy can also be mediated and conditioned by the provision of therapeutic support. Even in the client-centered tradition, therapists use support selectively to guide their clients. Further, specific phases and tasks in therapy require more support than others, regardless of client strengths. For example, a certain amount of support is helpful for all clients when they attempt to confront a problem, apply a solution, or try a new behavior.

Therapeutic Structure Variables as Common Factors: Prescriptive Applications

Phases or stages of therapy (Beitman, 1987; Howard, Lueger, Maling, & Martinovich, 1993), stages of change (Prochaska & DiClemente, 1992), and level of problem assimilation (Stiles et al., 1990) are three somewhat different constructs that represent comparable conceptualizations of the therapeutic process. The first emphasizes therapy as an encounter; the second focuses on client self-change; and the third describes how clients progress in assimilating each single problem in therapy. These descriptions of the therapeutic structure, all well researched and useful from different perspectives, can serve both as eclectic and common-factors dimensions. Their importance as eclectic variables consists of matching the appropriate intervention to client stage or level of change in order to maximize therapeutic efficacy and minimize time in therapy. For example, motivated clients who enter therapy with relatively clearly formulated ideas of what the problem is and what needs to be changed will probably spend less time in motivational, goal-setting, and problem-exploration activities. For these clients, the focus of therapy should turn to problem-solving processes rather quickly. They will probably progress faster compared to less psychologically minded clients with limited self-awareness and insight into their problems, who will require an initial therapeutic focus that emphasizes exploratory activities.

Besides choosing interventions based on client readiness for change (i.e., eclectic applications), the stage-like concepts have important common-factors applications. Since they describe common change pathways that people follow regardless of their therapist's theoretical orientation, they have high heuristic value to guide therapeutic efforts in a common direction. Among the stage models, Stiles' assimilation model (seven levels of assimilation of problematic experience: warded off, unwanted thoughts, vague awareness-emergence, problem statement-clarification, understanding-insight, application-working through, problem solution, and mastery) seems promising. The assimilation model describes the change of problems through a series of sequential therapeutic processes (or better, change events). It appears more concrete and specific compared to other generally defined stage models, and thus has a higher guiding value in clinical practice.

Specifically, it is argued that the seven levels of the assimilation model can be used as common stages through which all therapists should guide their clients. In order to facilitate client progress through these stages, a variety of individual (eclectic) variables should be taken into account in treatment selection. Examples of how interventions can be tailored to individual clients in different levels of assimilation follow. Similar treatment selection decisions can and should be made for all seven levels of client change.

The Exploration Phase of Treatment—The Early Levels of Problem Assimilation

This phase of change is generally described as an effort to facilitate client progress from a state of vague awareness to a state of understanding and insight into problems and behaviors. In this exploratory period of treatment, both theory and empirical research suggest that there are different roads (i.e., cognitive vs. experiential) toward awareness and insight (Elliott et al., 1994; Mahoney, 1991; Stalikas, Rogan, & Berkovic, 1996) that capitalize on either cognitive or emotional-experiential aspects, respectively. As an example of eclectic practice, Lampropoulos and Spengler (1999) proposed the respective use of cognitive and experiential interventions in the awareness phase of treatment of clients with a corresponding predominant thinking style (rational vs. experiential; Epstein, 1990). Indeed, testing comparable techniques from different therapies in specific stages of change through meaningful ATI designs seems promising. This is consistent with the 1986 NIMH workshop recommendation for research in psychotherapy integration (Wolfe & Goldfried, 1988), which suggests, "Inasmuch as change processes are likely to vary with the particular stage or phase of treatment, comparative research on

change processes should focus on a comparable phase across orientations" (p. 449).

Besides client thinking style, other variables to consider in the exploratory phase of treatment include but are not limited to the following:

Problem complexity. Mild and simple behavioral or interpersonal difficulties might be satisfactorily limited to the exploration of the problem and its dynamics. However, the existence of underlying unresolved intrapsychic conflicts may require psychodynamic and insight-oriented, in-depth self-explorations (Beutler & Clarkin, 1990; Wolfe, 1992).

Resistance. Interpretations, confrontations, and highly directive and controlling techniques should be avoided with high-resistance clients. These clients may respond better to self-directed and self-change interventions, as well as to client-centered approaches or paradoxical techniques (Beutler, Engle et al., 1991; Beutler et al., 1999).

A variety of other important personality, nondiagnostic client variables. Variables such as cognitive complexity, psychological-mindedness, dependency, emotional control, coping style, perceptual style, developmental level, neuroticism, extroversion, conscientiousness, agreeableness, and openness to experience may dictate that the therapist needs to choose specific exploratory interventions. The eclectic selection might be made according to the following dimensions: directive versus evocative, systemic versus person-centered, symptom versus relationship focused, planned versus spontaneous, homework versus in-session exploration, and so on (Anderson, 1998; Beutler, 1991; Garfield, 1994).

Client diagnostic variables and therapist personality variables. Client diagnostic variables (e.g., external attributions of problems; Stiles et al., 1997a; co-existing personality disorders) and therapist personality variables are also important to consider in prescriptive matching in this phase (Beutler et al., 1994). The interactions between therapist and client variables may also be taken into account (e.g., therapist difficulty to be directive and client need for direction, or a discrepancy between therapist-client levels of cognitive complexity).

The Action Phase of Treatment—The Later Levels of Problem Assimilation

This phase of change is generally described as an effort to facilitate client progress from the level of problem clarification to problem solution and then to control of the problem and mastery of the new learning experience. Action-oriented interventions are used in this phase, which focuses on exposure to and active confrontation of the problem, as well as acquisition, testing, and practice of new learning (interpersonal, cognitive, emotional, behavioral, etc.) during and between sessions. Practice helps the client master the new behaviors (and thoughts and feelings), which replace the old, maladaptive, and problematic patterns. Client internal attributions of change are also targeted.

Similar to the exploration phase, client, therapist, and problem (diagnostic) variables should dictate treatment selection. For example, client cognitive complexity and cognitive style may be important for choosing between imaginal versus in vivo exposure. A client's preexisting deficits or reasons, say, for depression, can determine a symptom versus relationship focus of the active intervention. The level of client conscientiousness is important for the degree of structure of action-oriented techniques (i.e., low conscientiousness requires high structure). Client self-efficacy, reactance, and need for guidance and advice also dictate the therapist's level of support and directiveness in exposing the client to the problem, modeling the new behavior, and testing it in and outside the session. Interactions between therapist and client variables should be considered in the treatment selection in the action phase of therapy, too.

Implications for Psychotherapy Theory, Practice, Research, and Training

Psychotherapy practice is the first area that can benefit from the integration of common factors and eclectic approaches. Clinicians, regardless of whether they (a) practice integratively based on a common factors or a technical-eclectic approach, or (b) practice integratively from a specific theoretical standpoint through an assimilative integrative fashion (Lampropoulos, in press-a), should always be aware of important commonalities and differences in problems, therapies, clients, and themselves. By applying as many common factors as necessary in an individualized and prescriptive fashion, a small but important step toward the evolution of psychotherapy integration is taken. Until the integration of common factors and technical eclecticism is thoroughly mapped, therapists can use the principles discussed in this article to guide treatment selection and integrative practice.

Psychotherapy research can also use these principles to explore this integration empirically and conceptually. It is hoped that detailed models that plot common and eclectic dimensions in matrices will be available in the future. The numerous client, therapist, and process variables reviewed in the Bergin and Garfield handbook (1994) and the various common factors proposed in various lists (Grencavage & Norcross, 1990) provide rich material to be studied. Following the examples discussed in this article, integrative researchers can further explore how each of these common factors can be most effectively applied and matched to different individual and situational characteristics. Existing empirical data and theoretical hypotheses can also help prioritize this research. However, work on defining common factors more clearly should precede these explorations.

Psychotherapy theory will be the next natural development. Following empirical research, theories of psychotherapy and change could be created. One of the most common critiques of eclecticism is that it is atheoretical. Although it may not be guided by a specific theory of personality and psychopathology, eclecticism's final goal is to develop empirical theories of change (Beutler, 1995). The same may be true for the common-factors approach. For example, Lampropoulos (in press-b) proposed a common-factors framework to describe and explain change in psychotherapy and other human interactions, such as parenting, education, religion, sales, politics, friendships, and mentoring and coaching of any kind (e.g., sports, acting).

Psychotherapy training should focus on teaching important eclectic and common-factors variables; these must be the first lessons in the education of novice integrative-eclectic therapists (Lampropoulos, Moahi-Gulubane, & Dixon, 1999). Beutler (1999) recently offered eight basic guidelines for the training of eclectic therapists. These guidelines cover major areas of treatment selection and matching (e.g., optimal format, type, and length of treatment; ESTs; indications and contraindications). By adding recommendations for (a) training in the identification and application of common factors, and (b) training in the foregoing integrative treatment selection system, we have the first "ten commandments" for the training of integrative therapists. Although these ten commandments may not be irreplaceable, their goal will always be sacred: to train therapists to provide clients with the optimal and cost-effective services they are looking for.

References

Alford, B. A., & Beck, A. T. (1997). Therapeutic interpersonal support in cognitive therapy. *Journal of Psychotherapy Integration, 7*, 105–117.

Anderson, K. W. (1998). Utility of the five-factor model of personality in psychotherapy aptitude-treatment interaction research. *Psychotherapy Research, 8*, 54–70.

Arkowitz, H. (1992). A common factors therapy for depression. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 402–432). New York: Basic.

Arkowitz, H. (1995). Common factors or processes of change in psychotherapy? *Clinical Psychology: Science and Practice, 2*, 94–100.

Arkowitz, H. (1997). The varieties of support in psychotherapy. *Journal of Psychotherapy Integration, 7*, 151–159.

Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, B. L. Duncan, & S. Miller (Eds.), *The heart and soul of change* (pp. 33–55). Washington, DC: American Psychological Association.

Beitman, B. D. (1987). *The structure of individual psychotherapy*. New York: Guilford.

Beitman, B. D. (1992). Integration through fundamental similarities and useful differences among the schools. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 202–230). New York: Basic.

Beitman, B. D. (1994). Stop exploring! Start defining the principles of psychotherapy integration: Call for a consensus conference. *Journal of Psychotherapy Integration, 4*, 203–228.

Bergin, A. E., & Garfield, S. L. (Eds.). (1994). *Handbook of psychotherapy and behavior change*. New York: Wiley.

Beutler, L. E. (1983). *Eclectic psychotherapy: A systematic approach*. Elmsford, NY: Pergamon.

Beutler, L. E. (1991). Have all won and must all have prizes? Revisiting Luborsky et al.'s verdict. *Journal of Consulting and Clinical Psychology, 59*, 226–232.

Beutler, L. E. (1995). Common factors and specific effects. *Clinical Psychology: Science and Practice, 2*, 79–82.

Beutler, L. E. (1999). Manualizing flexibility: The training of eclectic therapists. *Journal of Clinical Psychology, 55*, 399–404.

Beutler, L. E., & Clarkin, J. (1990). *Systematic treatment selection: Toward targeted therapeutic interventions*. New York: Brunner/Mazel.

Beutler, L. E., Clarkin, J. F., & Bongar, B. (2000). *Guidelines for the systematic treatment of the depressed patient*. New York: Oxford University Press.

Beutler, L. E., Clarkin, J., Crago, J., & Bergan, J. (1991). Client-therapist matching. In C. R. Snyder & D. R. Forsyth (Eds.), *Handbook of social and clinical psychology: The health perspective* (pp. 699–716). New York: Pergamon.

Beutler, L. E., Engle, D., Mohr, D., Daldrup, R. J., Bergan, J., Meredith, K., & Merry, W. (1991). Predictors of differential and self directed therapeutic procedures. *Journal of Consulting and Clinical Psychology, 59*, 333–340.

BEUTLER, L. E., GOODRICH, G., FISHER, D., & WILLIAMS, R. E. (1999). Use of psychological tests/instruments for treatment planning. In M. Maruish (Ed.), *Use of psychological testing for treatment planning and outcome assessment* (pp. 81–113, 2nd ed.). Hillsdale, NJ: Lawrence Erlbaum.

BEUTLER, L. E., MACHADO, P. P. P., & NEUFELDT, S. A. (1994). Therapist variables. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 229–269). New York: Wiley.

BEUTLER, L. E., & WILLIAMS, P. B. (in press). *Systematic Treatment Selection: Test manual and software user's guide*. Minneapolis, MN: New Standards.

BEUTLER, L. E., ZETZER, H. A., & WILLIAMS, R. E. (1996). Research applications of prescriptive therapy. In W. Dryden (Ed.), *Research in counseling and psychotherapy: Practical applications* (pp. 25–48). London: Sage.

BUTLER, S. F., & STRUPP, H. H. (1986). Specific and nonspecific factors in psychotherapy: A problematic paradigm for psychotherapy research. *Psychotherapy, 23*, 30–40.

CASTONGUAY, L. G. (1993). "Common factors" and "nonspecific variables": Clarification of the two concepts and recommendations for research. *Journal of Psychotherapy Integration, 3*, 267–286.

CASTONGUAY, L. G. (1997). Support in psychotherapy: A common factor in need of empirical data, conceptual clarification, and clinical input. *Journal of Psychotherapy Integration, 7*, 99–103.

CRITS-CHRISTOPH, P. (1997). Limitations of the Dodo bird verdict and the role of clinical trials in psychotherapy research: Comment on Wampold et al. (1997). *Psychology Bulletin, 122*, 216–220.

DANCE, K. A., & NEUFELD, R. W. J. (1988). Aptitude-treatment interaction research in the clinical setting: A review of attempts to dispel the 'patient uniformity' myth. *Psychological Bulletin, 104*, 192–213.

DOLAN, R. T., ARNKOFF, D. B., & GLASS, C. R. (1993). Client attachment style and the psychotherapist's interpersonal stance. *Psychotherapy, 30*, 408–412.

ELKIN, I. (1995). Further differentiation of common factors. *Clinical Psychology: Science and Practice, 2*, 75–78.

ELLIOTT, R., SHAPIRO, D. A., FIRTH-COZENS, J., STILES, W. B., HARDY, G. E., LLEWELYN, S. P., & MARGISON, F. R. (1994). Comprehensive process analysis of insight events in cognitive-behavioral and psychodynamic-interpersonal psychotherapies. *Journal of Counseling Psychology, 41*, 449–463.

EMMELKAMP, P. M. G. (1994). Behavior therapy with adults. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 379–427). New York: Wiley.

EPSTEIN, S. (1990). Cognitive-experiential self-theory. In L. Pervin (Ed.), *Handbook of personality theory and research* (pp. 165–192). New York: Guilford.

FIGURED, K. J., & NORCROSS, J. C. (1996). Defining the future of SEPI: A survey of the membership. *Journal of Psychotherapy Integration, 6*, 385–407.

FISCHER, A. R., JOME, L. M., & ATKINSON, D. R. (1998). Reconceptualizing multicultural counseling: Universal healing conditions in a culturally specific context. *The Counseling Psychologist, 26*, 525–588.

FISHER, D., BEUTLER, L. E., & WILLIAMS, O. B. (1999). Making assessment relevant to treatment planning: The STS clinician rating form. *Journal of Clinical Psychology, 55*, 825–842.

FRANK, J. D., & FRANK, J. B. (1991). *Persuasion and healing* (3rd ed.). Baltimore, MD: J. Hopkins University Press.

GARFIELD, S. L. (1986). An eclectic psychotherapy. In J. C. Norcross (Ed.), *Handbook of eclectic psychotherapy* (pp. 132–162). New York: Brunner/Mazel.

GARFIELD, S. L. (1994). Research on client variables in psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 190–228). New York: Wiley.

GLASS, C. R., & ARNKOFF, D. B. (1993). Research directions for psychotherapy integration. In J. C. Norcross (Ed.), Research directions for psychotherapy integration: A roundtable. *Journal of Psychotherapy Integration, 3*, 91–131.

GOLD, J. R. (1996). *Key concepts in psychotherapy integration*. New York: Plenum.

GOLDFRIED, M. R. (1991). Research issues in psychotherapy integration. *Journal of Psychotherapy Integration, 1*, 5–25.

GOLDFRIED, M. R., & WOLFE, B. E. (1998). Toward a more clinically valid approach to therapy research. *Journal of Consulting and Clinical Psychology, 66*, 143–150.

GREENBERG, L., RICE, L., & ELLIOTT, R. (1993). *Facilitating emotional change*. New York: Guilford.

GRENCAVAGE, L. M., & NORCROSS, J. C. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice, 21*, 372–378.

HAWKINS, P. J., & NESTOROS, J. N. (1997). Beyond the dogmas of conventional psychotherapy: The integration movement. In P. J. Hawkins & J. N. Nestoros (Eds.), *Psychotherapy: New perspectives on theory, practice, and research* (pp. 23–95). Athens, Greece: Ellinika Grammata.

HENRY, W. P. (1996). Structural analysis of social behavior as a common metric for programmatic psychopathology and psychotherapy research. *Journal of Consulting and Clinical Psychology, 64*, 1263–1275.

HORVATH, A. O., & GREENBERG, L. S. (Eds.). (1994). *The working alliance: Theory, research, and practice*. New York: Wiley.

HOWARD, K. I., LUEGER, R. J., MALING, M. S., & MARTINOVICH, Z. (1993). A phase model of psychotherapy outcome: Causal mediation of change. *Journal of Consulting and Clinical Psychology, 61*, 678–685.

HUBBLE, M. A., DUNCAN, B. L., & MILLER, S. (Eds.). (1999a). Directing attention to what works. In M. A. Hubble, B. L. Duncan, & S. Miller (Eds.), *The heart and soul of change* (pp. 407–447). Washington, DC: American Psychological Association.

HUBBLE, M. A., DUNCAN, B. L., & MILLER, S. (Eds.). (1999b). *The heart and soul of change*. Washington, DC: American Psychological Association.

KAZDIN, A. E., & BASS, D. (1989). Power to detect differences between alternative treatments in comparative psychotherapy outcome research. *Journal of Consulting and Clinical Psychology, 57*, 138–147.

LAMBERT, M. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94–129). New York: Basic.

LAMBERT, M. J., & BERGIN, A. E. (1994). The effectiveness of psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4th ed., pp. 143–189). New York: Wiley.

LAMPROPOULOS, G. K. (1999, July). *An expressive-interpretive approach to the resolution of unfinished busi-*

ness. Poster session presented at the Annual Conference of American Mental Health Counselors Association, Crystal City, VA.

Lampropoulos, G. K. (2000). Definitional and research issues in the common factors approach to psychotherapy integration: Misconceptions, clarifications, and proposals. *Journal of Psychotherapy Integration, 10*, 415–438.

Lampropoulos, G. K. (in press-a). Bridging technical eclecticism and theoretical integration: Assimilative integration. *Journal of Psychotherapy Integration*.

Lampropoulos, G. K. (in press-b). Common processes of change in psychotherapy and seven other social interactions. *British Journal of Guidance and Counseling*.

Lampropoulos, G. K., Moahi-Gulubane, S., & Dixon, D. N. (1999, April). *Integrative-eclectic training in counseling psychology*. Poster session presented at the 12th Annual Great Lakes Conference of Division of Counseling Psychology of the APA, Columbus, OH.

Lampropoulos, G. K., & Spengler, P. M. (1999, June). *Theory-driven, phase-specific, manual-guided, clinically meaningful aptitude-treatment interaction (ATI) research focusing on client's nondiagnostic personality variables*. Poster session presented at the 30th International Meeting of Society for Psychotherapy Research, Braga, Portugal.

Lazarus, A. A. (1993). Tailoring the therapeutic relationship, or being an authentic chameleon. *Psychotherapy, 30*, 404–407.

Lazarus, A. A., Beutler, L. E., & Norcross, J. C. (1992). The future of technical eclecticism. *Psychotherapy, 29*, 11–20.

Lazarus, A. A., & Messer, S. B. (1991). Does chaos prevail? An exchange on technical eclecticism and assimilative integration. *Journal of Psychotherapy Integration, 1*, 143–158.

Luborsky, L. (1995). Are common factors across different psychotherapies the main explanation for the Dodo bird verdict that "everybody has won so all shall have prizes?" *Clinical Psychology: Science and Practice, 2*, 106–109.

Luborsky, L., Singer, G., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that "everyone has won and all must have prizes?" *Archives of General Psychiatry, 32*, 995–1008.

Mahoney, M. J. (1991). *Human change processes*. New York: Basic.

Mahoney, M. J., & Norcross, J. C. (1993). Relationship styles and therapeutic choices: A commentary on the preceding four articles. *Psychotherapy, 30*, 423–426.

Messer, S. B., & Winokur, M. (1981). Therapeutic change principles: Are commonalities more apparent than real? *American Psychologist, 36*, 1547–1548.

Nestoros, J. N., & Vallianatou, N. G. (1990). *Synthetiki psychotherapia (Integrative psychotherapy)*. Athens, Greece: Ellinika Grammata.

Norcross, J. C. (1991). Prescriptive matching in psychotherapy: An introduction. *Psychotherapy, 28*, 439–443.

Norcross, J. C. (Ed.). (1993a). Research directions for psychotherapy integration: A roundtable. *Journal of Psychotherapy Integration, 3*, 91–131.

Norcross, J. C. (1993b). Tailoring relationship to stances to client needs: An introduction. *Psychotherapy, 30*, 402–403.

Norcross, J. C. (Ed.). (1995a). A roundtable on psychotherapy integration. *Journal of Psychotherapy Practice and Research, 4*, 248–271.

Norcross, J. C. (1995b). Dispelling the Dodo bird verdict and the exclusivity myth in psychotherapy. *Psychotherapy, 32*, 500–504.

Norcross, J. C. (1997). Emerging breakthroughs in psychotherapy integration: Three predictions and one fantasy. *Psychotherapy, 34*, 86–90.

Norcross, J. C., & Goldfried, M. R. (Eds.). (1992). *Handbook of psychotherapy integration*. New York: Basic.

Norcross, J. C., & Kaplan, K. J. (1995). Training in psychotherapy integration I: Integrative-eclectic programs. *Journal of Psychotherapy Integration, 5*(3).

Norcross, J. C., & Rossi, J. S. (1994). Looking weakly in all the wrong places? Comment on Shapiro et al. (1994). *Journal of Consulting and Clinical Psychology, 62*, 535–538.

Ogles, B. M., Anderson, T., & Lunnen, K. M. (1999). The contribution of models and techniques to therapeutic efficacy. In M. A. Hubble, B. L. Duncan, & S. Miller (Eds.), *The heart and soul of change* (pp. 201–225). Washington, DC: American Psychological Association.

Omer, H., & London, P. (1989). Signal and noise in psychotherapy: The role and control of nonspecific factors. *British Journal of Psychiatry, 155*, 239–245.

Orlinsky, D. E., & Howard, K. I. (1987). A generic model of psychotherapy. *Journal of Integrative and Eclectic Psychotherapy, 6*, 6–27.

Paivio, S., & Greenberg, L. S. (1995). Resolving unfinished business: Experiential therapy using empty chair dialogue. *Journal of Consulting and Clinical Psychology, 63*, 419–425.

Paul, G. L. (1967). Strategy of outcome research in psychotherapy. *Journal of Consulting Psychology, 31*, 109–118.

Piper, W. E., Joyce, A. S., McCallum, M., & Azim, H. F. (1998). Interpretive and supportive forms of psychotherapy and patient personality variables. *Journal of Consulting and Clinical Psychology, 66*, 558–567.

Prochaska, J. O., & DiClemente, C. C. (1984). *The transtheoretical approach: Crossing the traditional boundaries of therapy*. Homewood, IL: Dow Jones-Irwin.

Prochaska, J. O., & DiClemente, C. C. (1992). The transtheoretical approach. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 300–334). New York: Basic.

Project MATCH Research Group. (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol, 58*, 7–29.

SEPI-Society for the Exploration of Psychotherapy Integration. (1999). *Directory*. (Available from the SEPI, c/o Dr. George Stricker, The Derner Institute, Adelphi University, Garden City, NY 11530).

Sexton, T. L., & Whiston, S. C. (1994). The status of the counseling relationship: An empirical review, theoretical implications, and research directions. *The Counseling Psychologist, 22*, 6–78.

Shadish, W. R., & Sweeney, R. B. (1991). Mediators and moderators in meta-analysis: There's a reason we don't let dodo birds tell us which psychotherapies should have prizes. *Journal of Consulting and Clinical Psychology, 59*, 883–893.

Shapiro, D. A., Barkham, M., Rees, A., Hardy, G., Reynolds, S., & Startup, M. (1994). Effects of treatment duration and severity of depression on the effectiveness of cognitive-behavioral and psychodynamic-interpersonal psychotherapy. *Journal of Consulting and Clinical Psychology, 62*, 522–534.

Shoham, V. (1993). Research directions for psychotherapy integration. In J. C. Norcross (Ed.), Research directions for psychotherapy integration: A roundtable. *Journal of Psychotherapy Integration, 3*, 91–131.

SHOHAM, V., & ROHRBAUGH, M. (1995). Aptitude × treatment interaction (ATI) research: Sharpening the focus, widening the lens. In M. Aveline & D. Shapiro (Eds.), *Research foundations for psychotherapy practice* (pp. 73–95). Sussex, England: Wiley.

STALIKAS, A., ROGAN, K., & BERKOVIC, M. S. (1996). Insight in counseling research. Measurement and methodological issues. *Journal of Psychotherapy Integration, 6*, 265–279.

STILES, W. B., ELLIOTT, R., LLEWELYN, S. P., FIRTH-COZENS, J., MARGISON, L., SHAPIRO, D. A., & HARDY, G. (1990). Assimilation of problematic experiences by clients in psychotherapy. *Psychotherapy, 27*, 411–420.

STILES, W. B., SHANKLAND, M. C., WRIGHT, J., & FIELD, S. D. (1997a). Dimensions of clients' initial presentation of problems in psychotherapy: The Early Assimilation Research Scale. *Psychotherapy Research, 7*, 155–171.

STILES, W. B., SHANKLAND, M., WRIGHT, J., & FIELD, S. (1997b). Aptitude-treatment interactions based on clients' assimilation of their presenting problems. *Journal of Consulting and Clinical Psychology, 65*, 889–893.

STRICKER, G., & GOLD, J. R. (Eds.). (1993). *Comprehensive handbook of psychotherapy integration*. New York: Plenum.

WALLERSTEIN, R. S., & DEWITT, K. N. (1997). Intervention modes in psychoanalysis and in psychoanalytic psychotherapies: A revised classification. *Journal of Psychotherapy Integration, 7*, 129–150.

WAMPOLD, B. E., MONDIN, G. W., MOODY, M., STICH, F., BENSON, K., & AHN, H. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "All must have prizes." *Psychological Bulletin, 122*, 203–215.

WEINBERGER, J. (1993). Common factors in psychotherapy. In G. Stricker & J. R. Gold (Eds.), *The comprehensive handbook of psychotherapy integration* (pp. 43–56). New York: Plenum.

WEINBERGER, J. (1995). Common factors aren't so common: The common factors dilemma. *Clinical Psychology: Science and Practice, 2*, 45–69.

WOLFE, B. E. (1992). Integrative psychotherapy of the anxiety disorders. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 373–401). New York: Basic.

WOLFE, B. E., & GOLDFRIED, M. R. (1988). Research on psychotherapy integration: Recommendations and conclusions from an NIMH workshop. *Journal of Consulting and Clinical Psychology, 56*, 448–451.

YALOM, V., & BUGENTAL, J. F. T. (1997). Support in existential-humanistic psychotherapy. *Journal of Psychotherapy Integration, 7*, 119–128.