Chapter 1

Challenges from the Psychotherapy Literature: What *Do* Therapists Know?

In an evaluation of the current status of psychoanalytic thinking, Stephen Mitchell (1993) includes a chapter similar in title to this one and concludes that a "crisis in confidence" exists within analytic circles today. He contends that psychoanalysis was historically characterized by an assumption that there was a single theory which represented "scientific truth." But, today

> there are many psychoanalytic schools, each with claims to an exclusive possession of objective truth. . . . It is hard to imagine a time when any one theoretical perspective will demonstrate such compelling reasonableness and truth that proponents of the others will change ranks, and psychoanalysis will once again be whole. (p. 45)

Further, he proposes that this change in thinking within psychoanalysis parallels intellectual trends in the larger culture and has involved a shift "not on the level of theory but on the level of metatheory: theory about theory" (p. 42). That is, one can discern and comprehend this shift in thinking in the analytic community only by stepping back from the concrete, multitudinous changes in psychoanalytic theorizing and asking what they imply for the question, "What does the analyst know?"

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Mitchell's characterization of psychoanalysis anticipates some conclusions which could be reached for the general field of psychotherapy, and his focus on "metatheory" parallels the strategy which I will employ here. Since the literature on psychotherapy is so vast and unwieldy, it is important in a work of this kind to approach it from a particular, limited vantage point. Therefore, those aspects of the historical, comparative, empirical, and theoretical literature on psychotherapy which are reviewed were selected because of their direct bearing on the metatheoretical question, "Now what does this tell us about what therapists really know?"

THE PROLIFERATION OF THERAPEUTIC THEORIES AND METHODS

It would be no surprise to the practicing clinician, who is constantly bombarded by flyers in the daily mail touting seminars on new therapeutic techniques and strategies, to find the following conclusion supported by the literature: Mitchell's observations about the proliferation of theory and method in psychoanalysis apply to the field of psychotherapy as a whole. The number of therapeutic alternatives available in this field has increased dramatically within the relatively short period of less than 40 years. London (1986) cites Harper (1959) as describing 36 "systems" of psychotherapy, Parloff (1976) as counting 130 "titles" but only 17 distinct modalities, and Herink (1980) as cataloging more than 250 non-redundant types of treatment (p. 42). More recently, Karasu (1992) estimates that there are over 400 types of therapy, a number more than ten times that of Harper's original formulation.

Of course, these numbers may be inflated to some unspecified degree because there is disagreement over exactly what should be called a therapeutic theory or method. Certainly, the higher estimates encompass a variety of ways of defining therapy including the traditional approach of naming the school/theoretical stance (cognitive therapy or narrative therapy) as well as the newer strategy of counting approaches which represent a specific problem or population (sex therapy or substance abuse therapy), a specific modality (family therapy or group therapy), or a specific technique (hypnotherapy or relaxation training). In addition, London (1986), pointing to usages such as "Horticultural Therapy" and "Poetry Therapy" (p. 42), suggests that "there are more psychotherapies than there used to be because the boundaries of what can legitimately be called psychotherapy have shifted radically, and the taxonomy of treatments has had to shift with them" (p. 43).

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Debates about criteria for inclusion, however, should not detract from the agreement which has been reached about the larger issue. There has been a virtual explosion in theories and methods by which one might conduct psychotherapy, and it is directly related to the guiding question of this chapter. Whether or not one would see this proliferation of theory and method as adding to our collective knowledge about psychotherapy, it appears to have the opposite impact on the individual level. It can be experienced as a constant din of claims that something *newer* and *better* has been discovered which *must* be added to the repertoire of any responsibly informed therapist. Prochaska and Norcross (1994) write: "A healthy diversity has deteriorated into an unhealthy chaos. Students, practitioners, and patients are confronted with confusion, fragmentation, and discontent. With so many therapy systems claiming success, which theories should be studied, taught, or bought?" (p. 1).

HISTORICAL AND COMPARATIVE APPROACHES TO PSYCHOTHERAPY

It is interesting to juxtapose the current proliferation of therapeutic systems with historical and comparative views of the definition of psychotherapy and its identity as a cultural institution. Reviews (Kiev, 1964; Bromberg, 1975; Ehrenwald, 1966, 1976a; Frank, 1973; Frank & Frank, 1991) of the history of mental healing, broadly considered, underscore that Western psychotherapists are not the first socially sanctioned mental health practitioners to assume that cultural role:

> If mental healers were to be summoned to the patient's bedside in the order of their appearance in history, the magician or medicine man would be the first one to answer the call. He[1] would be followed by the philosopher-priest of various religious denominations, who would, in turn, yield his place to the scientifically oriented psychotherapist. (Ehrenwald, 1976b, p. 17)

Different views of the causation and amelioration of mental distress are associated with each of these identities and include "the religiomagical, the rhetorical, and the empirical or naturalistic" (Frank & Frank, 1991,

[1] Throughout the text the reader is asked to judge seemingly sexist language in quoted matter in relation to the prevailing standards when the passage was written.

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p. 3). The cause and cure of mental distress are found in the spiritual domain by the former and in the physical and psychological domains by the latter. "Rhetoric" is historically associated with the combination of a philosophical and naturalistic outlook, such as that of the ancient Greeks, who saw the role of the rhetorician as one of exerting a kind of moral influence on the listener through facilitating the adoption of "noble" beliefs (pp. 65–66).

Jerome Frank has been so impressed with the parallels among religiomagical healing, religious revivalism and cults, thought reform, the placebo effect in medicine, and Western psychotherapy that his classic study (1961) of comparative psychotherapy, and its subsequent revisions (Frank, 1973; Frank & Frank, 1991), define "psychotherapy" broadly enough to encompass all of these manifestations. For Frank, all of these psychotherapies involve a special relationship between a socially sanctioned healer and a sufferer, where the healer attempts to modify the sufferer's thoughts/beliefs, feelings, and behaviors. Thus, all psychotherapy represents an attempt at "persuasion," whether the healer's influence is direct or indirect, unacknowledged or acknowledged.

Ehrenwald (1976c) suggests that healers as diverse as magicians and shamans in preindustrial societies, demonologists in the European Middle Ages, Mesmer in eighteenth-century France, and the Christian Scientist Mary Baker Eddy in nineteenth-century America probably all had a "modicum of success" in their attempts to heal sufferers (pp. 571–572). This observation offers a clue to understanding the proliferation of Western psychotherapies, described in the last section. Perhaps all of these psychotherapies, like their historical predecessors, have a "modicum of success" in improving the lives of clients who are seen and, therefore, find at least a temporary niche in the therapeutic marketplace. While the empirical evidence for this proposition will be examined in the next section, stating it here provides some context for the historical/comparative approach.

Indeed, the comparative work of Ehrenwald and Frank represents an early and, especially in Frank's case (Weinberger, 1993), influential statement of what has come to be known as the "common factors" approach to psychotherapy. Both are interested in addressing two intriguing questions. What does it mean that there have been a series of quite different approaches to mental healing which have occurred across different cultures and times? And, what does it mean that so many different approaches to psychotherapy have been produced in our own culture and time?

Ehrenwald and Frank bring conceptual order to a vast number of contradictory observations through making a simple assumption: All of

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these historical modes of healing and all of the contemporary approaches to psychotherapy are characterized by certain common elements which contribute to their success on both the individual and societal level. Frank and Frank (1991) propose that the following four factors appear in all forms of psychotherapy, whether the practitioner is a shaman, a psychoanalyst, or a behavior therapist:

> An emotionally charged, confiding relationship with a helping person (often with the participation of a group). . . .
>
> A healing setting. . . .
>
> A rationale, conceptual scheme, or myth that provides a plausible explanation for the patient's symptoms and prescribes a ritual or procedure for resolving them. . . .
>
> A ritual or procedure that requires the active participation of both patient and therapist and that is believed by both to be the means of restoring the patient's health. (pp. 40–43, italics omitted)

The "myth" and "ritual" prescribed by the therapist not only must fit with the client's beliefs and expectations to the extent that "faith" and "hope" are awakened but also must provide specific learning which will allow the client to make concrete changes in areas such as emotional expression, sense of self-efficacy, and behavior.

It is important to note that Frank's analysis is more textured and subtle than it may appear in this brief summary. He does not simply reduce psychotherapy to "faith" or the placebo effect, and he is not saying that "training in any particular theory or technique is superfluous" or that "anything goes" in psychotherapy (Frank & Frank, 1991, p. xiv). In fact, he acknowledges that it is valuable for therapists to have in their repertoire a variety of theoretical / methodological approaches which can accord "with the patient's personal characteristics and view of the problem" (p. xv).

The historical/comparative approach to psychotherapy represents a serious challenge to the thinking of most clinical practitioners, undermining many assumptions about what is known. While it is generally presumed without question that Western psychotherapy is a unique approach to dealing with human problems, these historians of the field argue that there are vestiges of religiomagical healing and rhetoric in present-day practice. Worse yet, Ehrenwald (1976c) suggests that it may be more difficult than is generally assumed to demonstrate "conclusively the superiority of scientific psychotherapy over its primitive forerunners" (p. 573).

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Frank further jostles our assumptions by taking to task our cherished theories of personality and therapeutic change. He refers to such theories as "myths," not because they invoke spirits or supernatural powers, but because: "(1) they are imagination-catching formulations of recurrent and important human experiences; and (2) they cannot be proved empirically. Successes are taken as evidence of their validity (often erroneously), while failures are explained away" (Frank & Frank, 1991, p. 42).

It might be more accurate to say that therapeutic failures or disconfirming observations in the psychotherapy field do not lead to the displacement of old theories but to the generation of new theories. When Carl Jung and Alfred Adler began to see a different way of conceptualizing human problems that better described their own experience and was seemingly more effective with their patients, then two new theories took their place alongside Freudian theory. The same process has continued unabated up to the present time and is no doubt a major contributor to the proliferation of theory and technique in psychotherapy.

Further, Frank emphasizes the *function* rather than the *content* of therapeutic theories, and this emphasis leads to the clarification of another puzzle of the therapeutic field. Returning to an earlier assumption that therapies must have some success with at least some clients to survive in the marketplace, a focus on theoretical content might lead to the faulty conclusion that all of the different accounts of therapeutic change are somehow "equally true." Shifting to a comparative analysis highlights a factor which crosscuts the different theories and which is no doubt a universal need of human beings. From this perspective, the function of theory is to provide new meanings for the client, and this function is independent of any one theory or technique.

Framing this same point in the context of psychotherapeutic interpretation, Frank (1973) would contend that interpretations need not be true to benefit the client, they need only be plausible (p. 224). Plausible interpretations serve many functions including: (*a*) demonstrating the therapist's understanding and concern, (*b*) evoking emotional release, (*c*) providing reassurance, and (*d*) giving the client a new set of meanings for self-understanding. Thus, Frank's thinking is similar to that of Spence (1982), who argues that interpretations work, not because of their "historical truth," but because of their "narrative truth." Both of these accounts provide an explanation for the widely observed phenomenon that clients in different therapies often produce dreams, free associations, or insights that conform to the particular theoretical leanings of the therapist they happen to be seeing (Ehrenwald, 1976c, p. 573).

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The impact of the historical and comparative literature on the question "What do therapists know?" can be summarized by turning to the issue of therapist identity in contemporary America. Bromberg, writing in 1975, offers an observation which in the context of subsequent developments seems prescient: "The present scene in this country represents virtually a recapitulation of the entire history of the art and science of mental healing" (p. 347).

On the one hand, the majority of psychotherapists who practice in the United States, and presumably the majority of clients who seek psychotherapy, associate its practice with the tradition of medical or "scientific" healing. This includes therapists who are empirically oriented and identify specifically with a "scientist-practitioner" model of practice. It also includes therapists who intentionally or unintentionally don the mantle of science through the seemingly scientific nature of their theoretical language, their therapeutic methods, or the locale of their practice. "Secular therapies typically take place in a therapist's office, a hospital, or a clinic. Many of these sites carry the aura of science" (Frank & Frank, 1991, p. 41). This identity for the therapist is congruent with many current societal expectations—including those stated and enforced by the managed care industry, state licensing boards, and professional organizations—where objectivity and accountability are seen as defining sound practice.

On the other hand, there are a significant number of psychotherapists, and pockets of consumers of psychotherapy, who embrace a nonscientific identity for psychotherapy, including identities associated with the prehistory of Western psychotherapy. An informal sign that some therapists are returning to a religiomagical identity is given by the directories which have appeared in many urban areas and guide prospective clients to "alternative" therapists and healers. While this trend may be more developed in the San Francisco Bay Area than in some other parts of the country, a local directory (*Common Ground*, 1996) advertises approaches such as "Alchemical Hypnotherapy," "the Animal Imagery Circle," and "Phoenix Rising Yoga Therapy." A relatively mainstream expression of the same trend is represented by the development of "Transpersonal Psychology" as a branch of the field with its own membership, annual conference, and journal. While not all transpersonally oriented theorists and therapists reject science as a way of knowing, many are interested in investigating (Lukoff, Turner, & Lu, 1993) and applying (Waldman, 1992) spiritual/religious healing practices.

Other movements within the American psychotherapeutic community seem to embrace neither a scientific nor a religiomagical identity

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and represent a return to what Frank would call "rhetoric." While it's doubtful that many therapists of this persuasion would embrace his term as a description of their philosophy and practice, they might identify more readily with his characterization of this approach to psychotherapy as "the transformation of meanings" (Frank & Frank, 1991, chap. 3). This redefinition moves psychotherapy from a natural science, intent on discovering facts, to a kind of "human science" (Giorgi, 1970)—or even to a form of "moral discourse" (Cushman, 1993)—concerned with the question of how individual and culture intersect to create meaning and being. While such a formulation may ignore some important points of difference among the various psychotherapies emphasizing a rhetorical approach, it is broadly descriptive of psychotherapists who champion either an older ("humanistic-existential") or a newer ("social constructionist," "hermeneutic," or "narrative") alternative identity for therapeutic practice.

Like the proliferation of theoretical theories and methods outlined in the last section, these contrasting identities for the psychotherapist are another reflection of the confusion and upheaval surrounding the status of psychotherapeutic knowledge. At the very moment that external forces are pushing psychotherapy to become more accountable and to justify its societal value on empirical grounds, internal challenges to a strictly scientific and empirical agenda are increasing in both number and credibility. These two contrary trends are certainly visible within the American Psychological Association (APA), as some of its recent publications would attest. For example, this organization's Division of Clinical Psychology has established a special Task Force to respond to the cultural press for empirically validated treatments. It has proposed criteria for choosing treatments on this basis, drafted lists of specific treatments which meet these criteria, and emphasized the importance of the dissemination of this information to clinical psychologists and training programs (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). Further, given that this effort has been inspired in part by the fear that legal and managed care guidelines for the treatment of psychological disorders will come to be dominated by psychiatry and psychopharmacology (Barlow, 1996), the Task Force recommendations could also have future implications for health care policy, third party payers, and reimbursement.

Meanwhile, APA's flagship journal, the *American Psychologist,* has been peppered during recent years with pieces that critique a singularly empirical approach to questions of method, identity, and social value. Three of the many such articles include a suggested identity for the clin-

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ical psychologist as that of "metaphysician-scientist-practitioner" (O'Donohue, 1989), a proposal for "multiplicity" in the research methods on which clinical practice and training are built (Hoshmand & Polkinghorne, 1992), and a recommendation that a "constructive relationship" between religion and psychological science be established (Jones, 1994).

THE EMPIRICAL LITERATURE ON PSYCHOTHERAPY

To this point, a review of the literature has demonstrated considerable confusion in the general field of psychotherapy, marked by a proliferation of theories and methods and by contrasting identities for the psychotherapists who hold those theories and practice those methods. As Mitchell (1993) documents for the subfield of psychoanalysis, during such periods of disagreement and chaos, it is not unusual for the principals to turn to empirical research with the hope that "the facts" will dispel the confusion. Of course, this is the very strategy recommended above by the APA Task Force, and from the standpoint of those who would advocate a reformulated identity for psychotherapy, it is not without its illusions and biases. However, bracketing that objection for now, let us see how psychotherapy researchers themselves might respond to the question, "What do therapists know?"

Research on Psychotherapy Outcome and Its Interpretation

More than 40 years after Eysenck (1952) threw down the gauntlet, challenging therapists to prove the effectiveness and value of psychotherapy, a consensus has been reached by psychotherapy researchers. The editors and authors of the standard reference in this area, *Handbook of Psychotherapy and Behavior Change* (4th ed.) (Bergin & Garfield, 1994a), are largely in agreement: Psychotherapy "works"! There is evidence that clients in psychotherapy as a group show improvement which is both "statistically significant" and "clinically meaningful," and these gains exceed those of comparable clients receiving placebo or control treatments (Lambert & Bergin, 1994, pp. 180–181).

However, while there is robust data attesting to the efficacy of the different psychotherapeutic approaches which have been studied to this point, it has been much more difficult to establish differences in outcome among these methods. For example, Sloane, Staples, Cristol, Yorkston,

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and Whipple (1975) found no overall difference between brief psychodynamic and behavior therapy with a general outpatient population. The massive NIMH Collaborative Depression Study (Elkin et al., 1989; Imber et al., 1990) produced more complex results, but no real differences between interpersonal psychotherapy and cognitive-behavioral therapy were found. Lambert and Bergin (1994) summarize the available data by indicating that no therapy is clinically superior across the board with "moderate outpatient disorders," but that

> behavioral and cognitive methods appear to add a significant increment of efficacy with respect to a number of difficult problems (e.g., panic, phobias, and compulsion) and to provide useful methods with a number of nonneurotic problems with which traditional therapies have shown little effectiveness (e.g., childhood aggression, psychotic behavior, and health-related behaviors). (p. 181)

Although the outcome measures used by researchers are a popular critical target of surveyed clinicians (Morrow-Bradley & Elliott, 1986), the data regarding psychotherapeutic outcome, for the most part, are not in dispute. However, ambiguities and disagreements abound when interpretations of the meaning of these data are offered.

One of the most popular and influential interpretations of the very minor differences in outcome among different therapeutic approaches was made by Luborsky, Singer, and Luborsky (1975). These reviewers borrowed a line from the Dodo bird in *Alice in Wonderland*, and proclaimed that "Everybody has won and all must have prizes." This "Dodo bird" conclusion was later supported by meta-analytic studies (e.g., M. L. Smith, Glass, & Miller, 1980) and has become something of a truism of the field (Stiles, Shapiro, & Elliott, 1986): All psychotherapies produce largely similar outcomes.

When Norcross (1995) and Beutler (1995) were invited to participate in a journal section on "myths of psychotherapy," both cited the above conclusion as one of their pet peeves. Norcross points out that—of the 400 plus different therapies supposedly in existence—only "7 or 8" therapeutic approaches have been studied extensively (p. 500). Therefore, from his perspective, it is a mistake to assume that all psychotherapies are equivalent when most psychotherapies have not yet been systematically researched. Both also object to the "uniformity myths" (Kiesler, 1966) implicit in the conclusion that all psychotherapies are equivalent. The first assumes that all therapists of the same ori-

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entation are equivalent in effectiveness, and the second assumes that there are no important client differences which might lead to differential outcome. Norcross suggests that the latter assumption "defies clinical reality," since experienced therapists do not believe that "all things work equally well for all patients" (p. 502), and Beutler cites empirical work in support of this view. Thus, the question for Norcross and Beutler is not the general one of whether psychotherapy works, but the specific one of how different therapies and therapists match with different client problems and characteristics.

It is important not to lose sight of one point which can bring some clarity to the above-mentioned dispute. The disagreement here is really a restatement of the contrast between "common" and "specific" factors in psychotherapy, and the question really isn't whether one or the other exists. Even those who have been most influential in espousing a common factors view (Frank & Frank, 1991; Garfield, 1980) acknowledge the existence of specific factors. The issue, therefore, involves relative emphasis and whether the individual theorist sees psychotherapy research and practice advancing most surely through a focus on similarities or differences.

This theme is echoed in a second popular interpretation of the outcome literature, offered by Bergin and Garfield (1994b). They identify a general trend in the field, not unrelated to the "equal outcomes phenomenon," toward eclecticism in theory and practice. If the major therapeutic schools do not produce substantial differences in outcome, then perhaps it makes most sense to rethink one's commitment to a single viewpoint and consider some other theoretical or empirical strategy which fits better with the available data and might in time improve outcome.

Norcross and Newman (1992) document this development, indicating that many therapists now prefer the term "integrationism" over "eclecticism," since the latter still has a negative (unsystematic) connotation for many practitioners. They see three popular approaches to integration, two of which reiterate the contrast between specific and common factors. Beutler and Clarkin (1990) and Lazarus (1992) are exponents of *technical eclecticism,* which eschews traditional theory and focuses on matching specific intervention to specific problem / client. The *common factors approach* has previously been illustrated through the work of Jerome Frank and seeks to identify the core ingredients of successful therapy. *Theoretical integrationism* is a more ambitious attempt to combine two or more therapeutic approaches, with the expectation that the best aspects of each might contribute to a more

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powerful, comprehensive approach. Wachtel and McKinney (1992), with their interest in bringing together psychodynamic, family systems, and behavioral theories, represent an example of this integrationist tactic.

Implications of Outcome Data for the Validity of Theories

What do these data on outcome tell us about the validity of the theories which lie behind the different therapeutic methods that have been studied? Protter (1988) comments on the position within psychoanalysis which confuses a "theory of the mind" with a "practice of treatment" and which assumes, therefore, that "the theory can be proven true by the therapy curing" (p. 499). He and others (Grünbaum, 1984; Holzman, 1985) argue that this conclusion is unwarranted, and the same can be said of any like conclusions which might be drawn from the general outcome data on psychotherapy. Research on outcome is not designed to answer the question of "why" or "how" a given psychotherapy works, only that it does so compared to no treatment. As Frank illustrated with his common factors theory, change in the client could be due to countless influences, many of which might have very little to do with what the theory of therapy predicts.

Interest in discovering the actual variables that produce change in psychotherapy is pursued not through outcome research but through "process research," which "is even more complicated than the research on outcome" (Garfield & Bergin, 1994, p. 10). A brief account of research on the behavioral technique of systematic desensitization will both emphasize this point and illustrate what is known about the validity of theoretical rationales.

Wolpe (1958) developed the theoretical rationale for systematic desensitization, which he called "reciprocal inhibition," by applying animal research to the human level. Conditioned avoidance could be established in cats by pairing electrical shock and some neutral stimulus—for example, the cage where the cats normally would feed. This reaction could be deconditioned by feeding the cat at some distance from the cage and then gradually bringing the food nearer to the cage, but never increasing the proximity faster than the fear reaction was dissipating. Wolpe reasoned that the positive response of eating inhibited the negative response of fear because the two were physiologically incompatible: It is impossible to be afraid and relaxed simultaneously.

He then devised the method of systematic desensitization, which combines training in relaxation with exposure in imagination to a hierarchy of fear situations, for humans suffering from conditioned fear

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reactions (phobias). Clients are not taken to the next step in the fear hierarchy until they can become relaxed in the presence of the present hierarchy item. As they move through the imagined situations, they are also encouraged to begin confronting a comparable level of their fears in real-life situations. Improvement in clients' fear and avoidance is then seen as confirming Wolpe's theory: The deep muscle relaxation acts as an inhibitor of autonomic arousal and thereby suppresses the fear response, allowing clients to approach the phobic situations.

"Until recently, systematic desensitization . . . has been the best known behavioural therapeutic procedure" (Emmelkamp, Bouman, & Scholing, 1995, p. 69), and it has been extensively studied through outcome and process research. However, this research has often produced surprising findings, and Leitenberg (1976) suggests that "almost every aspect of the systematic desensitization procedure has at some time been experimentally demonstrated to be unessential" (p. 131). For example, it has been found that neither a hierarchy nor relaxation training are critical to obtain positive results. Over time, Wolpe's theoretical rationale was rejected, and it was concluded that this procedure in all likelihood is effective "because it indirectly encourages patients to expose themselves to actual feared objects" (p. 133). In fact, "exposure" is the principle on which most behavioral treatments for fear and panic rest today (Barlow, 1988).

This research underscores the fallacy of equating the success of a treatment with the validity of its theoretical rationale. Moreover, congruent with Frank's viewpoint, an invalid theoretical rationale can still be instrumental in producing positive outcome. Leitenberg (1976) observes that "patients believe the rationale of systematic desensitization" (p. 132), and this belief, combined with success in reducing anxiety in session, makes it more likely that they will try confronting their fears in real life. Frank and Frank (1991) suggest that this kind of therapy is not without its persuasive elements as well, since "its ritual persuades patients to remain in actual or imagined contact with the phobic situation long enough for the fear to subside" (pp. 55–56).

Finally, it should not be concluded that the new principle of "exposure" itself answers all questions about a theoretical rationale. In fact, it is not really an explanation or a "theory of therapeutic action" but merely "an observation of a common procedure in many treatments" (Barlow, 1988, p. 286). While Sweet, Giles, and Young (1987) contend that cognitive and behavioral methods are the treatment of choice for anxiety disorders, they confess that they appear to "provide their efficacy through as yet mysterious channels, which are the subject of much controversy and debate" (p. 55).

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If it is this laborious to establish the crucial aspects of theory behind a simple behavioral technique, imagine the difficulty in establishing the validity of the theoretical rationales behind more complex therapeutic procedures such as those based on object relations theory, self psychology, or even cognitive therapy. Silberschatz (Persons & Silberschatz, 1998) observes that "little is known about basic mechanisms of change in psychotherapy," and that existing outcome research often ignores this question by incorporating the *presumed* crucial ingredients of change—the therapeutic technique and the implicit or explicit theory which grounds it—into the treatment manual (p. 128). It is for this reason that Bergin and Garfield (1994b, pp. 821–822) are seeing a turn away from work on the "macro" level (What is the nature of personality or therapy?) to research work guided by "minitheories" (What aspects of the therapeutic alliance are crucial to positive outcome? Do cognitive methods add to the effect of relaxation in reducing panic?).

Implications of the Empirical Literature for Clinical Practice

In sum, Bergin and Garfield (1994b) characterize current trends in the field by emphasizing an advance toward "empiricism," "eclecticism," and "minitheories" accompanied by "a steady decline in strict adherence to traditionally dominant theories of personality and therapeutic change, such as the behavioral, psychoanalytic, humanistic, and other major approaches" (p. 821). Omer and London (1988), whose review declares an "end of the systems' era" in psychotherapy, agree with this general conclusion.

Have Clinical Practitioners Become More Empirically Oriented?

While it is obvious that these observations are quite descriptive of many developments in the theoretical and empirical literature on psychotherapy, are they equally applicable to clinical practice? Bergin and Garfield (1994b) believe that they are, and assert that "psychotherapy research has had a profound effect on how the major traditional orientations to therapy are being construed" (p. 824). They note that behavior therapists have become more cognitive and cognitive therapists have become more behavioral and that research is one of the factors influencing this change. They also see the influence of research on the decreasing impact of the nondirective experiential (client-centered) approach and on the increasing definition of psychodynamic approaches as "more eclectic, abbreviated, and specifically targeted" (p. 824). Finally, they perceive a fundamental change in the psychodynamic assumption that interpretation, especially transference interpretation, is

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the key to therapeutic change, and they believe that this revision "has been brought about largely by careful therapy research" (p. 824).

A variety of social, economic, political, and cultural factors have shaped theory and practice in American psychotherapy over this century (Cushman, 1992; VandenBos, Cummings, & DeLeon, 1992) and it seems naive to weight one factor, research, so heavily in producing the changes which Bergin and Garfield catalog. Further, in some instances they overgeneralize the impact of circumscribed empirical developments, and their comment about a general shift in the centrality of psychodynamic interpretation is a good case in point. Although they later specify that their statement about psychodynamic therapy refers only to certain—not all—manual-driven brief psychodynamic therapies, the question then arises if it makes sense to claim an empirical "trend" when the referent is so restricted. Interestingly, a transformation of the meaning and use of interpretation within the larger field of psychoanalysis and psychodynamic therapy appears to be well underway today, but it reflects metatheoretical influences, not specifically empirical ones (Mitchell, 1993).

Other observations which could be made about the field also fit less well with the hypothesis that empiricism is greatly influencing practice. Garfield and Bergin (1994) themselves acknowledge "the surprising increase in the number of different forms or orientations in psychotherapy" (p. 6), a development which goes counter to the trend toward both empiricism and eclecticism. By definition, when new therapies come on the scene, they are untested and typically assert some unique viewpoint. Gold (1993), reflecting on how developments in psychotherapy have historically emerged, suggests that new therapies have often incorporated "ideas and methods from the social and natural sciences, from medicine, philosophy, theology, and literature" (p. 6). Relative newcomers to the therapy arena such as the narrative (Parry & Doan, 1994), constructivist (R. A. Neimeyer & Mahoney, 1995), and intersubjective (Orange, 1995) perspectives have all been influenced by philosophical views imported from the larger culture, and some of these philosophical positions are inclined to question the very foundation on which much of the current research in psychotherapy is based.

Norcross (1995) was quoted earlier as asserting that "only 7 or 8" of hundreds of therapeutic approaches have been studied extensively, and he adds: "Neurolinguistic, Jungian, existential, and Ericksonian therapies, for example, have never been subjected to rigorous testing, to my knowledge" (p. 500). Surely, practitioners of these approaches, like those of scores of other therapies, are continuing to practice their

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therapeutic approaches in the absence of confirming outcome data. If Bergin and Garfield are correct in assuming that client-centered therapists have decreased in numbers in some direct relationship to the "poor effect sizes" generated by their approach in meta-analytic studies, then they would no doubt be the first school of therapy to disband based on disappointing empirical results!

In addition, the argument that empirical work is having a direct and significant impact on clinical practice contradicts the existence of a considerable gap between the data which researchers produce and the information which practitioners value and utilize (Morrow-Bradley & Elliott, 1986; Cohen, Sargent, & Sechrest, 1986; Talley, Strupp, & Butler, 1994; Goldfried & Wolfe, 1996). The first study cited above consisted of a mail survey of psychologists belonging to the Division of Psychotherapy of APA. About half of the respondents ranked direct experience with clients as their primary source of information for conducting psychotherapy, and another 32% identified a variety of other nonresearch activities (theoretical / practical books, the experience of being a client, supervision-consultation, and practical workshops / conferences) as their primary source. Only 4% of the sample ranked empirical books / articles as their primary source, with another 6% ranking psychotherapy research presentations as most important. When respondents were asked what information they utilized when faced with difficult cases, only 24% reported that they turned to psychotherapy research.

Cohen et al. (1986) were interested in obtaining more extensive information about psychologists' attitudes toward research than a mail survey might provide, and they conducted an interview study. Although their sample of child psychologists was small (N=30), the psychologists' rankings of information sources were similar to the results previously described and to those obtained by Cohen in a prior national mail survey of psychologists. Research articles and books were ranked lowest among potential information sources for conducting therapy, discussions with colleagues were ranked highest, and workshops on clinical practice, theoretical books / articles on clinical practice, and "how-to" books / articles on clinical practice were intermediate. Interviews indicated that written material would not be enough to encourage therapists to adopt a "positively evaluated treatment": Specific training, including some direct interpersonal contact (workshop, supervision), would be required. Further,

> the psychologists stated that it would be difficult for them to provide a treatment modality that was not consistent with their

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> clinical style and personality, even a modality that had been shown by research to be effective. Variables related to clinical style and personality seem to us to have been underemphasized in the dialogue on psychotherapy research use. . . . Given the personal meaning attached to being psychodynamic or behavioral, it is unlikely that a positively evaluated psychotherapy will be readily adapted if it is inconsistent with a clinician's theoretical (and often personal) identity. (p. 204)

Beutler, Williams, Wakefield, and Entwistle (1995) found clinicians to be more interested in research than is often thought, and unquestionably more interested in research than researchers are interested in clinical writings. But clinicians are "discriminating readers" of research who "generally read research from the vantage point of his or her own, usually very personal, clinical experience, embracing research findings that support what he or she already holds true and disregarding findings that do not" (p. 991).

The above studies were conducted with psychologists, who represent the mental health specialty which historically has most identified its training with empirical research. It is likely that the gap between research and practice would be even larger if therapists trained in other programs—for example, social workers, counselors, nurses, and psychiatrists—were studied.

Have Clinical Practitioners Embraced Eclecticism, Ending the "Systems' Era"?

The observation that eclecticism is now the dominant orientation of therapists, resulting in the end of the era of theoretical systems, is also a complex issue, and the relevant data can be interpreted differently, depending on one's emphasis and purpose. Jensen, Bergin, and Greaves (1990) summarize 25 studies conducted between 1953 and 1990 on the theoretical orientations of clinicians, and the percentage of those endorsing an eclectic orientation varied widely: findings ranged from 19% to 68%, with the latter figure obtained by the authors. Variations in the data have been summarized by estimating that between one-third and one-half of American psychotherapists endorse an eclectic orientation (Arnkoff & Glass, 1992).

Milan, Montgomery, and Rogers (1994) studied psychologists listed in the National Register of Health Service Providers in Psychology to determine if some of the predicted shifts in theoretical orientation had occurred during the 1980s. Samples were taken from the 1981, 1985,

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and 1989 editions of the Register, during which time registrants could identify up to three orientations, in order of preference, from a list of eleven. The percentage of psychologists selecting eclecticism as their primary orientation actually declined slightly from 1981 (43.3%) to 1989 (39.1 %). There was a significant increase in those identifying with a rational emotive-cognitive orientation (2.9%–1981; 6.8%–1989), a significant decrease in those endorsing an existential-humanistic orientation (9.0%–1981; 6.4%–1989) and little change in those endorsing behavioral (7.4%–1981; 8.9%–1989), psychoanalytic (14.6%–1981; 14.2%–1989), and interpersonal (10.3%–1981; 11.9%–1989) orientations. The authors note that approximately 90% of the respondents during the sampled years identified secondary or secondary and tertiary orientations, and these data certainly indicate a strong willingness to entertain alternative frameworks.

Norcross, Prochaska, and Farber (1993) report a 1991 random survey of psychologists in the Division of Psychotherapy allowing a comparison with data previously collected on this division in 1981 (Prochaska & Norcross, 1983). Like the study summarized above, they did not find an increase in those endorsing an eclectic/integrative orientation over the 10 year period (30%–1981; 29%–1991). Surprisingly, they found that the psychodynamic / neo-Freudian (18%–1981; 21%–1991) and psychoanalytic (9%–1981; 12%–1991) orientations each rose somewhat in popularity over the decade. In summary, they found about one-third of the respondents endorsing an eclectic-integrative orientation, about a third identifying with some variation of a psychodynamic orientation, and the remaining third distributed across behavioral, cognitive, systems, and various humanistic orientations.

Therefore, from these data, one could emphasize that one-third to one-half of clinical practitioners are primarily eclectic in orientation or one could stress that one-half to two-thirds of clinical practitioners still strongly identify with a particular therapeutic framework. More importantly, this disagreement in emphasis may obscure one similarity between the two groups: Eclectic therapists are not necessarily any more empirically grounded than their colleagues who endorse a single orientation. While psychotherapy researchers may see an eclectic orientation as the modal, informed response to what is known about psychotherapy outcome, the adoption of that orientation is not itself based on empirical factors. Although it stands to reason that flexibility in theory and technique would produce a better outcome—given that clients and problems may be differentially responsive—outcome data of this kind are not yet available. Thus, Lambert (1992) concludes that,

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"despite the openness of eclectic theorists to knowledge derived from clinical practice and basic research, the eclectic approach has not yet produced a distinguishable body of research that supports its claims of superior efficacy" (p. 119).

Something *is* known of the most popular combinations of orientations chosen by eclectic therapists and how these have shifted over time. A study of psychologists done by Garfield and Kurtz (1977), and updated by Norcross and Prochaska (1988), found that the "modal combination" of the 1970s was behavioral-psychoanalytic (25%). For the 1980s sample, 32% of the respondents endorsed combining cognitive therapy with some other modality (behavioral, humanistic, or psychoanalytic). Jensen et al. (1990) found that dynamic, and then systems orientations were chosen most frequently by eclectic psychiatrists, social workers, and marriage and family therapists, while eclectic psychologists chose cognitive, and then dynamic orientations. Yet, beyond identification with these broad labels, it is not known how eclectic therapists came to choose these particular combinations of orientations or what specific techniques are selected from them: It is not known what eclectic therapists actually *do* in practice. Garfield and Bergin (1994) admit that "the use of the term *eclectic* does not have any precise operational meaning beyond the general definition of selecting from diverse sources what is considered best for the individual case" (p. 7).

Returning to the question of a general movement of the field to an eclectic orientation, evidence definitely supports the conclusion that many clinicians have moved away from "strict adherence" to a single theoretical / therapeutic framework. Nonetheless, many therapists also continue to identify with unitary frameworks, and it is not clear that the end of the era of theoretical systems is at hand. Milan et al. (1994) conclude that the behavioral, interpersonal, and psychoanalytic orientations "continue as powerful forces in contemporary clinical psychology," and that the cognitive orientation is now joining this elite group (p. 400). Norcross et al. (1993), when they combine primary and secondary theoretical orientations, report that 70% of their respondents endorse some form of neo-Freudian orientation leading them to conclude that psychoanalysis is experiencing "a revival or a resurgence . . . with an interpersonal twist" (p. 697). Lazarus (1990), in an introduction to a clinical exchange over issues confronting eclectic and integrationist therapists, indicates that "the integrative therapy movement . . . has had little impact in many quarters, and prominent clinicians are still inclined to adhere to a single or unitary perspective" (p. xiv).

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Summary: What Does the Empirical Literature Add to the Clinician's Knowledge?

So, has further clarification of the question "What do therapists know?" resulted from this sometimes tedious excursion into the empirical literature on psychotherapy? Obviously, I agree with psychotherapy researchers that practicing psychotherapists should be familiar with this literature—or else it would not have been included in this review. However, I also understand why many clinicians contend that existing research has provided less new and usable information than researchers might assume, and I will support that statement in relation to five components of the clinician-literature interaction:

First, it is enormously difficult to conduct research in the area of psychotherapy, and the work of researchers to establish the efficacy of psychotherapy represents a monumental achievement. Yet, since it is something of an occupational necessity, clinicians—aside from moments of doubt—have always assumed that "psychotherapy works."

Second, evidence which supports the conclusion that different psychotherapies—when applied to a heterogeneous outpatient population—are generally equivalent regarding outcome may be surprising to clinicians, just as it has been to researchers. However, it is unclear what implications should be drawn from these data by the practicing clinician. Should therapists who are wedded to a given theoretical framework see it as reassuring that their approach has produced positive outcome, or should they be distressed that other approaches also received confirmation? What does the existence of "common factors" imply for the work of clinicians who practice within a single orientation? Based on their meta-analytic study of psychotherapy outcome, M. L. Smith, Glass, and Miller (1980) propose that "one of the paradoxes of psychotherapy . . . may be that although all therapies are equally effective, one must choose only one to learn and practice" (p. 185). It is likely that the great majority of practicing psychotherapists and clinical trainees, as well as many other psychotherapy researchers, would find this conclusion to be both baffling and unsatisfactory. Indeed, the therapists surveyed by Morrow-Bradley and Elliott (1986) were most critical of "research that treats all therapists or all responses by therapists as interchangeable" thereby obscuring crucial differences (p. 193, table 5).

Third, the difficulty clinicians experience in utilizing research findings about common factors reflects a larger issue which was previously reviewed. Based on their own experience with clients, their theoretical commitments, and their personal identity and style (Morrow-Bradley & Elliott, 1986; Cohen et al., 1986; Beutler et al., 1995), clinicians will

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