ONE

An Overview of and Rationale for a Generalist-Eclectic Approach to Direct Social Work Practice

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The focus of this book is on theories for direct (or clinical, micro) social work practice. More specifically, the book focuses on theories for practice with individuals, although the relevance of these theories for practice with families and groups is also considered. Beyond simply offering a survey of clinical theories in this book, we promote what we call a *generalist-eclectic approach* for the use of theory in direct practice.

Including the word *generalist* in the name of our approach might seem odd because one of the generally accepted hallmarks of generalist social work practice is that it spans direct and indirect (or macro) practice methods, whereas our approach focuses only on direct practice. By using the word *generalist* to describe our approach to direct practice, we want to emphasize our belief that specialization in direct practice must be firmly grounded in the generalist perspective of social work practice. Simply put, we believe that the values, principles, generic processes, and holistic perspective that are integral to generalist social work practice are a necessary foundation for direct practice specialization. Although this might be taken for granted by some, we think this sometimes gets lost in the rush for specialization.

One reason it is important to ensure that direct practice is grounded explicitly within the generalist perspective is because most theories that clinical social workers use have been developed outside of the profession, and aspects of such theories may not fit well with some social work principles. When this is the case, we think that modifications to these aspects of theories are necessary. For example, theories that place the worker in the role of expert should be used in a more egalitarian, collaborative manner, and theories that have a specific and narrow conception of human problems should be broadened to include consideration of a wide range of factors (e.g., environmental and sociocultural factors need to be considered along with biological, intrapsychic, and interpersonal factors).

A second reason for embedding direct practice within the generalist perspective is that the latter can function to broaden the mandate and role of direct practitioners beyond narrow clinical confines. For instance, we think it is important that the

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focus of clinical social work should include helping clients to meet basic needs by providing them with or linking them to resources and services, and engaging in social advocacy for clients—and the generalist perspective reminds us of the importance of such helping strategies.

This chapter provides an overview of our generalist-eclectic approach to direct practice. First, we review the major elements of the generalist social work perspective that are central to our generalist-eclectic approach to direct practice. Then, we provide an overview of the distinctive aspects of our generalist-eclectic approach. Finally, we discuss in some detail the issue of eclecticism, primarily with regard to the trend toward eclecticism over the last 35 years in the broad field of counseling/psychotherapy. The latter discussion includes (a) an overview of eclecticism that documents historical resistance to eclecticism, the fact of and reasons for the trend toward the eclectic use of theory and technique, and continuing resistance to eclecticism (particularly in the form of the empirically supported treatment movement); (b) a review of the four major approaches to eclecticism in the literature and some of the specific eclectic models within each of the approaches; and (c) a delineation of our approach to eclecticism.

ELEMENTS OF THE GENERALIST PERSPECTIVE THAT ARE CENTRAL TO OUR GENERALIST-ECLECTIC APPROACH

There are many characteristics that are common to the various descriptions of the generalist perspective in the literature. The major elements of generalist social work practice that we have adopted for our generalist-eclectic approach to direct social work practice have been drawn from a range of literature (Derezotes, 2000; Hepworth, Rooney, Rooney, & Strom-Gottfried, 2013; Johnson & Yanca, 2007; Kirst-Ashman & Hull, 2009; Landon, 1995, 1999; Locke, Garrison, & Winship, 1998; Miley, O'Melia, & DuBois, 2013; Shatz, Jenkins, & Sheafor, 1990; Sheafor & Horejsi, 2006; Sheafor & Landon, 1987; Timberlake, Farber, Zajicek, & Sabatino, 2008; Tolson, Reid, & Garvin, 2003; Walsh, 2009). These elements are summarized in Table 1.1 and discussed subsequently.

A Person-in-Environment Perspective Informed by Ecological Systems Theory

"The central focus of social work traditionally seems to have been on people in their life situation complex—a simultaneous dual focus on individuals and environment" (Gordon, cited in Compton, Galaway, & Cournoyer, 2005, p. 6). A generalist approach embraces this traditional person-in-environment perspective of social

TABLE 1.1 Elements of the Generalist Perspective That Are Central to Our Generalist-Eclectic Approach
■ A person-in-environment perspective that is informed by ecological systems theory
■ An emphasis on the development of a good helping relationship that fosters empowerment
■ The flexible use of a problem-solving process to provide structure and guidelines for work with clients
■ A holistic, multilevel assessment that includes a focus on issues of diversity and oppression and on strengths
■ The flexible and eclectic use of a wide range of theories and techniques that are selected on the basis of their relevance to each unique client situation.

work practice. This perspective emphasizes the need to view the interdependence and mutual influence of people and their social and physical environments. Also, it recognizes the link between private troubles (i.e., individual problems) and public issues (i.e., social problems; Mills, 1959). The person-in-environment perspective has been one of the primary factors that has distinguished direct social work practice from the practice of other helping/counseling professions (i.e., psychology, marriage and family therapy, psychiatry).

Ecological systems theory (see Chapter 4) is a conceptual framework for the person-in-environment perspective that "has been almost universally accepted in social work over the past three decades" (Mattaini & Lowery, 2007, p. 39). This theory "recognizes an interrelatedness of human problems, life situations, and social conditions" (Shatz et al., 1990, p. 223). As explained in Chapter 2, it is a high-level or meta-theory that is particularly useful for helping workers to see the big picture in terms of the reciprocal influence of people and the various systems (e.g., family, work, community) with which they interact. As such, it provides an "organizational tool for synthesizing the many perspectives that social workers apply in practice" (Miley et al., 2013, p. 27).

The Development of a Good Helping Relationship That Fosters Empowerment

Historically, social work has led the helping professions to advocate the importance of a collaborative, warm, empathic, supportive worker–client relationship. Social workers have described this type of relationship as the "soul" (Biestek, 1957), "heart" (Perlman, 1979), and "major determinant" (Hollis, 1970) of the helping endeavor. Although clinical social work has drifted away from such an emphasis over the last few decades in favor of attention to the theoretical/technical/scientific aspects of practice (Coady, 1993a; Perlman, 1979), the generalist perspective has reemphasized the importance of the helping relationship.

Along with a reaffirmation of the importance of a good helping relationship, the generalist perspective has promoted a focus on empowerment. A number of authors of generalist textbooks (e.g., Landon, 1999; Locke et al., 1998; Miley et al., 2013; Timberlake et al., 2008) have combined a consideration of empowerment and the strengths perspective (Saleebey, 2013). For example, Miley and colleagues (2013) argued that "an orientation toward strengths and empowerment compels social workers to redefine their relationships to embrace the notion of collaboration and partnership" (p. 85). Gutiérrez (cited in Miley et al., 2013) noted that this involves basing the helping relationship on "collaboration, trust, and shared power; accepting the client's definition of the problem; identifying and building upon the client's strengths; actively involving the client in the change process; [and] experiencing a sense of personal power within the helping relationship" (p. 133).

The Flexible Use of a Problem-Solving Model

Since Perlman's (1957) formulation of the problem-solving model for social casework, problem solving has been an integral part of social work practice. Most generalist approaches to social work practice include some version of the problem-solving model, and although there are various conceptualizations of the stages or phases of problem solving, all versions include guidelines for the entire helping process, from initial engagement to termination.

Some generalist approaches, in an effort to emphasize a strengths focus versus a problem focus, have renamed the problem-solving model. For example, Locke and colleagues (1998) called their version of the problem-solving model a "phase model," and Miley and colleagues (2013) called their version "phases and processes of empowering practice" (p. 103). We agree, however, with McMillen, Morris, and Sherraden (2004) who contended that the "grudge match" within social work that pits strengths-based against problem-focused approaches represents a false and destructive dichotomy. Thus, our use of the term *problem-solving model* does not denote a deficit or pathology orientation to practice. As is generally the case within social work, we construe problem solving as a collaborative process between workers and clients that has the ultimate goal of capacity building and empowering clients (see Chapter 3 for a more detailed discussion of problem solving).

A Holistic, Multilevel Assessment

The person-in-environment perspective and ecological systems theory suggest the necessity of a holistic, multilevel assessment. The term *holistic* refers to a "totality in perspective, with sensitivity to all the parts or levels that constitute the whole and to their interdependence and relatedness" (McMahon, 1996, p. 2). This represents a focus on the whole person (i.e., the physical, emotional, spiritual) in the context of his or her surroundings. Multi-level assessment goes hand-in-hand with a holistic focus because this means considering the entire range of factors, from micro to macro, that could be impacting a client. Thus, in conducting an assessment, the generalist-oriented direct practitioner should consider the potential influence of biophysical, intrapsychic, interpersonal/familial, environmental, and sociocultural factors. With regard to the latter class of factors, a generalist approach to direct practice assessment includes particular sensitivity to issues of diversity (e.g., gender, race, culture, class, sexual orientation, disability, age, religion) and oppression (Shatz et al., 1990). A generalist approach also demands that the assessment process includes a focus on clients' strengths, resources, and competencies.

The Flexible and Eclectic Use of a Wide Range of Theories and Techniques

The commitment to a holistic, multi-level assessment precludes a rigid adherence to narrow theories of human problems. A generalist approach should be "unencumbered by any particular practice approach into which the client(s) might be expected to fit" (Sheafor & Landon, 1987, p. 666). Theories can be useful in the assessment process if they are tentatively considered as potential explanations for clients' problems; however, theories represent preconceived ideas about human problems and can blind one to alternative explanations.

Just as the assessment process must avoid rigid adherence to narrow theoretical perspectives, the same is true for the intervention process: "the generalist perspective requires that the social worker be *eclectic* (i.e., draw ideas and techniques from many sources)" (Sheafor & Horejsi, 2006, p. 87). Generalists are open to using theories and techniques that seem most relevant to the understanding of the unique client situation: "Single model practitioners do a disservice to themselves and their clients by attempting to fit all clients and problems into

their chosen model" (Hepworth, Rooney, & Larsen, 2002, p. 17). Guidelines for selecting theories and techniques for particular types of clients and problems are reviewed later in this chapter in the discussion of approaches to eclecticism, as well as in Chapter 3.

DISTINCTIVE ASPECTS OF OUR GENERALIST-ECLECTIC APPROACH

A Differentiated Understanding and Demystification of Theory

One distinctive aspect to our approach of using theory in practice is differentiating between types and levels of theory, and classifying clinical theories in like groupings. Our approach to understanding theory differentiates between (a) high-level, metatheories (ecological systems and human development theories, the strengths perspective; see Part II, Chapters 4–6); (b) mid-level practice theories (see Part III, Chapters 7–20); and low-level models for specific populations and problems. Metatheories provide general guidance for holistic assessment and the generation of ideas for intervention, mid-level practice theories provide more specific ideas and directions for assessment and intervention for a range of presenting concerns, and low-level models provide more specific guidelines for work with specific populations and problems.

Furthermore, in an effort to demystify the vast array of practice theories that exist, we classify these theories in like groupings (psychodynamic [Chapters 7–9], cognitive behavioral [Chapters 10–12], humanistic [Chapters 13–15], critical [Chapters 16–17], and postmodern [Chapters 18–20]) and provide a brief overview of the distinguishing characteristics of each of these larger classifications of theory (see Chapter 2).

A Critical Perspective on the Use of Theory and Valuing the Artistic Elements in Practice

Perhaps the most distinctive feature of our generalist-eclectic approach is that it includes a critical perspective on the *scientific* view of practice, which contends that use of theory and technique reflects the essence and is the cornerstone of effective direct social work practice. We certainly do not deny the value of this scientific approach to practice (after all, this book focuses on the use of theory in practice), although we clearly favor an eclectic use of theory and technique over adherence to a single theory and its techniques. Still, a key element of our framework is the recognition and valuing of the *artistic* elements of practice (Coady, 1995; Goldstein, 1990; Kinsella, 2010; McCoyd & Kerson, 2013; Schön, 1983).

An artistic approach to practice, often referred to as reflective practice (Schön, 1983), includes the use of relationship-building skills, intuition, gut instincts, empathic listening, and inductive reasoning to collaboratively build with the client a theory that fits his or her unique situation and to problem solve creatively. We believe that practice is at least as much art as science, and is based at least as much on reflection-in-action (Schön, 1983), intuition, inductive reasoning, theory building, and general interpersonal/relationship skill as on the deductive application of theoretical knowledge and technical skill. Theory and research that pertain to this issue are reviewed both later in this chapter and in the second part of Chapter 2,

where the artistic, reflective, intuitive-inductive approach to practice is discussed. Our stance is that the best social work practice integrates scientific (i.e., theoretical/technical) and artistic (i.e., reflective, intuitive-inductive) elements.

Use of the Problem-Solving Model to Integrate the Art and Science of Practice

One of the main difficulties with both theoretically eclectic and artistic, reflective, intuitive-inductive approaches to practice is a lack of structure and guidelines for practice. For example, workers who are theoretically eclectic are sometimes overwhelmed by the sheer number of theories from which to choose. Also, practice can lack coherence and direction when one moves back and forth between theories, and sometimes workers can become preoccupied with or distracted by multiple theoretical considerations. When this happens, the worker's understanding of and relationship with the client can suffer.

On the other hand, workers who prefer a more artistic, humanistic approach to practice that is based on reflection, intuition, and inductive reasoning sometimes feel as if they are "flying by the seat of their pants." Their practice can similarly lack coherence and direction. This is a major reason why some practitioners prefer to adhere to a single theoretical orientation in their practice—a single theory approach provides clear structure and guidelines. The cost of adherence to a single theory is too large; however, there is no one theory that is comprehensive enough to fit for all clients, and clients should not be forced into theoretical boxes.

We believe that the problem-solving model offers a solution to the lack of structure and guidelines for practice that are commonly experienced by workers who prefer theoretically eclectic and/or reflective, intuitive-inductive approaches to practice. The general strategies for the various phases of helping (from engagement to termination) that constitute the problem-solving model provide useful and flexible structure and guidelines for both the scientific and artistic approaches to practice and enable workers to integrate these two approaches in their work. The generality and flexibility of the guidelines in each phase of the problem-solving process provide sufficient structure and direction for practice while also allowing workers to integrate theory and use reflection, intuition, and inductive reasoning. This issue is discussed briefly later in this chapter, and in more depth in Chapter 3.

AN OVERVIEW OF ECLECTICISM

As is evident from the earlier discussion, eclecticism is an inherent orientation in generalist practice and is endorsed by most authors of generalist (e.g., Locke et al., 1998; Sheafor & Horejsi, 2006; Tolson et al., 2003) and direct practice (Derezotes, 2000; Hepworth et al., 2002) social work textbooks. For example, Hepworth and colleagues (2002) argued that "because human beings present a broad array of problems of living, no single approach or practice model is sufficiently comprehensive to adequately address them all" (p. 17). Also, "surveys of practitioners repeatedly indicated that one half to two-thirds of providers prefer using a variety of techniques that have arisen from major theoretical schools" (Lambert, 2013a, p. 8). One survey (Jensen, Bergin, & Greaves, 1990) of a wide variety of mental health professionals revealed that the majority (68%) of social workers consider themselves eclectic, although this was the second lowest percentage among the four professional groups

surveyed (corresponding figures for marriage and family therapists, psychologists, and psychiatrists were 72%, 70%, and 59%, respectively). Despite clear and logical arguments for eclecticism and its prevalence in practice, it is still a contentious issue in the helping professions—and we think this is particularly so in clinical social work (see discussion in the Historical Resistance to Eclecticism section later in this chapter).

We would like to alert readers to the fact that our consideration of eclecticism in much of the rest of this chapter relies heavily on literature in clinical psychology because this is where most of the theory and research on eclecticism has been generated. Because of the reliance on literature from outside our profession, terms other than what we would normally use appear frequently (e.g., *therapist* instead of *worker*, *patient* instead of *client*, *therapy* instead of *direct practice* or *counseling*). We emphasize that we do not endorse the use of such terms and that our approach to eclecticism in direct practice is firmly rooted in social work values. Furthermore, we would like to point out that although most of the research on psychotherapy that we review has been conducted by psychologists and published in the psychology literature, this research has included direct social work practice. As Lambert (2013a) has pointed out, "in the United States, as much as 60% of the psychotherapy that is conducted is now provided by social workers" (p. 10).

Historical Resistance to Eclecticism

A historical perspective is necessary to understand the contentiousness of eclecticism. For most of this century, the helping professions have been marked by rigid adherence to narrow theories. Up until the 1960s, psychodynamic theory remained relatively unchallenged as the dominant theory in the helping professions (Lambert, Bergin, & Garfield, 2004). As humanistic and behavioral theories gained increasing prominence in the 1960s, they began to challenge the dominance of psychodynamic theory, and this initiated the era of the "competing schools of psychotherapy." For the most part, the next 25 years were marked by rigid adherence to one or another of an increasing number of theoretical camps, rancorous debate about which theory was right, and extensive research focused on proving which therapeutic approach was the most effective. Although there were some efforts to bridge the differences among the numerous competing schools of therapy, eclecticism was clearly a dirty word. As Norcross (1997) has commented:

> You have all heard the classic refrains: eclectics are undisciplined subjectivists, jacks of all trades and masters of none, products of educational incompetency, muddle-headed, indiscriminate nihilists, fadmeisters, and people straddling the fence with both feet planted firmly in the air. (p. 87)

Unfortunately, such negative views of eclecticism are still prevalent within the field of counseling, particularly within clinical social work. Despite the endorsement of eclecticism by the generalist perspective, many social workers do not seem aware of or at least have not embraced the movement toward eclecticism that has been sweeping the larger field of psychotherapy. Also, despite the prevalence of eclecticism in practice, many social workers seem loath to admit this publicly because they know that eclecticism is still a dirty word in some circles. We have encountered many clinical social workers (academics and practitioners) who have

disdain for eclecticism. One of the social work academics whom we approached to write a chapter for the first edition of this book, and who ascribed to a psychodynamic perspective, declined to contribute because of our endorsement of both a generalist perspective and eclecticism. Similarly, another academic who ascribed to a critical perspective declined to contribute a chapter to the current edition of this book for similar reasons. Unfortunately, such traditional negative views of eclecticism are difficult to change and they quickly filter down to students. We have had students tell us that their field instructors counsel them to never admit to an eclectic orientation in a job interview because it would count against them.

It is not surprising that adherence to one theoretical orientation is most prevalent for those who were trained in an older, more traditional theory. The Jensen et al. (1990) survey found that the most common exclusive theoretical orientation was psychodynamic. Furthermore, to bolster our contention about the traditional nature of clinical social work, this survey found that "of individuals endorsing an exclusively psychodynamic approach, 74% were either psychiatrists or social workers" (Jensen et al., 1990, p. 127; 25% of social workers and 36% of psychiatrists identified themselves as exclusively psychodynamic, whereas less than 10% of the other professional groups did so).

It should also be pointed out, however, that this phenomenon of adherence to one theoretical perspective also seems to be common for social workers who embrace more recent therapeutic approaches—for example, in the 1980s, family systems therapy (see Coady, 1993b); in the 1990s and forward, solution-focused therapy (see Stalker, Levene, & Coady, 1999); and from the late 1990s and forward, many critical approaches to social work practice. Thus, we felt that it was important to emphasize our endorsement of eclecticism in the title of the book and to review the fact of and rationale for the trend toward eclecticism.

Documenting the Trend Toward Eclecticism in Counseling/Psychotherapy

Three decades ago, with regard to the broad field of counseling/psychotherapy, Garfield and Bergin (1986) concluded that the era of the competing schools of psychotherapy was over:

> A decisive shift in opinion has quietly occurred; and it has created an irreversible change in professional attitudes about psychotherapy and behavior change. The new view is that the long-term dominance of the major theories is over and that an eclectic position has taken precedence. (p. 7)

The trend toward eclecticism is evidenced in a number of ways. First, the precedence of eclecticism has been demonstrated by surveys. The Jensen et al. (1990) survey found that the majority of practitioners in each of the four groups of helping professionals were eclectic (68% overall). Furthermore, similar surveys have repeatedly indicated that one half to two thirds of practitioners in North America prefer some type of eclecticism (Lambert, 2013a).

Second, an international professional organization, the Society for the Exploration of Psychotherapy Integration (SEPI), which has been in existence for over 30 years, has been influential in furthering the study of eclecticism in psychotherapy. SEPI has published the *Journal of Psychotherapy Integration* since 1991, holds annual conferences, and has a website (www.sepiweb.org). We should clarify

that the term *integration* is often used together with or instead of the term *eclecticism* in the literature. In brief, the difference between these approaches is that integration focuses on joining two or more theoretical approaches to arrive at a new, more comprehensive theory, while eclecticism simply draws on different theories and their techniques (Lambert, 2013a). The difference between eclectic and integrative models is revisited in our discussion of approaches to eclecticism; however, for the most part, we use the term *eclecticism* to encompass both approaches.

Third, there has been a proliferation of literature on eclecticism. The number of journal articles focused on eclecticism continues to increase annually. This is also true for books on this topic. *Psychoanalysis and Behavior Therapy* (Wachtel, 1977), *Systems of Psychotherapy: A Transtheoretical Analysis* (Prochaska, 1979), and *Psychotherapy: An Eclectic Approach* (Garfield, 1980) were three of the first books that presented arguments for eclecticism and/or integration. Some of the more recent editions of such books include Dryden (1992), Stricker and Gold (1993), Garfield (1995), Gold (1996), Beutler and Harwood (2000), Lebow (2002), Norcross and Goldfried (2005), Stricker and Gold (2006), and Prochaska & Norcross (2014).

Reasons for the Trend Toward Eclecticism: Key Conclusions From Cumulative Research

Although various writers have argued for eclecticism (e.g., Thorne, 1950), or have promoted the integration of various theories (e.g., Dollard & Miller, 1950), in the more distant past, it is only in the last 35 years that a definite trend toward eclecticism has emerged in the broad field of counseling/psychotherapy. The trend toward eclecticism has been fueled primarily by two interrelated sets of research findings, which are discussed here.

The Equal Outcomes/Dodo Bird Phenomenon

The era of the competing schools of psychotherapy spawned an immense volume of research which overall has failed to demonstrate the superiority of one type of psychotherapy over another. Two recent, comprehensive reviews of research (Lambert, 2013b; Wampold & Imel, 2015) examined both numerous meta-analyses (a quantitative method that aggregates the findings of numerous studies in order to test hypotheses; e.g., Smith & Glass, 1977; Wampold et al., 1997) and exemplary studies (large, well-designed studies; e.g., the National Institute of Mental Health Treatment of Depression Collaborative Research Program [NIMH TDCRP; Elkin, 1994]) of the comparative outcomes of different therapy models.

These comprehensive reviews of the research have both reinforced what is commonly referred to as the *equal outcomes* or *Dodo bird effect* conclusion. That is, overall, studies have indicated that the various types of therapy (psychodynamic, cognitive behavioral, humanistic, etc.) have roughly equal effectiveness and therefore, in the words of the Dodo bird from *Alice in Wonderland*, "everybody has won, and all must have prizes" (Carroll, cited in Wampold et al., 1997, p. 203).

Although the equal outcomes conclusion is widely accepted, there are those who continue to question its legitimacy. Some critics (e.g., Beutler, 1991) have surmised that in the future, more sophisticated research designs may yield superior outcomes for specific therapy–client problem combinations. Others criticize various aspects of meta-analytic studies that support the equal outcomes conclusions

(Wampold & Imel, 2015). Still, others point out that some studies have found differences in outcome between approaches to treatment. In particular, some researchers contend that cognitive behavioral approaches are more effective than other approaches with specific anxiety disorders (Wampold & Imel, 2015). We believe, however, that these contentions are not supported by empirical evidence to date. Lambert (2013b) has acknowledged tentative evidence that cognitive behavioral approaches may yield superior outcomes for a few specific, difficult problems (e.g., panic, phobias, and compulsions); however, he still accepts the general validity of the equal outcomes conclusion:

> differences in outcome between various forms of therapy are not as pronounced as might have been expected. . . . Behavioral therapy, cognitive therapy, and eclectic mixtures of these methods have shown marginally superior outcomes to traditional verbal therapies in several studies on specific disorders, but this is by no means the general case. (Lambert, 2013b, p. 205)

Wampold and Imel (2015) are even less accepting of the claims that cognitive behavioral approaches may be more effective with some specific problems. Their thorough, meticulous review of the research concluded that the equal outcomes result has held even in studies that have focused on specific treatments for depression and anxiety. These are two problems for which cognitive behavioral treatments were thought to be particularly appropriate and these are among the most common client problems for clinical social workers. Wampold and Imel (2015) concluded: "Claims that specific cognitive-behavioral therapies are more effective than bona fide comparisons are common but overblown and in need of additional testing" (p. 156).

Thus, we agree with Wampold and Imel's (2015) conclusion that "the Dodo bird conjecture has survived many tests and must be considered 'true' until such time as sufficient evidence for its rejection is produced" (p. 156). The acceptance of this conclusion does not lead directly to an argument for eclecticism; however, it does promote acceptance of the validity of alternative approaches. This, along with the recognition that "no single school can provide all theoretical and practical answers for our psychological woes . . . [makes it seem sensible] to cross boundaries, to venture beyond one's borders in search of nuggets that may be deposited among the hills and dales of other camps" (Lazarus, 1996, p. 59).

The Importance of Relationship and Other Common Factors

The cumulative results of psychotherapy research have stimulated interest in what has come to be known as "common factors." The findings of nonsignificant outcome differences among the variety of different therapies (the equal outcomes phenomenon) led many researchers to latch on to the ideas promoted earlier by Rosenzweig (1936) and Frank (1961) that factors specific to the various therapies (i.e., distinctive theory and techniques) had less impact on outcomes than factors that were common across therapies—particularly worker–client relationship factors. Early research on the client-centered core conditions of empathy, warmth, and genuineness, and later research on the related concept of the therapeutic alliance, have established that relationship factors are the most powerful predictors of client outcome and that a good helping relationship is necessary for good outcome regardless of the approach to

therapy (Horvath, Del Re, Fluckiger, & Symonds, 2011; Horvath & Symonds, 1991; Lambert & Barley, 2001; Wampold & Imel, 2015).

Cumulative research suggests that "common factors are probably much more powerful than the contribution of specific techniques. . . . Learning how to engage the client in a collaborative process is more central to positive outcomes than which process (theory of change) is provided" (Lambert, 2013b, p. 202). The two editions of Wampold's (2001; Wampold & Imel, 2015) book, *The Great Psychotherapy Debate*, focused on reviewing research related to the controversial question of whether therapy effectiveness is related more to common factors (e.g., therapeutic relationship) or specific factors (e.g., theory and technique). Wampold and Imel (2015) concluded that the research evidence provides overwhelming support for the importance of common versus specific factors. They found that the effects produced by common factors were much larger than the effects produced by specific factors and that "these effects make it evident that the 'common factors' are important considerations in the outcome of psychotherapy" (Wampold & Imel, 2015, p. 256). Furthermore, they concluded that despite concerted efforts by many researchers to establish the importance of specific factors, "there is no compelling evidence that the specific ingredients of any particular psychotherapy . . . are critical to producing the benefits of psychotherapy" (p. 253).

Although a variety of factors that are common across therapies have been conceptualized and there is empirical support for the importance of a number of such factors (e.g., reassurance, affective experiencing/catharsis, mitigation of isolation, encouragement of facing problems/fears, encouragement of experimenting with new behaviors; Lambert, 2013b), the therapeutic relationship or alliance "is the most frequently mentioned common factor in the psychotherapy literature" (Grencavage & Norcross, 1990) and it has been called the "quintessential integrative variable" (Wolfe & Goldfried, cited in Wampold, 2001, p. 150) in counseling. On the basis of their thorough review of psychotherapy research, Wampold and Imel (2015) conclude that the "relationship, broadly defined, is the bedrock of psychotherapy effectiveness" (p. 50). Again, although the research on common factors does not lead directly to an argument for eclecticism with regard to theory and technique, it does promote openness to crossing therapeutic boundaries. In fact, from within social work, Cameron (2014) has suggested that "eclecticism is equivalent to a common factors approach . . . in that common factors practitioners use strategies and skills that are found in many different practice approaches" (p. 152; see Approaches to Eclecticism section for further discussion of common factors).

Summary

Although there have been longstanding and persuasive arguments for eclecticism, the trend toward eclecticism has been fueled largely by research findings—both the equal outcomes phenomenon and the importance of relationship and other common factors relative to specific (i.e., theory and technique) factors. As Lambert (2013b) has noted, the trend toward eclecticism "appears to reflect a healthy response to empirical evidence" (p. 206). This has led practitioners to "increasingly acknowledge the inadequacies of any one school and the potential value of others" (Norcross, 1997, p. 86). From within social work, having reviewed much of the same psychotherapy research that has been reviewed in

this chapter, Cameron (2014) has concluded that "eclecticism, idiosyncratically shaped by the unique needs of clients as well as the person of the practitioner, is most effective" (p. 152).

Pockets of Resistance to Eclecticism

Acceptance of the research findings that have fuelled the trend toward eclecticism has not been easy for many mental health practitioners. Four decades ago, Frank (as cited in Lambert & Ogles, 2004) anticipated resistance to his hypotheses about equal outcomes across therapies and the importance of common factors when he noted that "little glory derives from showing that the particular method one has mastered with so much effort may be indistinguishable from other models in its effects" (p. 175). Similarly, as Glass suggested in the foreword to Wampold's (2001) book, giving up the idea that one's cherished theory and associated techniques are no more effective than another approach to therapy and that effectiveness is due largely to factors that are common across therapies "carries a threat of narcissistic injury" (p. x).

Even more dramatically, Parloff (cited in Wampold, 2001) contended that, in some practitioners' minds, if the conclusion about the primary importance of common factors is accepted, "then the credibility of psychotherapy as a profession is automatically impugned" (p. 29). With regard to this last point, we would argue that acceptance of these research findings does not impugn the credibility of psychotherapy, but it does change the general conceptualization of psychotherapy from a primarily scientific, theoretical/technique-oriented enterprise to one that is more humanistic, artistic, and reflective. Wampold and Imel (2015) have called for such a shift toward what they call a "contextual model" of therapy, in which common factors are emphasized, to replace the current "medical model." Still, there is "tremendous resistance" (Lambert, Garfield, & Bergin, 2004, p. 809) to accepting these research findings and this reconceptualization of psychotherapy/clinical practice.

The Challenge of the Empirically Supported Treatment (EST) Movement

The research findings on equal outcomes across different types of therapy, the importance of relationship and other common factors to outcomes, and the weak effect of specific techniques on outcomes stand in stark contrast to the rise of the EST movement in psychology that arose in the 1990s. As part of the broader movement toward evidence-based practice (EBP) in psychology (Barlow, 2000) and social work (Gambrill, 1999, 2006; Gibbs & Gambrill, 2002; Howard, McMillen, & Pollio, 2003; Magill, 2006; Rubin & Parrish, 2007; Shdaimah, 2009), the EST movement was spurred by the Division of Clinical Psychology of the American Psychological Association, which created criteria for the empirical support of therapies.

It is clear that the implicit assumption of the EST movement is that specific ingredients (i.e., therapeutic techniques and their underlying theory) are the important curative factors in psychotherapy (Messer, 2001). The EST movement has pushed for using specific treatments with specific disorders and using only treatments that have been "proven" effective in randomized clinical trial research that includes a formal diagnosis of the client's problem, a specific treatment that is delivered in accordance with a treatment manual, and outcome measures related to the diagnosis. The result has been to develop a list of ESTs, the vast majority of which are cognitive behavioral in orientation. ESTs have become widely advocated

by managed care, insurance companies, and government (Messer, 2001). In this regard, Wampold (2001) has lamented that "doctoral level psychologists and other psychotherapy practitioners (e.g., social workers, marriage and family therapists) are economically coerced to practice a form of therapy different from what they were trained and different from how they would prefer to practice" (p. 2).

Before moving to a critique of the EST movement, it is important to stress that it is much narrower than the EBP movement. As Gambrill (2006) has pointed out:

> Descriptions of EBP differ greatly in their breadth and attention to ethical, evidentiary, and application issues and their interrelationships ranging from the broad, systemic philosophy and related evolving process initiated by its originators . . . to narrow views (using empirically supported interventions that leave out the role of clinical expertise, attention to client values and preferences, and application problems). (p. 339)

We agree with Gambrill (2006) that the EST movement represents "a narrow view of EBP . . . that is antithetical to the process and philosophy of EBP as described by its originators" (p. 354). Thus, although we are concerned that the broader EBP movement has to some degree gotten aligned with the narrower views of the EST movement, our argument is with the latter movement and its narrow and rigid conceptualization of what constitutes evidence. We hope it is clear from our review of psychotherapy research that we believe practice should be informed by research—we just disagree with those within the EST movement about what the research to date tells us about practice and what research should focus upon going forward.

Critique of the EST Movement

Critics have pointed out that the predominance of cognitive behavioral treatments (CBTs) in the EST list is due to the fact that other more process-oriented therapies do not readily fit the research protocol requirements for manualized treatment and focus on specific symptoms with associated specific outcome measures, and that these requirements are biased toward CBTs (Messer, 2001; Wachtel, 2010; Wampold & Imel, 2015). Wachtel (2010) has argued that "there is an impressive body of evidence demonstrating the efficacy of a range of therapeutic approaches not on the 'EST' lists" (p. 268). Furthermore, in a provocative manner, he has contended that when EST advocates dismiss this body of evidence as irrelevant because the studies do not meet their very narrow research protocol requirements, "they engage in a kind of deceptive casuistry similar to that which characterized for years the tobacco companies' denial of the adverse health effects of cigarettes" (p. 269).

The use of treatment manuals is one of the research requirements of the EST movement that has received extensive criticism. Beyond the fact that many theoretical approaches are not structured enough to be manualized, Messer (2001) argued that overly close adherence to treatment manuals can stifle "artistry, flexibility, reflection, and imagination" (p. 8). This view is supported by Wampold and Imel's (2015) review of research, which found that "the evidence suggests that rigid adherence to a treatment protocol, particularly if it damages the relationship . . ., is detrimental" (p. 274).

More generally, noting the decades of research that have confirmed the equal outcomes phenomenon and the importance of the counseling relationship,

Wampold and Bhati (2004) argued that "there is compelling evidence that it makes more sense to think of elements of the relationship as being empirically supported rather than particular treatments" (p. 567). Similarly, Lambert (2013a) has pointed out, "the fact is that success of treatment appears to be largely dependent on the client and the therapist, not on the use of 'proven' empirically based treatments" (p. 8). Henry's (1998) argument against ESTs is still valid today:

> The largest chunk of outcome variance not attributable to pre-existing patient characteristics involves individual therapist differences and the emergent interpersonal relationship between patient and therapist, regardless of technique or school of therapy. This is the main thrust of three decades of empirical psychotherapy research. (p. 128)

We agree with those who contend that the focus of EST research is misplaced and that the results are misleading. We also concur with Wampold's (2001) conclusion that "designated empirically supported treatments should not be used to mandate services, reimburse service providers, or restrict or guide the training of therapists" (p. 225). With regard to the latter issue, Wampold and Imel (2015) argued that "training programs need to teach a variety of treatments—and . . . the optimal training programs will combine training in treatments and relationship skills" (p. 276). From within social work, reflecting on the strong empirical support for the importance of the helping relationship, Furman (2009) has argued similarly:

> Increasingly, schools of social work and social work training centers that focus on methods or technique . . . may not sufficiently help future social workers develop the capacity for self-reflection, which is a key to developing functional or "good enough" helping relationships. (p. 84)

As noted earlier, it should be clear from the emphasis we have placed on reviewing research that we are not against the general concept of EBP; however, we think that psychologists and social workers who align themselves with the assumptions and principles of the EST movement are barking up the wrong tree in searching for empirically supported theories and techniques. Instead, we think that funders, researchers, and practitioners should shift to more productive research foci.

One example of a more productive research focus is that of the APA Task Forces (Norcross, 2001, 2002; Norcross & Lambert, 2011; Norcross & Wampold, 2011) that explored evidence-based therapy relationships. These task forces were established to counter, or at least balance, the EST movement. In fact, one of the conclusions of the second task force (Norcross & Wampold, 2011) was that "efforts to promulgate best practices or evidence-based practices (EBPs) without including the relationship are seriously incomplete and potentially misleading" (p. 98). Among the general elements of the therapy relationship that the second task force concluded as "demonstrably effective" were the overall quality of the therapeutic relationship/alliance, empathy, and collecting client feedback. Other elements found to be "probably effective" were positive regard, collaboration, and goal consensus. "Promising" elements of the relationship but with insufficient research included genuineness/congruence and repairing problems in the therapy relationship (Norcross & Wampold, 2011).

Policy recommendations from this task force included educating clinicians about the benefits of evidence-based therapy relationships and advocating for the "research-substantiated benefits of a nurturing and responsive human relationship in psychotherapy" (Norcross & Wampold, 2011, p. 100). Reflecting on the research that supports the importance of the helping relationship, Lambert (2013b) said "It should come as no surprise that helping others . . . can be greatly facilitated in a therapeutic relationship that is characterized by trust, understanding, acceptance, kindness, warmth, and human consideration" (p. 206).

The second APA task force on evidence-based therapy relationships also found that adapting the relationship style to specific client characteristics enhances the effectiveness of counseling (Norcross & Wampold, 2011). Among the most important client characteristics to adapt one's relationship stance to were client preferences, resistance (highly resistant clients benefit more from a minimally directive worker, and vice-versa), culture, and religion/spirituality. As two of the first task force members concluded, research suggests that "improvement of psychotherapy may be best accomplished by learning to improve one's ability to relate to clients and tailoring that relationship to individual clients" (Lambert & Barley, 2001, p. 357).

Another example of a potentially productive focus for research is individual therapist differences. Although research has established equal outcomes across different types of therapy, it has also established that there are significant differences in effectiveness among therapists within each approach to therapy. Lambert (2013b) has noted that "some therapists appear to be unusually effective, while others may not even help the majority of patients who seek their services" (p. 206). From their review of research on this issue, Wampold and Imel (2015) concluded that the actions that differentiate more effective from less effective therapists include "warmth and acceptance, empathy, and focus on the other" (p. 211). On this issue, Lambert and Ogles (2004) have called for "research focused on the 'empirically validated psychotherapist' rather than on empirically supported treatment" (p. 169).

It is likely that differences in effectiveness among practitioners have much to do with the ability to establish good interpersonal relationships with clients, particularly difficult clients, and to use such relationships therapeutically (Asay & Lambert, 2001). Thus, promising foci for research on therapist differences include relationship and general interpersonal skills, interpersonal style, emotional well-being, and attitudes toward clients. Although we do not know how widespread it has become, Messer (2001) noted that it was encouraging that some "managed care companies are moving to a system of evaluating therapists and referring cases to the successful ones, rather than requiring the use of ESTs" (p. 9). On a related note, Lambert (2013b) has noted that "research suggests clients would be wise to pick a therapist as-a-person at least in parity with the selection of a kind of psychotherapy" (p. 206).

APPROACHES TO ECLECTICISM

Despite pockets of strong resistance such as the EST movement, the trend toward eclecticism and integration is clear in the broad field of counseling/psychotherapy and the profession of clinical psychology. As we have argued, however, despite the endorsement of eclecticism in the generalist perspective, this trend is less clear in

direct social work practice. We think it is important for social workers to become familiar with the literature on eclecticism and integration in psychotherapy. Many of the ideas and principles in this literature (e.g., the valuing of multiple perspectives for understanding and intervening, the centrality of the helping relationship) are consistent with and can inform social work practice.

Four broad approaches to eclecticism are commonly identified in the literature: technical eclecticism, theoretical integration, assimilative integration, and common factors (Castonguay, Reid, Halperin, & Goldfried, 2003; Lampropoulos, 2001; Norcross, 2005; Stricker, 2010; see Table 1.2). A survey (Norcross, Karpiak, & Santoro, cited in Norcross, 2005) of psychologists who self-identified as eclectics and integrationists found that a sizable proportion of therapists (19%–28%) are subscribed to each of these four approaches to eclecticism.

Each of the general approaches to eclecticism subsumes a number of more specific models of eclectic/integrative practice; however, not surprisingly, there are differences in the literature with regard to classifying some models. Although it is beyond the scope of this book to review specific eclectic/integrative models in detail, the following discussion of each of the four general approaches provides a brief discussion of some of the specific models that fall under their domain. Following this, we elaborate on the type of eclecticism we endorse for our generalist-eclectic approach.

TABLE 1.2 Approaches to Eclecticism/Integration

Broad Approaches	Examples of Therapies	General Characteristics of Approaches
Technical Eclecticism	Multimodal behavior therapy (MMT; Lazarus, 1981, 2005, 2006) Systematic treatment selection (STS; Beutler, 1983; Beutler & Clarkin, 1990; Beutler, Consoli, & Lane, 2005; Beutler, Harwood, Bertoni, & Thomann, 2006)	Using techniques from different theories based on their proven effectiveness with similar client problems/characteristics, without necessarily subscribing to any of the theories
Theoretical Integration	Integrative relational therapy (Wachtel, 1977, 1997; Wachtel, Kruk, & McKinney, 2005) The transtheoretical model (TTM; Prochaska & DiClemente, 1984, 2005; Prochaska & Norcross, 1999, 2014)	Integrating/synthesizing the strengths of two or more theories to create a more comprehensive theory to explain human problems and guide intervention
Assimilative Integration	Assimilative psychodynamic psychotherapy (Gold & Stricker, 2001; Stricker, 2006; Stricker & Gold, 2005) Widening the scope of cognitive therapy (Safran, 1990a, 1990b, 1998; Safran et al., 2014)	Incorporating other theories and techniques into one's primary theoretical orientation
Common Factors	Common factors/contextual meta-model (Frank & Frank, 1991; Wampold, 2001; Wampold & Imel, 2015) Eclectic/integrative approach (Garfield, 1995, 2000) Client-directed, outcome-informed clinical work (Duncan, Sparks, & Miller, 2006; Miller, Duncan, & Hubble, 2005)	Focusing on factors that are shared by all types of therapy and that are central to therapeutic effectiveness (e.g., a good helping relationship)

Technical Eclecticism

Technical eclecticism, which is sometimes referred to as systematic eclecticism or prescriptive matching, "refers to the relatively atheoretical selection of clinical treatments on the basis of predicted efficacy rather than theoretical considerations" (Alford, 1995, p. 147). Thus, those who ascribe to technical eclecticism use clinical knowledge and research findings about what has worked best with clients with similar characteristics or problems to draw techniques from different therapy models, without necessarily subscribing to any of the theories (Norcross, 2005; Wampold & Imel, 2015). Lazarus (1996) differentiated this type of eclecticism from "the ragtag importation of techniques from anywhere or everywhere without a sound rationale" (p. 61). Technical eclecticism attempts to address the specificity question posed by Paul (cited in Lampropoulos, 2001): "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under *which* set of circumstances" (p. 7). Of the four types of eclecticism, this type pays the least attention to the integration of theories (Gold & Stricker, 2006).

Multimodal Behavior Therapy (MMT)

Lazarus's (1981, 2005, 2006) MMT is one of the most prominent examples of technical eclecticism. MMT is based on assessment that specifies the client's problem and his or her primary aspects, or modalities, of functioning (i.e., behavior, affect, sensation, imagery, cognition, interpersonal relationships, and drugs/biological functioning [BASIC I.D.]). Lazarus contended that different techniques should be selected to address the client's various prominent modalities and that these should be addressed sequentially according to their "firing order" (e.g., if client affect leads to behavior and then cognition, these modalities should be treated in this order). He also argued that therapy should address as many modalities as possible. MMT uses techniques from a variety of theories, including humanistic, psychodynamic, and family systems theories, but there is an emphasis on cognitive behavioral techniques (Lazarus, 2005, 2006).

Systematic Treatment Selection (STS)

A second prominent example of technical eclecticism is Beutler's STS therapy (1983; Beutler & Clarkin, 1990; Beutler et al., 2005; Beutler & Harwood, 1995, 2000; Beutler et al., 2006). In this approach, techniques from a wide variety of theories are selected on the basis of "empirical evidence of usefulness rather than by a theory of personality or of change" (Beutler & Harwood, 1995, p. 89). STS focuses on matching treatment strategies and techniques to client characteristics (client–treatment matching) and is one of the most ambitious and thorough models of eclecticism. In this model, a thorough assessment of client variables (e.g., demographic qualities, coping style, level of distress, level of resistance, expectations of therapy, social supports, diagnosis) and a consideration of empirical evidence related to such variables leads to decisions about (a) treatment contexts (individual, group, marital, family therapy), (b) choice of therapist (e.g., based on interpersonal compatibility and demographic similarity), (c) goal of therapy (i.e., focus on symptoms or underlying themes), (d) primary level of experience to be addressed (affect, cognition, or behavior), (e) style of therapist (e.g., degree of directiveness, support, confrontation), and (f) therapeutic techniques (Beutler & Harwood, 1995).

The STS model has been researched extensively and the most promising results are related to matching treatment to client coping style and reactance/resistance level. With regard to coping style, it has been found that clients who externalize (e.g., blame others) do better in structured treatments such as CBT, whereas clients who internalize (e.g., blame themselves) do better in more process-oriented treatment (e.g., insight or relationship-oriented therapy). With regard to resistance, it has been found that clients who are highly resistant do better in less directive therapy (e.g., client centered), whereas clients low in resistance do better in more directive therapy (e.g., CBT; Schottenbauer, Glass, & Arnkoff, 2005).

Theoretical Integration

In this second category of approaches, "there is an emphasis on integrating the underlying *theories* of psychotherapy along with therapy techniques from each" (Prochaska & Norcross, 2014, p. 431). The goal is to produce a more comprehensive, overarching theoretical framework that synthesizes the strengths of individual theories. Norcross (2005) has referred to theoretical integration as "theory smushing" (p. 8). The ultimate form of theoretical integration would incorporate all of the various theories of therapy (i.e., those subsumed under psychodynamic, cognitive behavioral, humanistic/feminist, and postmodern classifications, as well as biological and family systems approaches) into a synthesized/unified whole. Leaving aside the question of whether such a lofty goal is viable or not, Stricker's (1994) conclusion that "psychotherapy integration has not succeeded in that grand attempt, . . . the leading current approaches usually incorporate two, or at most three, of these perspectives" (p. 6) still holds today. As Lampropoulos (2001) noted, theoretical integration is "the ideal, optimistic, but utopian view" (p. 6).

Integrative Relational Therapy

Wachtel's (1977, 1997; Wachtel et al., 2005) integration of psychodynamic and behavioral theories is the most commonly cited example of an integrative approach. Building on the earlier work of Dollard and Miller (1950), Wachtel integrated the strengths of the social-learning model of behavioral theory with his interpersonal type of psychodynamic theory to create Integrative Relational Therapy (Wachtel et al., 2005). This integrative theory posits that unconscious conflicts/anxieties and interpersonal interactions are mutually influencing and create vicious cycles (e.g., anxiety about dependency needs results in keeping people at arm's length, which heightens the anxiety). In this model, intervention involves integrating a psychodynamic focus on insight with a behavioral focus on action (e.g., skills training).

The Transtheoretical Model (TTM)

The TTM (Prochaska & DiClemente, 1984, 2005; Prochaska & Norcross, 1999, 2014) is another influential integrative model. In the TTM, the selection of interventions, or change processes as they are called, is based on the assessment of two factors. First, consideration is given to the "stages of change" through which people progress. Thus, the worker needs to assess which of the five stages of change a client is in:

1. Precontemplation (relatively unaware of problems with no intention to change)
2. Contemplation (aware of a problem and considering, but not committed to, change)
3. Preparation (intending and beginning to take initial steps toward change)
4. Action (investment of considerable time and energy to successfully alter a problem behavior)
5. Maintenance (working to consolidate gains and prevent relapse)

Second, the "level/depth of change" required needs to be assessed. Thus, the worker and client need to mutually determine which of five problem levels to focus on:

1. Symptom/situational problems
2. Maladaptive cognitions
3. Current interpersonal conflicts
4. Family/systems conflicts
5. Intrapersonal conflicts

After an assessment of the client's stage of change and the level of change required, the TTM suggests that available empirical evidence of effectiveness be considered, as much as possible, to determine which interventions from different theoretical perspectives to use. In general, with regard to stages of change, techniques from cognitive, psychodynamic, and humanistic therapies are thought to be most useful in the precontemplation and contemplation stages, whereas "change processes traditionally associated with the existential and behavioral traditions . . . are most useful during the action and maintenance stages" (Prochaska & Norcross, 2014, p. 467). More specifically, when the level of change required is considered in the action stage, behavioral techniques would usually be chosen for the symptom/situational level, cognitive techniques would be employed at the level of maladaptive cognitions, and psychodynamic interventions would be used at the intrapersonal conflict level. The general principle in this model is to focus intervention initially at the symptom/situational level and then to proceed to deeper levels only if necessary.

Assimilative Integration

This approach to eclectic/integrative practice was the last of the four categories of eclecticism to be developed (Stricker, 2010), and was proposed initially by Messer (1992). This approach maintains that it is important to keep a firm grounding in one theory of therapy while incorporating ideas and techniques from other theories. Lampropoulos (2001) explained how assimilative integration can be seen as a bridge between technical eclecticism and theoretical integration:

> When techniques from different theoretical approaches are incorporated into one's main theoretical orientation, their meaning interacts with the meaning of the "host" theory, and both the imported technique and the pre-existing theory are mutually transformed and shaped into the final product, namely the new assimilative, integrative model. (p. 9)

Assimilative Psychodynamic Psychotherapy

One example of assimilative integration is Assimilative Psychodynamic Psychotherapy (Gold & Stricker, 2001; Stricker, 2006; Stricker & Gold, 2005). As its name indicates, this is clearly a psychodynamic therapy, but one that allows for the incorporation of more active/directive interventions "borrowed from cognitive, behavioral, and humanistic approaches" (Stricker, 2006). Gold and Stricker (2001) acknowledged that psychodynamic therapy "is very good at answering the 'why' and 'how did this happen' questions . . . but it is not as effective at answering questions such as 'so now what do I do' or 'how do I change this'" (p. 55). In this approach, there is an effort to introduce techniques from other theories in such a way that they are "experienced as part and parcel of a consistent approach rather than an arbitrary intrusion on the ongoing work" (Stricker, 2006, p. 55).

Widening the Scope of Cognitive Therapy

Another example of this approach is Safran's (1990a, 1990b, 1998; Safran & Segal, 1990) attempt to widen the scope of cognitive therapy by incorporating aspects of psychodynamic (psychoanalytic and interpersonal) and humanistic theories. Beyond the cognitive and behavioral dimensions of human functioning, which are the sole foci of most CBTs, Safran's model also considers emotional, developmental, interpersonal, and conflictual dimensions. Techniques from other theoretical orientations are incorporated to address issues associated with these additional aspects of human experience. A more recent development by Safran and colleagues (Safran et al., 2014) has been to augment CBT with alliance-focused training (AFT), which is derived from the relational model of psychodynamic theory and focuses on resolving problems or ruptures in the therapeutic alliance.

Common Factors

In this last category of approaches to eclecticism, there is an attempt to identify and utilize the "effective aspects of treatment shared by the diverse forms of psychotherapy" (Weinberger, 1993, p. 43). This approach has been influenced largely by the extensive work of Jerome Frank, particularly his classic book entitled *Persuasion and Healing* (Frank, 1961, 1973, and co-authored with his daughter, J. D. Frank & J. B. Frank, 1991). Frank's writing on common factors amounted to a meta-model of psychotherapy, rather than a specific approach to therapy. Wampold (2001; Wampold & Imel, 2015) has adopted Frank's broad common factors conceptualization of psychotherapy, calling it a contextual model of psychotherapy, and contrasting it to the medical model, which purports that theory and technique (i.e., specific factors) are the keys to therapeutic effectiveness.

As we have noted earlier, Wampold's (2001) and Wampold and Imel's (2015) thorough analysis of psychotherapy research provides compelling empirical support for the common factors/contextual model of psychotherapy. Although Wampold (2001) clearly attributed the meta-model discussed in his book to Frank, because of Wampold and Imel's (2015) further conceptual development and empirical validation of the model, we see this model as a joint product of these authors' work. We will review the common factors/contextual model of Frank and Wampold and Imel in some depth before considering more specific common factors therapy models.

Common Factors/Contextual Model

Building on Rosenzweig's (1936) earlier ideas, Frank developed the demoralization hypothesis, which proposes that most of the distress suffered by clients stems from being demoralized and that "features shared by all therapies that combat demoralization account for much of their effectiveness" (Frank, 1982, p. 32). Frank (1982; Frank & Frank, 1991) suggested four factors that are shared by all forms of psychotherapy, as well as by religious and other secular types of healing, that represent means of directly or indirectly combating demoralization and that are primarily responsible for the effectiveness of any approach to healing.

First, and foremost, is an "emotionally supportive, confiding relationship with a helping person" (Frank, 1982, p. 19). If helpers can convince clients that they care and want to help, then this decreases clients' sense of alienation, increases expectations of improvement, and boosts morale.

Second is a "healing setting" that heightens the helper's prestige, thereby increasing the client's expectation of help, and provides safety. In psychotherapy, the healing setting is usually an office or clinic that carries the aura of science; in religious healing, it is usually a temple or sacred grove.

Third is a theoretical rationale or "myth" that provides a believable explanation for clients' difficulties. Frank uses the word *myth* to underscore the contention that the accuracy of the explanation is less important than its plausibility in the eyes of the client. Any explanation of their difficulties that clients can accept alleviates some distress and engenders hope for change.

Fourth is a set of therapeutic procedures or a "ritual" that involves the participation of helper and client in activities that both believe will help the client to overcome the presenting difficulties. With regard to the fourth common factor, on the basis of empirical studies of therapy, Frank and Frank (1991) contended that therapeutic procedures will be optimally effective if they

- Provide new learning experiences for clients (these enhance morale by helping clients to develop more positive views of themselves and their problems).
- Arouse clients' emotions (this helps clients to tolerate and accept their emotions and allows them to confront and cope more successfully with feared issues and situations—thus strengthening self-confidence, sense of mastery, and morale).
- Provide opportunities for clients to practice what they have learned both within therapy and in their everyday lives (thus reinforcing therapeutic gains, a sense of mastery, and morale).

Lambert (2013b) and Wampold (2001; Wampold & Imel, 2015) concurred with Frank that there is substantial empirical support for these therapeutic procedures that are common across therapies.

Although there is extensive empirical support for the first (therapeutic relationship) and fourth (common therapeutic procedures) of Frank's common factors, there is little research on the healing setting or on the theoretical rationale/myth. There is indirect support, however, for the latter factor. Frank's hypothesis about the importance of a theoretical rationale/myth that provides a believable explanation to clients of their problems is linked to "goal consensus and collaboration," which is one of the aspects of the therapeutic alliance for which there is strong

empirical support (Ackerman et al., 2001; Norcross & Wampold, 2011). Clearly, in order to establish goal consensus and collaboration, clients must believe in workers' explanation for their difficulties and strategies for ameliorating problems. Frank and Frank (1991) maintained that in order to maximize the sense and quality of an alliance with clients,

> therapists should select for each patient the therapy that accords, or can be brought to accord, with the patient's personal characteristics and view of the problem. Also implied is that therapists should seek to learn as many approaches as they find congenial and convincing. Creating a good therapeutic match may involve both educating the patient about the therapist's conceptual scheme and, if necessary, modifying the scheme to take into account the concepts the patient brings to therapy. (p. xv)

Following Frank and Frank's line of argument, and based on his review of research, Wampold (2001) has suggested that therapists should choose an approach to counseling that accords with the client's worldview: "the therapist needs to realize that the client's belief in the explanation for their [sic] disorder, problem, or complaint is paramount" (p. 218).

Wampold and Imel's (2015) most recent development of the common factors/contextual model posits three pathways that explain the benefits of psychotherapy. The first pathway is what they call the "real" relationship, which is the development of an authentic, genuine, trusting, open, and honest relationship in which the client experiences the worker's empathy. The second pathway involves the creation of positive expectations about therapy. This relates to Frank's ideas about clients being demoralized and therapists needing to instill hope and boost morale. It also relates to Frank's ideas about providing an explanation for the client's problem that is plausible to him or her and suggesting therapeutic actions that are in keeping with the explanation. The third pathway is what they call "specific ingredients." This does not refer to the importance of specific (theory and technique) factors, but rather to the fact that all therapies, in one way or another, involve encouraging clients to engage in activities (cognitive, behavioral, and/or emotional) that promote psychological well-being or symptom reduction.

Wampold and Imel (2015) emphasize that the common factors/contextual model is primarily a relationship-based model of psychotherapy: "The intervention we discuss in this book is still mostly a human conversation—perhaps the ultimate in low technology. Something in the core of human connection and interaction has the power to heal" (p. ix).

Eclectic/Integrative Approach

Another therapy that has been classified as a common factors model is Garfield's (1995, 2000) eclectic/integrative approach. Garfield contended that despite the many apparent differences among the various therapeutic approaches and the fact that these schools of therapy tend to emphasize the importance of their specific techniques, factors that are common across therapies account for much of their success. Garfield's (1995) model places a strong "emphasis on the therapeutic relationship and on the common factors in psychotherapy" (p. 167), while also supporting the eclectic use of interventions from different theoretical approaches.

Echoing Frank, Garfield (1995) contended that "being given some explanation for one's problems by an interested expert in the role of healer, may be the important common aspect of these divergent therapies" (p. 34). Garfield (1995) rationalized the theoretical openness of his approach:

> Although the absence of a unifying and guiding theory has its drawbacks, an awareness of one's limitations and of the gaps in our current knowledge is, in the long run, a positive thing—even though it may make for uncertainties. It is better to see the situation for what it really is than to have what may be an incorrect or biased orientation. (p. 216)

Garfield's (1995) model does, however, provide some structure for practitioners by presenting general guidelines for the various stages of therapy (beginning, middle, later, and termination). This is very similar to the use of the problem-solving model in the generalist-eclectic approach. Also, Garfield's approach has elements of technical eclecticism in that therapists are advised, where possible, to choose techniques "which on the basis of empirical evidence seem to be most effective for the specific problems presented by the client" (p. 218).

Client-Directed, Outcome-Informed Clinical Work

Another, more recent, common factors approach is the client-directed, outcome-informed clinical work model (Duncan et al., 2006; Hubble, Duncan, & Miller, 1999; Miller et al., 2005). This model focuses on the importance of the therapeutic relationship. It emphasizes three core ingredients of the alliance: (a) shared goals for counseling, (b) consensus on the approach to counseling (means, methods, tasks), and (c) the emotional bond between worker and client. It is proposed that one key to developing a strong alliance is to adopt the client's theory of change, that is, "the client's frame of reference regarding the presenting problem, its causes, and potential remedies" (Miller et al., 2005, p. 87).

A second important key is to solicit and respond to, on an ongoing basis, client feedback regarding the therapeutic alliance. This is the "outcome-informed" element of the model. If the client voices concern about any aspect of the alliance, then "every effort should be made to accommodate the client" (p. 94). This model places very little emphasis on theory:

> The love affair with theory relegates clients to insignificant roles in bringing about change. . . . When therapists' models, whether integrative or not, crowd our thinking, there is little room left for clients' models—their ideas about their predicaments and what it might take to fix them—to take shape. (Duncan et al., 2006, p. 236)

Summary

It needs to be emphasized that these four broad approaches to eclecticism are not mutually exclusive and "the distinctions may be largely semantic and conceptual, not particularly functional, in practice" (Norcross, 2005, p. 10). For example, it is unlikely that models within technical eclecticism and common factors approaches

totally ignore theory, and it is quite likely that all of the approaches to eclecticism incorporate an emphasis on common factors.

We should note that there is another trend within the overall trend toward eclecticism, which is the development of eclectic/integrative therapies for specific populations and problems. Prominent examples of these include Linehan's (1993; Heard & Linehan, 2005) dialectical behavior therapy (DBT) for borderline personality disorder, McCullough's (2000, 2006) cognitive behavioral analysis system of psychotherapy (CBASP) for chronic depression, and Wolfe's (2005) integrative psychotherapy for anxiety disorders.

We do not count these eclectic/integrative therapies for specific populations and problems as a fifth classification of approaches to eclecticism because each of these more specific therapies can be subsumed under one of the four broader approaches to eclecticism. For example, DBT and CBASP can be classified as assimilative integration models because, although they integrate a number of different theories, their primary theoretical base is cognitive behavioral. Wolfe's therapy for anxiety, however, can be classified as a theoretical integration model because it blends psychodynamic and cognitive behavioral views of and treatment strategies for anxiety.

Finally, we would like to note that research on eclectic/integrative models has increased substantially over the years, although it still lags behind research on single theory approaches. In a review of research on eclectic/integrative therapies, Schottenbauer et al. (2005) concluded that there is substantial empirical support (i.e., 4 or more randomized controlled studies) for 7 such therapies, some empirical support (i.e., 1–4 randomized controlled studies) for another 13, and preliminary empirical support (i.e., studies with nonrandomized control group or no control group) for another 7. In 1992, Lambert predicted:

> to the extent that eclectic therapies provide treatment that includes substantial overlap with traditional methods that have been developed and tested, they rest on a firm empirical base, and they should prove to be at least as effective as traditional school-based therapies. (Lambert, 1992, p. 121)

It would seem that Lambert was right. Still, we agree with those researchers who contend that it would be more productive to focus research on exploring common factors and therapist factors that impact on outcome than continuing to focus on validating individual models of therapy, whether these are single theory or eclectic models.

RELATIONSHIP-BASED THEORETICAL ECLECTICISM: OUR APPROACH

Given our commitment to the spirit of eclecticism, as well as the obvious overlap among the various approaches to eclecticism, we believe there is value in all four approaches discussed in this chapter. Although our approach to eclecticism incorporates some aspects of all of the approaches identified in the literature, it is closest to the common factors approaches. Similar to common factors models, our approach to eclecticism embraces the prime importance of the helping relationship.

We believe that a warm, genuine, trusting, empathic relationship is necessary, and sometimes sufficient, for good helping outcomes. Also, similar to the client-directed, outcome-informed clinical work common factors model, our approach to eclecticism is critical of an overreliance on theory and values the artistic, reflective, intuitive-inductive processes of collaboratively building theories that fit the circumstances of each unique client. We agree with Cameron and Keenan (2010), who contended that a common factors model is "consistent with social work values, ethics, and practice wisdom from social work's traditions (that is, start where the client is, respect for the dignity of each person, the importance of relationships, and so forth)" (p. 64; see Cameron [2014] and Cameron & Keenan [2009, 2010, 2013] for an example of the application of the general common factors model to social work practice).

We think, however, that our approach to eclecticism does not fit neatly into the common factors category of approaches because our use of theory differs in some important ways from these approaches (see discussion later in this chapter). We think that our approach to eclecticism is distinct enough from the four approaches currently identified in the literature, and that it has enough merits, to warrant a fifth classification of eclectic practice, which we call *relationship-based theoretical eclecticism*.

Our relationship-based theoretically eclectic approach values the potential relevance of all theories and promotes the use of multiple theories and their associated techniques with individual clients. The essence of theoretical eclecticism is to consider the relevance of multiple theoretical frameworks to each client's problem situation in order to develop, collaboratively with the client, a more complex, comprehensive understanding that fits for the client, and then to choose intervention strategies or techniques that fit with this in-depth understanding. As noted, however, our generalist-eclectic approach to practice does not rely solely on the use of theory to develop in-depth understanding and choose intervention strategies. The eclectic use of theory is complemented by artistic, reflective, intuitive-inductive processes, and both of these are guided by the problem-solving model.

Comparison of Relationship-Based Theoretical Eclecticism to the Four Major Approaches to Eclecticism

Our approach to eclecticism is different from technical eclecticism in that it emphasizes the use of multiple theoretical perspectives, rather than focusing primarily on the techniques that are derived from theories and matching these to client characteristics or problems. It is different from theoretical integration because it does not attempt to synthesize or "smush" theories. Relationship-based theoretical eclecticism is different from assimilative integration in that it does not promote primary reliance on one theory of practice. Similar to these three approaches to eclecticism, however, our approach supports the idea of drawing techniques from a wide variety of theories, depending on their fit for particular clients. In contrast to some models in these approaches, however, our approach to matching techniques to client variables (e.g., coping style, level of resistance, stage of change) relies at least as much on worker judgment as empirical evidence.

There are two reasons why we do not favor an exclusive reliance on empirical evidence for choosing techniques. First, we agree with Stiles, Shapiro, and

Barkham (1995) and Wampold and Imel (2015) who contended that there is not enough empirical evidence to warrant firm decisions about such matching of techniques to client variables. Second, we do not like the mechanistic flavor of some prescriptive matching models because individual clients are too unique to rely on formulaic decisions about a certain type of intervention for a certain type of client or problem.

For these reasons, we favor what has been called *responsive matching* (Stiles et al., 1995). "Responsive matching is often done intuitively, we suspect, as practitioners draw techniques from their repertoire to fit their momentary understanding of a client's needs" (Stiles et al., 1995, p. 265). This type of matching should draw on theory and empirical findings but is more tentative and open to modification based on sensitivity to the client's response: "it is grounded in both theory and observation of the individual case" (Stiles et al., 1995, p. 265). In the same vein, Garfield (1995) has argued that:

> In the absence of research data, the therapist has to rely on his own clinical experience and evaluations, or on his best clinical judgment . . . and make whatever modifications seem to be necessary in order to facilitate positive movement in therapy. (p. 218)

Such an approach fits well with our valuing of the artistic, reflective, intuitive-inductive aspects of practice.

As mentioned, our approach to eclecticism has the most similarities with common factors approaches, particularly with regard to the emphasis placed on the worker–client relationship. Similar to all common factors approaches, and supported by a vast body of research, we emphasize the importance of a trusting, collaborative, supportive, warm, empathic helping relationship that is focused on instilling hope, boosting morale, and empowering the client. Other common factors that have received strong empirical support, and that we endorse, include addressing and resolving problems in the worker–client relationship (Norcross & Wampold, 2011), achieving consensus on problem formulation and goals (Ackerman et al., 2001; Norcross & Wampold, 2011), soliciting and responding supportively to client feedback (Miller et al., 2005; Norcross & Wampold, 2011), supporting emotional expression/catharsis, providing the client with mastery experiences (Lambert, 2013b), and helping clients attribute change to their own efforts (Weinberger, 1993). Also, we agree with Wampold's (2001) recommendation that, at least in parity with the emphasis placed on learning theory and technique, clinical practitioners should be trained to "appreciate and be skilled in the common . . . core therapeutic skills, including empathic listening and responding, developing a working alliance, working through one's own issues, . . . and learning to be self-reflective about one's work" (pp. 229–230).

Relationship-based theoretical eclecticism differs, however, from most common factors approaches in how theory is used in practice. Although Garfield's (1995) model does support the eclectic use of theory, this is largely with regard to choosing techniques and procedures for intervention. Curiously, in Garfield's (1995) book, there is virtually no discussion of using various theoretical perspectives in the assessment process to develop understanding of the client's situation, which is a central feature of our approach.

Although the common factors/contextual model of Frank and Frank (1991) and Wampold and Imel (2015) espouses the value of multiple theoretical perspectives, there are important differences between their use of theory and ours. Wampold and Imel (2015) and Frank and Frank (1991) argued that practitioners should learn as many therapy models as possible so that they can better match or modify a model to fit clients' worldview or understanding of their problems. This follows from Frank's (1961; Frank & Frank, 1991) use of the word *myth* to underscore his contention that the accuracy of a theoretical rationale for the client's problem is less important than its plausibility in the eyes of the client. He argued that any explanation of their difficulties that clients can accept alleviates distress and engenders hope. Thus, Frank allowed for the therapist to "persuade" the client that his or her theoretical rationale makes sense or to modify his or her preferred theoretical understanding to fit better with the client's understanding.

What is missing from the common factors/contextual model is the emphasis our relationship-based theoretical eclecticism places on an open, holistic assessment that is conducted collaboratively with the client. In this process, the views of both worker and client are considered together with multiple theoretical perspectives in an effort to build a comprehensive and shared understanding of the client's situation. This process allows for the development of understanding by both worker and client that may be different from and/or more comprehensive than either of their initial understandings of the problem. A more comprehensive understanding of the problem situation can lead to formulation of strategies for intervention that have a higher likelihood for success. We agree that it is necessary to eventually arrive at an understanding of the problem that fits for the client, but we think that an open, collaborative exploration/assessment can not only expand awareness of the problem and potential solutions, but can also foster the development of a strong therapeutic alliance and a sense of empowerment for the client, all of which help to overcome demoralization and instill hope.

One of the most important distinguishing features of our approach to eclecticism, which stems from its grounding in social work's generalist perspective, is that it is broader in focus and scope of intervention than most of the approaches to eclecticism that are in the clinical psychology literature. The generalist perspective of social work demands a holistic, person-in-environment focus that is sensitive to issues of diversity, oppression, and empowerment. It necessitates that direct practice be viewed broadly. Thus, as mentioned earlier, we think that the mandate and role of clinical social work includes helping clients to meet basic needs by providing them with or linking them to resources and services, engaging in social advocacy, and supporting clients to engage in broader social change efforts.

It is heartening and worth noting that some of the leaders of the movement toward eclecticism in clinical psychology are also beginning to attend to a traditional social work holistic focus. In a consideration of the future of psychotherapy integration in the concluding chapter of Norcross and Goldfried's (2005) *Handbook of Psychotherapy Integration*, it is suggested that "in order to understand and effectively meet clients' needs, therapists should attend more to the broader social context of clients' lives, including social values . . ., economic realities . . ., and cultural differences" (Eubanks-Carter, Burckell, & Goldfried, 2005, pp. 506–507). Also, in the introductory chapter to this same volume, Norcross (2005) noted that recent thrusts in psychotherapy integration include focus on multicultural theory, spirituality, and

social advocacy. Furthermore, in elaborating upon the necessity for therapists to align their theoretical views with the client's worldview, Wampold (2001) noted:

> Clients from populations of historically oppressed persons will benefit particularly from therapists who understand this dynamic, who are credible to the client, who can build an alliance with a client who may mistrust therapists representing institutional authority, (and) who are multiculturally competent. (p. 226)

Although some might view these recent trends in eclecticism as an incursion by psychologists into the domain of social work, we welcome this broadened understanding of eclecticism in direct practice by an allied helping profession with the hope that all helping professionals can move together in such a direction.

One potential drawback to relationship-based theoretical eclecticism, which is also shared by the common factors and technical eclecticism approaches, is that without a primary theoretical base (as in assimilative integration), or a synthesis of two or three theoretical bases (as in theoretical integration), there can be a lack of structure and guidelines for practice. In our approach, however, this is remedied by the use of social work's general problem-solving model. As explained earlier, the problem-solving model provides structure and guidelines for practice across all the phases of helping (from engagement to termination), but these are general and flexible enough to allow for an eclectic use of theory and techniques. We think that the use of the problem-solving model to guide practice in our relationship-based theoretically eclectic approach is better than using a primary theoretical base, as in assimilative integration, or using a synthesis of theories, as in theoretical integration. The latter approaches are less theoretically open and have more theoretical biases than a theoretically eclectic approach that uses a problem-solving model. Our use of the problem-solving model has parallels to Garfield's (1995) common factors approach, which provides general guidelines for what he calls "the stages of the therapeutic process" (beginning, middle, later, and termination stages).

SUMMARY

This chapter has provided an overview of our generalist-eclectic approach to direct practice. It has included a description of the elements of a generalist social work perspective that are central to our approach, a delineation of the distinctive aspects of our generalist-eclectic approach, an overview of the rationale for and trend toward eclecticism in direct practice, a review of the major approaches to eclecticism in the literature, and a discussion of relationship-based theoretical eclecticism—our particular approach to eclecticism. It was beyond the scope of this chapter to discuss many of the topics in the depth that they deserve. Readers are directed to the literature cited in our discussions for a more detailed review of topics that are of interest to them. In the next chapter, the types, levels, and classifications of theories for direct practice are discussed in an effort to demystify theory and facilitate its use in practice. In addition, a critical examination of how and the extent to which theory is used in practice is presented, and a complementary, intuitive-inductive approach that represents the art of practice is considered.

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