8-1-2002

Psychotherapy Integration: Examination of Clinical Utilization

Gregory T. Tierney

PSYCHOTHERAPY INTEGRATION:

EXAMINATION OF CLINICAL UTILIZATION

by

Gregory T. Tierney
Master of Arts, Loyola University Chicago, 1999

A Dissertation

Submitted to the Graduate Faculty

of the

University of North Dakota

in partial fulfillment of the requirements

for the degree of

Doctor of Philosophy

Grand Forks, North Dakota

August

2002

UMI Number: 3062879

ProQuest Information and Learning Company
300 North Zeeb Road
P.O. Box 1346
Ann Arbor, MI 48106-1346

This dissertation, submitted by Gregory T. Tierney in partial fulfillment of the requirements for the Degree of Doctor of Philosophy from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.

(Chairperson)

This dissertation meets the standards for appearance, conforms to the style and format requirements of the Graduate School of the University of North Dakota, and is hereby approved.

Dean of the Graduate School

July 22, 2002
Date

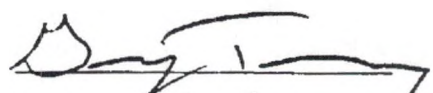
PERMISSION

Title Psychotherapy Integration: Examination of Clinical Utilization

Department Counseling

Degree Doctor of Philosophy

In presenting this dissertation in partial fulfillment of the requirements for a graduate degree from the University of North Dakota, I agree that the library of this University shall make it freely available for inspection. I further agree that permission for extensive copying for scholarly purposes may be granted by the professor who supervised my dissertation work or, in her absence, by the chairperson of the department or the dean of the Graduate School. It is understood that any copying or publication or other use of this dissertation or part thereof for financial gain shall not be allowed without my written permission. It is also understood that due recognition shall be given to me and the University of North Dakota in any scholarly use which may be made of any material in my dissertation.

Signature 

Date 7/17/02

TABLE OF CONTENTS

LIST OF FIGURES v

LIST OF TABLES vi

ACKNOWLEDGEMENTS vii

ABSTRACT ix

CHAPTER

I. INTRODUCTION 1

II. METHOD 39

Participants 39

Procedure 40

Materials 41

Hypotheses 43

Analyses of Data 43

III. RESULTS 45

IV. DISCUSSION 70

APPENDIX 90

REFERENCES CITED 94

LIST OF FIGURES

Figure | Page

1. Primary Theoretical Orientation Across Studies 5

2. Rational/Intuitive and Objective/Subjective Dimension Scores by Cluster from Heirarchical Cluster Analysis of Psychologists who Explicitly Reported Psychotherapy Integration 56

3. Rational/Intuitive and Objective/Subjective Dimension Scores by Cluster from Heirarchical Cluster Analysis of Psychologists who Implicitly Reported Psychotherapy Integration 58

4. Rational/Intuitive and Objective/Subjective Dimension Scores by Cluster from Heirarchical Cluster Analysis of Psychologists who Implicitly Defined Personal Use of Psychotherapy Integration 61

LIST OF TABLES

Table		Page
1.	Distribution of Primary Theoretical Orientation	47
2.	Distribution of Secondary Theoretical Orientation	48
3.	Distribution of Tertiary Theoretical Orientation	48
4.	Distribution of Primary Theoretical Orientation from Implicit Report	50
5.	Distribution of Primary Techniques by Theory from Implicit Report	50
6.	Primary Explicit Theoretical Orientation by Latent Theoretical Orientation Descriptive Statistics	53
7.	Homogeneous Subsets for Rational/Intuitive Dimension	54
8.	Homogeneous Subsets for Objective/Subjective Dimension	55
9.	Distribution by Cluster for Psychologists who Explicitly Reported Psychotherapy Integration	56
10.	Crosstabulation of Form of Explicit Psychotherapy Integration by Cluster Affiliation from Hierachical Cluster Analysis	57
11.	Distribution by Cluster for Psychologists who Implicitly Reported Psychotherapy Integration	59
12.	Crosstabulation of Primary Theoretical Orientation by Cluster Affiliation from Hierarchical Cluster Analysis with Implicitly Reported Psychotherapy Integration	60
13.	Distribution by Cluster of Psychologists who Implicitly Defined Personal Use of Psychotherapy Integration	61
14.	Crosstabulation of Primary Theoretical Orienation by Cluster Affiliation from Hierarchical Cluster Analysis with Self-Defined Use of Psychotherapy Integration	62

15. Psychologists' Reported Use of Formal Approaches to Psychotherapy Integration 63

16. Psychologists' Reported Use of Form of Psychotherapy Integration 65

17. Rank 1 Influences on Use of Theory and Technique 66

18. Rank 2 Influences on Use of Theory and Technique 67

19. Rank 4 Influences on Use of Theory and Technique 67

20. Rank 3 Influences for Psychologists Explicitly Reporting Psychotherapy Integration 68

21. Rank 3 Influences for Psychologists Explicitly Reporting Pure Theory 69

ACKNOWLEDGEMENTS

I would like to express my sincere appreciation to the members of my committee, who provided beneficial professional advice and critiques, which helped to guide my dissertation. I would especially like to thank my dissertation Chair, Sue C. Jacobs, Ph.D., for her time and encouragement. I appreciate your professional and personal support, which allowed me to complete my dissertation.

To my beautiful and supportive wife Frances Tierney

ABSTRACT

Psychotherapy integration has been consistently found to be the modal or bimodal primary theoretical orientation explicitly reported by psychologists. Considering influences on the field of psychology, psychotherapy integration will likely remain a significant approach to psychotherapy for the foreseeable future. However, not much is known about the clinical application of psychotherapy integration. It is questionable whether current classifications of psychotherapy integration, including theoretical integration, eclecticism, and common factors, can adequately describe clinical approaches. The assessment of latent theoretical orientation, as a means of assessing primary theoretical orientation, is a promising way to examine the clinical use of psychotherapy integration. My primary purpose in this study was to examine any differences in latent theoretical orientation between psychologists who report practicing psychotherapy integration versus those who report practicing a single school therapy and to determine whether or not approaches to psychotherapy integration could be classified into distinct categories using latent theoretical orientation.

A total of 800 practicing psychologists, who are doctoral level members of The National Register of Health Service Providers in Psychology, were mailed the Professional Issues in Applied Psychology Survey. The Professional Issues in Applied Psychology Survey is composed of three sections. The first section requests demographic information. The second section consists of questions related to the clinical use of psychotherapy theories and technique. The third section consists of the Counsellor

Theoretical Position Scale (CTPS) (Poznanski & McLennan, 1998). The CTPS is a 40-item instrument designed by Poznanski and McLennan (1998, 1999) to measure two dimensions of latent theoretical orientation: Rational-Intuitive and Objective-Subjective.

Consistent with past research, psychologists endorsed psychotherapy integration and psychodynamic approaches as the two most prominent primary theoretical orientations. Based on the results of a discriminant analysis using the two dimensions of latent theoretical orientation as dependent variables, distinctions can best be identified between psychologists endorsing behavioral, cognitive, cognitive-behavioral, or systems approaches from psychologists endorsing psychodynamic, humanistic/existential, or interpersonal approaches. Within approaches to psychotherapy integration between 4 and 5 clusters were formed using hierarchical cluster analyses based on the two dimensions of latent theoretical orientation. Implications of these results are discussed.

CHAPTER I

INTRODUCTION AND REVIEW OF LITERATURE

Personal beliefs and values greatly influence the choices one makes in day to day living as well as the affiliations that one chooses. One clear example of this is the political arena of the United States. Never has there been anywhere near a unanimous vote for a presidential candidate; in fact the typical winner of a presidential election usually does not even receive half of the votes. This, taken with the fact that US elections typically have poor voter turnouts, illustrates the influence of personal beliefs and values.

The dominance of the Democratic and the Republican parties demonstrate that each represents the values of a significant portion of the US populace. There are, however, those unaccounted for residents who choose not to vote, for any of a multitude of reasons. Whatever the reason, this does speak significantly of these individuals' beliefs and values. Two examples of this may be the belief that neither party nor candidate identifies with and/or represents an individual's beliefs and values or the belief that voting is futile because one vote doesn't change an election.

In addition to these political parties, which appear to be the most widely representative, there have always been smaller less funded and publicized political parties, such as the Socialist and Green parties. In recent elections, there appears to be a growing amount of support for candidates who are not from the traditional two parties, such as Reform party candidates and Independent candidates. The details of the political

scene and party affiliation, however, are secondary to the illustrative point that given some criteria individuals choose to affiliate with one of many parties for a given election or to abstain from the voting process.

The same process is true for theoretical orientation of psychologists. The four most widely represented broad-band theoretical orientations are Psychodynamic, Humanistic-Experiential, Behavioral, and Eclectic/Integrative (Castonguay & Goldfried, 1994). Here the traditional choices are the single school orientations, while the newer Eclectic/Integrative orientations focus on multiple schools of thought. I do not intend to imply an encompassing analogy between this latter broad-band group of psychologists with those citizens who choose not to vote, but I do see one commonality. The primary reason for the emergence of Eclectic/Integrative approaches seems to be dissatisfaction with the traditional single school orientations (Hollanders & McCleod, 1999).

In addition to the shift toward Eclectic/Integrative approaches there has been a boom in the number of narrow-band single school approaches that fall under the umbrella of the traditional broad-band orientations. Unfortunately, overlooked in this categorization are influential theories that do not fit under the umbrella of the traditional three, such as cognitive, feminist, or family systems. Karasu (1986) estimated that this explosion in the number of theoretical approaches has resulted in more than 400 approaches to psychotherapy; there is little doubt that this estimate has since grown. While a shift in politics may be seen as an opportunity for more voters to feel represented by the government, there is great dissention in opinions of the effect that these non-traditional orientations, particularly Eclectic/Integrative approaches, have on the field of psychology.

In regards to the influence of Eclectic/Integrative approaches, psychologists' reactions cover the gamut. On the one hand, in favor of Eclectic/Integrative approaches Winnicott (cited by Castonguay & Goldfried, 1994) states, "I want to kill behavior therapy. Its naiveté should do the trick. If not, then there must be a war" (p.159). On the other hand, according to Carl Rogers, "the person who attempts to reconcile them (schools of thought) by compromise will find himself left with a superficial eclecticism which does not increase objectivity, and which leads nowhere" (cited by Russell, 1986). Despite such negative views of Eclectic/Integrative approaches, there is evidence to support the current pervasiveness of these approaches with practicing counselors and psychologists.

Psychotherapy integration, a relatively new approach to psychotherapy, has been consistently found to be the, or one of two, predominant theoretical orientation(s) selected by professional psychologists since the 1960s (Garfield & Kurtz, 1974; Milan, Montgomery, & Rogers, 1994; Norcross & Prochaska, 1982; Norcross, Prochaska, & Farber, 1993; Smith, 1982; Stone & Yan, 1997). Given the popularity of these approaches it is commonly felt that this is a growing trend in psychology and thus referred to as the psychotherapy integration movement (Mahoney, 1993).

The development of the Society for the Exploration of Psychotherapy Integration (SEPI) and the Journal of Psychotherapy Integration, along with the number of psychologists selecting psychotherapy integration as their primary theoretical orientation, illustrate the recognition this approach is currently receiving. However, there has been little attention in the literature to how and why psychotherapy integration is used clinically. I intend, therefore, to examine the underlying beliefs that are associated with

the selection of a particular theoretical orientation, including psychotherapy integration, in order to provide insight into the clinical utilization of psychotherapy integration. I begin, in this chapter with a review of the literature regarding psychotherapy integration. I will first discuss the theoretical distribution among practicing psychologists, in order to illustrate the prevalence of the use of psychotherapy integration. This will also illustrate the general lack of understanding of the distribution of narrow-band approaches to psychotherapy integration among practicing psychologists. Next, I will review factors that contribute to the prevalence and utility of psychotherapy integration. I will present the current classification system for psychotherapy integration, including definitions of narrow-band approaches, examples of these approaches, and limitations of this classification system. Finally, I will review the concept of latent theoretical orientation and discuss potential implications for psychotherapy integration.

Theoretical Orientation Distribution

In reviewing published surveys of the distribution of theoretical orientation as a means of examining this "trend" toward psychotherapy integration, it is evident that since Kelly's study of trends in clinical psychology in 1961 (cited by Garfield and Kurtz, 1974) there have been numerous studies focused on the theoretical orientation of therapists in the United States. The general finding from these surveys is that the Eclectic/Integrative approaches are the modal or one of the bimodal theoretical orientations chosen by practicing psychologists. I will illustrate a representative portion of this research by reviewing seven studies, focusing on the samples used, variations between studies, and the findings for broad-band orientations. The percentages I present in this paper for broad-band orientations are often compilations of the individually reported narrow-band

orientations, which were presented in the original studies. I used this strategy in an attempt to provide a more accurate comparison across studies. A visual illustration of study results is presented in Figure 1, in order to provide a reference point for the discussion below.

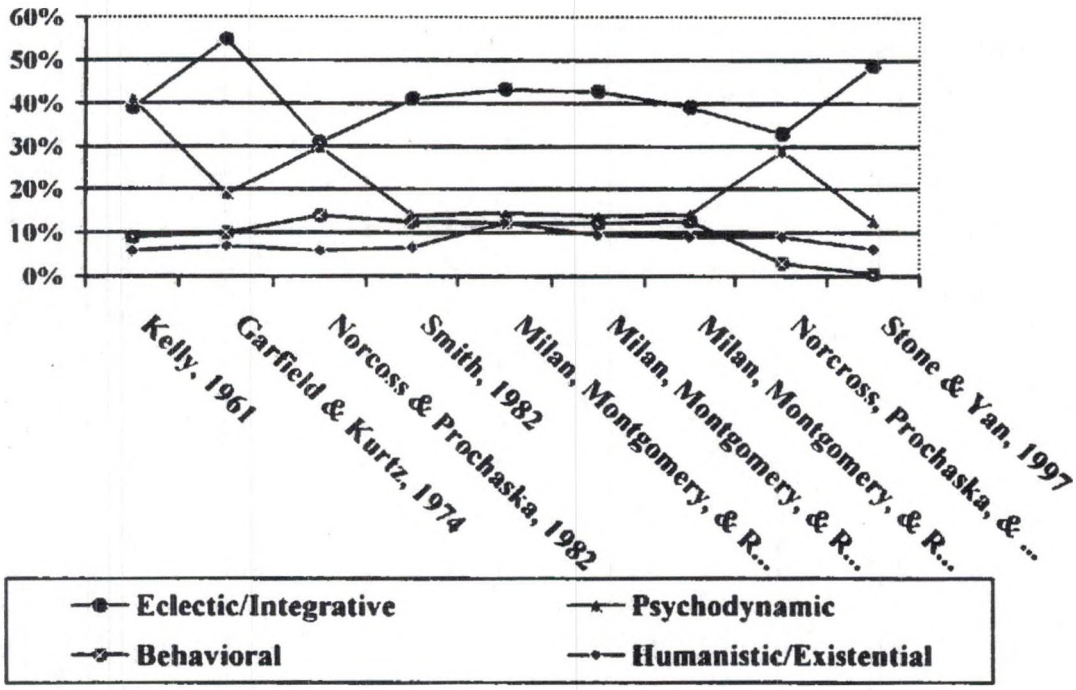


Figure 1. Primary Theoretical Orientation Across Studies.
Note. Studies vary by sample and survey characteristics.

In Kelly's 1961 study, as reported by Garfield and Kurtz (1974), approximately 39% of those surveyed reported an eclectic theoretical orientation while 41% reported narrow band affiliations that fall under the broad band of Psychodynamic. Behavioral and Humanistic/Experiential orientations were each selected by less than 10% of respondents. Therefore, in Kelly's sample from the American Psychological Association (APA) Division of Clinical Psychology, Psychodynamic and Eclectic/Integrative theories were represented approximately equally in numbers and significantly more so than competing theories.

Replicating Kelly's study, Garfield and Kurtz (1974) examined the distribution of theoretical orientations of members and fellows of the APA Division of Clinical Psychology. Fifty-five percent of this sample endorsed the use of Eclectic/Integrative approaches as their primary theoretical orientation, clearly indicating a penchant for Eclectic/Integrative approaches. This growth, since Kelly's 1961 study, appears to have been predominantly at the expense of the Psychodynamic orientations, which were endorsed by only about 19% of the sample, while Behavioral and Humanistic/Existential approaches remained relatively consistent. Garfield and Kurtz (1974) concluded their study with the statement: "it would appear as if there were some tendency for individual clinical psychologists to move away from a primary identification with one theoretical view and to adopt a more eclectic orientation" (p.10).

Norcross and Prochaska (1982) conducted a follow-up to Garfield and Kurtz's (1974) study using a similar survey. They also focused exclusively on members and fellows of the APA Division of Clinical Psychology. In sharp contrast between the apparent shift that occurred between Kelly's study in 1961 and Garfield and Kurtz's in 1974, the percentage of those clinical psychologists selecting eclecticism as their primary theoretical orientation was significantly lower than in the Garfield and Kurtz (1974) study, less than 31%, while those selecting Psychodynamic orientations was higher, 30%. It should be noted, that in this study Sullivanian was not included in its report of Psychodynamic, as in the Garfield and Kurtz (1974) study. When I included the Sullivanian orientation with the Psychodynamic orientations, in order to compare the studies, the percentage of psychologists selecting Psychodynamic orientations increased to 33%. Behavioral, Humanistic/Experiential, Cognitive, and Systems theories were each

selected as the primary theoretical orientation by a relatively small but significant percentage of respondents (Norcross & Prochaska, 1982). The authors speculate that this apparent trend away from Eclectic/Integrative approaches may be due to both an apparent failure of the movement to culminate in "adequate models of systematic eclecticism" (Norcross & Prochaska, 1982, p. 5) and the failure of comparative research to differentiate the efficacy of therapeutic approaches, thus making eclecticism unnecessary.

Smith (1982) published a study the same year as the Norcross and Prochaska (1982) study broadening the representiveness of the sample of previous studies to include members of the Division of Counseling Psychology, as well as members of the Division of Clinical Psychology. The findings of this study differ from the Norcross and Prochaska (1982) study in several ways, particularly in regards to the percentage of respondents choosing Eclectic/Integrative and Psychodynamic theories. In Smith's (1982) study, 41% of the sample chose Eclectic/Integrative theories, while only 14% chose a Psychodynamic theory. These results more closely resemble the results of the Garfield and Kurtz (1974) study, than they do the study published in the same year (Norcross & Prochaska, 1982). A significant change in this survey from earlier surveys was the inclusion of Cognitive-Behavioral as a distinct option, while by definition it would be classified as a theoretical integration.

Milan, Montgomery, and Rogers (1994) used yet another sampling method in their examination of theoretical orientation. Focused on examining the reported trend toward Eclectic/Integrative approaches, they reviewed the theoretical orientations of a sample of psychologists listed in the *National Register of Health Service Providers in Psychology* in three different years of publication, 1981, 1985, and 1989. Their primary conclusion was

that there were no significant changes in theoretical affiliation, for the majority of orientations, across this time period.

Selection of Eclectic/Integrative theories as primary theoretical orientation, for example, ranged from 43.3% in 1981 to 39.1% in 1989, not a significant change. In each of the three years sampled, Eclectic/Integrative theories were the modal theoretical orientation. Following this, Psychodynamic, Behavioral, and Humanistic/Existential all closely fell within 15% and 9% across the three years, with Psychodynamic consistently the highest. Interestingly, a non-traditional theoretical orientation, Interpersonal Relations, also consistently fell with-in this range. Cognitive/Rational Emotive and Systems were the only theories that showed significant increases in selection as primary theoretical orientation.

Norcross, Prochaska, and Farber (1993) assessed professional issues, including theoretical orientation, in members of the APA Division of Psychotherapy. They found that Psychodynamic theories and Eclectic/Integrative approaches were the most prevalent, with 33% and 29% respectively of those sampled choosing one as their primary theoretical orientation. Humanistic/Existential and Behavioral theories were chosen as primary orientation by less that 10% of respondents each. Cognitive, Interpersonal, and Systems were the primary orientations of 10%, 7%, and 4%, respectively.

Stone and Yan (1997) analyzed differences between psychologists working in university counseling centers and independent practice. They asked members of the APA Division of Counseling Psychology, who reported working in independent practice, and staff psychologists at university counseling centers, who were recruited through mailings

to Counseling Center Directors, to complete a survey that included an assessment of theoretical orientation. I will report the theoretical orientation of the two groups of psychologists as one, as I am not interested in the work-setting distinction for the purposes of this paper.

The predominant primary theoretical orientation chosen by those sampled in this study (Stone & Yan, 1997) was Eclectic/Integrative, which was selected by 49% of psychologists. The second most selected theoretical orientation was Cognitive-Behavioral, chosen by 24% of psychologists. Traditional theoretical orientations, including Psychodynamic, Humanistic/Existential, and Behavioral theories, were selected by only 19% of psychologists as their primary theoretical orientation.

Issues in the examination of theoretical orientation distribution. Assessment of theoretical orientation appears on first consideration to be as simple as asking psychologists to identify their theoretical orientation. There are, however, many difficulties in this area of study and these reported studies illustrate this fact. First, as with any study, a goal is to obtain a large and representative sample, but with an availability of a large group of psychologists come criteria for inclusion and exclusion prevent a wholly representative sample. For example, when selecting psychologists from the Division of Counseling Psychology, one is excluding psychologists who are not members due to association with other Divisions or those who choose not to become members. The effect of this is that previous studies reported above each represent a distinct subsection of psychologists; therefore, it may be presumptuous to assume parallels between them.

Second, in order to allow comparison, studies should evaluate the same criteria, but this is not found in such studies. Possibly due to changing times or a different set of values, the theories assessed in each of these studies were relatively inconsistent. This inconsistency was seen in the use of different names for theories and different groupings for broad-band theories. The use of different names was commonly seen with Behavioral and Cognitive theories, which were also termed as Learning theory and Rational-Emotive, respectively, in several studies. An example of the different clustering of theories is seen when, as discussed above, Sullivanian was grouped with Psychodynamic theories in one study and with Interpersonal theories in another.

Third, these studies use only explicit measures of theoretical orientation. Most of these studies asked participants to identify their primary, as well as secondary and sometimes tertiary theoretical orientation. Little, however, is done with this information other than to calculate the theories' overall influence (Norcross & Prochaska, 1982). The selection of more than one theoretical orientation should, by definition, be considered Eclectic/Integrative. Further, while some psychologists may adhere to only one theoretical orientation they may also incorporate techniques from other theories into their practice, which would also, by definition, relegate the label of Eclectic/Integrative.

Hollanders and McLeod (1999), in a study conducted in the United Kingdom, correct for this by going beyond explicit reporting of an eclectic orientation. They assessed for an implicit use of Eclectic/Integrative orientation, through counting those that did not identify themselves as Eclectic/Integrative, but did indicate that they used more than one theoretical orientation. When counting these individuals, as well as those that reported an eclectic orientation, they found that 87% of British practitioners worked from an

eclectic/integrationist perspective. They still went further by asking these same practitioners to identify any techniques that they use in their practice from a list of techniques that varied in theoretical orientation of origin. In this portion of the study, they determined that 94.8% of the British practitioners indicated the use of techniques from more than one theoretical orientation.

Finally, in the majority of these studies, there is very little insight into the use of approaches to psychotherapy integration by psychologists. "The fact that a therapist identifies himself or herself as an eclectic does not actually inform us concerning how the therapist conducts the therapy, what procedures are used, how effective the therapy is, and similar matters" (Garfield, 1994, p. 124). Only two of the above studies addressed this issue, by asking those that selected an Eclectic/Integrative approach to further delineate this selection (Hollanders & McCleod, 1999; Norcross & Prochaska, 1982).

Norcross and Prochaska (1982) attempted to gather more descriptive information regarding the use of psychotherapy integration among psychologists from the United States. In this study, they asked respondents to select one of three forms of Eclectic/Integrative approaches, atheoretical, technical, or synthetic (theoretical integration) eclecticism as well as to identify the primary theoretical component of their approach (Norcross & Prochaska, 1982). In regards to the particular form of eclecticism selected by psychologists, 61.3% chose synthetic eclecticism (theoretical integration), 28.9% chose technical eclecticism, while only 10% chose atheoretical eclecticism. In regards to the primary theoretical component, 47.6% identified a Psychodynamic eclecticism, 25.8% chose a Behavioral eclecticism, 10.0% selected a Humanistic/Existential eclecticism, and 16.6% reported their eclectic approach was

guided by another unspecified theory. Therefore, Norcross and Prochaska (1982) concluded that in regards to use of theory, "the theoretical preferences underlying eclecticism are in general agreement with the relative distribution of orientations in our 'non-eclectic' clinicians" (p. 5).

Hollanders and McCleod (1999) also addressed this issue in the United Kingdom. They asked those respondents who selected an Eclectic/Integrative approach to further select which, if any, formal framework they used to guide their practice. Selections were made from Egan's 'skilled helper' model, Prochaska and DiClemente's transtheoretical model, Ryle's cognitive analytic therapy, Garfield's eclectic therapy, an existential framework, a gestalt framework, or no formal framework. They found that the majority (57%) indicated using no formal framework. Hollanders and McCleod (1999) failed to provide statistics on the distribution of respondents who did select formal frameworks, but it is clear that the majority admit to not following a formal Eclectic/Integrative approach.

Conclusions from surveys of theoretical orientation distribution. Comparison across the studies listed above need to be made with caution, due to the fact that different samples and survey characteristics were used in the studies. The results, therefore, should not be examined on a statistical level for change effects. Also, apparent shifts between studies should not be assumed to be attributable to actual shifts in the distribution of theoretical orientation across applied psychologists. Instead, these results should be examined only on the global level.

At this level, the conclusions drawn by Milan, Montgomery, and Rogers (1994) appear applicable. "Assertions concerning the profession's movement toward eclecticism

are clearly not supported by the data reported herein" (p. 400). Instead, relying simply on explicit reports of primary theoretical orientation, it appears that Eclectic/Integrative approaches have maintained a constant and predominant role as the most often cited primary theoretical orientation, since the 1960's.

Interestingly, while theoretical orientation across decades and samples of psychologists appears relatively stable, there is evidence that at the individual psychologist level theoretical orientations are not very stable over time (Hollanders & McCleod, 1999; Sammons & Gravitz, 1990; Stone & Yan, 1997). For example, in a study of psychologists' reported theoretical orientation, 40% were found to have changed theoretical orientation since graduate school (Sammons & Gravitz, 1990). Further, among those who changed theoretical orientations, Eclectic/Integrative approaches were the new orientation for 68%. This trend was also noted by Stone and Yan (1997), when they found that approximately 50% of psychologists had changed orientations since training and "most of the change occurred from humanistic and psychodynamic training orientations to the eclectic/integrational or cognitive-behavioral orientation-in-use" (p. 55). Psychologists with more psychological work experience have also been to found to have a significantly more positive opinion of Eclectic/Integrative approaches (Smith, 1982).

Based on the relative global consistency of theoretical orientation and the findings that change in orientation post-training are predominantly to Eclectic/Integrative approaches, there is circumstantial evidence that a lack of satisfaction with traditional single school orientations is responsible for the popularity of Eclectic/Integrative approaches. This is reasoned in that, with increased clinical experience there is more

opportunity to identify short-comings of theories and to become disillusioned by single school attempts to explain human behaviors, thoughts, and emotions. Alternative explanations, however, abound, such that with increased experience psychologists may drift from their theoretical base relying, dangerously, on only clinical intuition. The "true" explanation for a tendency to shift toward Eclectic/Integrative approaches with experience or for the general popularity of these approaches, however, has not been adequately addressed through research.

In one identified attempt to address this issue, Hollanders and McCleod (1999) asked Eclectic/Integrative practitioners in the United Kingdom, who had changed to this orientation post-training, to identify reasons for such a shift. They found that approximately half of their sample identified client needs, innovative techniques, and therapist satisfaction as the predominant reason for such a shift. Of note, 8% identified organizational requirements as a contributing factor to this shift. This attempt, however, only considers explicit reporting of influences and most likely allows little generalization to U.S. psychologists, due to differences in social factors such as the role of managed care. I will now examine the factors that are relevant to psychologists who practice in the United States.

Factors in the "Trend" towards Eclecticism and Integrationism

There has been a great deal of speculation on factors that may have contributed to the psychotherapy integration "movement". Researchers have not clearly indicated the existence of an actual "movement" or "trend" toward psychotherapy integration. It is clear, however, that psychotherapy integration is a significant force in psychology. Therefore, it is important to focus on the contributing factors to this broad-band approach

to psychotherapy. Such factors cluster in three groups, those that are within the field of psychology, those that are forces directly acting on psychology, and societal factors that indirectly shape psychology. A brief discussion of the apparent lack of individual influences on the shaping of the psychotherapy integration "movement" is also provided.

Factors within psychology. As discussed above, there has been a proliferation of therapeutic schools of thought in recent years. It is argued that this change from the more traditional schools to smaller factional schools may have created a situation in which there is less apparent distinctiveness between schools, leading to an inability or an indifference to subscribing to one such school (Goldfried & Norcross, 1995). Also, psychologists may interpret this proliferation as suggesting a potentially infinite number of ways to conceptualize personality and therapeutic factors, which has led to mystification with the creation of theories of personality and psychotherapy and led instead to the promotion of the use of current theories and techniques (Arkowitz, 1997). With the number and diversity of theories and techniques available due to this proliferation, psychotherapy integration is armed with an immense set of tools with which to work from (Arkowitz, 1997).

Along with the influence of the sheer number of theories and techniques in psychotherapy, there is also reason to believe that the inability to distinguish the effectiveness of such therapies also appears to have promoted approaches to psychotherapy integration (Arkowitz, 1997; Costanguay & Goldfried, 1994; Gold, 1993; Goldfried & Norcross, 1995). This failure to find any one theory superior to others across client presenting issues, through outcome research, seems to have sparked a desire to improve upon therapeutic efficacy, through transcending theoretical orientations.

Costanguay and Goldfried (1994) discuss a related issue, asserting that therapists have become critical of their own theoretical orientations. This critical perspective appears to shed doubt on the adequacy and reality of tenets of theories, as well as entire theories, to promote effective and comprehensive psychotherapy. Further, it is commonly observed and suggested by some research evidence that there is a significant discrepancy between therapists' reported theoretical orientation and the therapeutic techniques employed in therapy (Beutler, 1989; Costanguay & Goldfried, 1994). Taken together there appears ample evidence that such critical theoretical concerns are effecting the practice of psychotherapy, with the incorporation of theories and techniques outside of the primary theoretical orientation.

Another factor, which may be closely related to external and societal influences, is the trend toward short-term solution focused therapy (Arkowitz, 1997; Goldfried & Norcross, 1995). In this approach, therapeutic techniques are ultimately selected on the basis of their efficiency and effectiveness, often irrespective of theoretical origin. This approach may be a result of a self-initiated process of improving the outcome of psychotherapy while eliminating excess time requirements, however, this approach also appears to be significantly influenced by managed care and an enhanced focus on client needs.

The final internal factor to be discussed also appears to be influenced by external and social factors. Empirically validated treatments, specifically the use of positivist research based primarily on quantitative methods, has become a focus of many researchers and practitioners in order to provide scientific evidence to the practice of psychology (Arkowitz, 1997; Costanguay & Goldfried, 1994; Gold, 1993; Goldfried & Norcross,

1995). In order to accomplish this goal, there is a related trend toward the creation of treatment manuals, which provide operational definitions of therapeutic techniques (Arkowitz, 1997). Critics of this approach argue that this methodology, by reducing theory to specific and individual techniques, loses much of what the theory offers, which cannot always be directly observed (Russell, 1986). Further, arguments state that this process leads to misinterpretation of techniques, when viewed separate from the theory, and the results of such research misrepresent the effectiveness of both the techniques and theories. The end result despite such arguments appears to be the creation of an independence of techniques from the theoretical assumptions that are inherent to that theory. Given this perceived independence from theory, these techniques may be selected and used by therapists strictly on the basis of treatment efficacy.

External factors. Probably the most influential and most discussed current external factor on the field of psychology is managed care (Castonguay & Goldfried, 1994; Gold, 1993; Goldfried & Norcross, 1995; Moldawsky, 1995; Smith 1999). In an effort to curb the rising costs of health care, managed care has changed the focus of therapeutic decision making in psychology from clinical to economic (Messer & Wachtel, 1997; Vandenbos, Cummings, & DeLeon, 1992). The reasoning for this overarching system is to regulate the provision of therapeutic services in order to ensure that clients are receiving adequate care at minimal cost. The methods of accomplishing this goal are to often prescribe the therapeutic strategy for the client and provide limits to the number of sessions to accomplish therapeutic goals. The end result of managed care is fewer funds available to psychologists. Therefore, to survive as a psychologist working under managed care, it is imperative to be knowledgeable of and proficient in multiple theories

and techniques that are tools of the managed care trade. This financial reality often counters reliance on preferred theoretical orientations and instead imposes a need to be familiar with a range of theories and techniques.

A second external factor influencing the popularity of psychotherapy integration is the medicalization of mental illnesses (Castonguay & Goldfried, 1994; Gold, 1993; Honos-Webb & Leitner, 2001). In short, the increased focus of the medical field on mental illnesses and the popularity and efficacy of psychopharmacological treatment offers competition to the field of psychology. "A disorder has become something to be cured or controlled by medication" (Honos-Webb & Leitner, 2001, p. 44). Such competition provides motivation to improve treatment efficacy, again in order to survive financially. Such a motivation to improve efficacy increases the use of Eclectic/Integrative approaches, in order to use effective strategies across orientation. This has also resulted in increased cross discipline integration, based on the established increase in efficacy commonly associated with combined treatment, medical and psychological, for a significant portion of mental illnesses.

Social factors. As discussed by Leahey (2000), the United States economy, since the 1960s, has changed from an economy based on production to an economy based on service and information. Mirroring this change, psychology also became more service oriented with subfields of applied psychology showing the greatest growth. With this increased focus on applied psychology the opinions of the public are more important than ever before. In regards to the effect of public opinion on psychology, Beutler (1989) writes:

> I mourn the loss of great philosophers like Carl Rogers and Virginia Satir. Yet, I believe that we must face the need for change lest we risk our credibility among those whom we seek to serve. However exciting it is for us to create theories, to the degree that this is seen as indecisive and based on ignorance, our effectiveness is compromised at the public level. (p. 18)

In short, it appears that the public is amused by several of the most popular figures in the history of psychology, such as a common belief that Freud placed too great an emphasis on sexual factors. It is this reputation that Beutler (1989) speaks of and proposes a need to separate from, if the public is to take psychology seriously. It is his contention that inferential and explanatory theory should be replaced with reliance on research results organized into a cohesive model that predicts "treatment-response relationships" (p.19).

In psychology's turn to service, the needs of clients also took on more emphasis than ever before. Instead of accountability being based on theoretical soundness, it appears, rightfully so, that therapists should be held accountable for serving the needs of the client. According to APA's current ethical guidelines, therapists should not push their own agenda, but instead should take into consideration the client's needs and values (Canter, Bennett, Jones, & Nagy, 1994). When serving a diverse clientele with a diverse set of presenting issues, it appears presumptuous to assume that any one of the typically European-American based theories could explain and promote techniques that would address client's needs universally. The impetus for such a shift in thought appears to come from societal recognition of different perspectives and how perspectives between groups may vary as a result of group specific values and beliefs. The result of this,

within psychology and society in general, appears to be the recognition of validity in different perspectives, instead of focusing on a single "truth".

Individual contributions. In discussing this point it is important to address the relative absence of contributions by historic figures, in relation to the influence of internal, external, and social factors. Traditional schools of psychology, on the other hand, each have identifiable figures that acted as originator and/or central figure for their respective theory, such as Sigmund Freud, John Watson, and Carl Rogers. In examining the role of "Great" individuals in Eclectic/Integrative approaches it is easy to turn toward the creators of eclectic and integrative frameworks, such as Beutler, Egan, Garfield, Lazarus, or Wachtel. The issue with this, however, is that the majority of those who practice from an eclectic or integrationist perspective do not subscribe to any of these formal models. Instead, therapists appear to use their own eclectic or integrationist models based on personally intuitive criteria (Hollanders & McLeod, 1999). In regards to the influence of personal factors on the use of theory, Beutler (1989) summarized the point well:

> Once we accept the idea that any psychotherapist's theoretical viewpoint is hopelessly intertwined with personal experiences and beliefs, it follows that one cannot expect to find an acceptable integration among all therapist's theories any more than one can find a single religion to which all the world will pay homage. (p. 20)

Current Perspectives in Psychotherapy Integration

A common theme among the factors contributing to psychotherapy integration is the movement toward improving treatment efficacy and efficiency. It appears that approaches to psychotherapy integration are especially alluring for this purpose, due to

the ability to freely incorporate different treatment strategies and techniques (Norcross, 1995). These approaches are also amenable to changes in regulations established by such governing agencies as managed care (Smith, 1999). With this, it is evident that such factors have seemingly come to contribute to the popularity of psychotherapy integration.

Discussion to this point has restricted the focus to broad-band eclectic/integrative approaches, but with this comes a drastic over-simplification of the status of psychotherapy integration. As I stated above, there is a relative lack of information on the distribution of narrow-band approaches to psychotherapy integration used by practicing psychologists. According to the literature, however, there are three dominant types of narrow-band approaches: theoretical integration, technical eclecticism, and common factors (Arkowitz, 1997; Castonguay & Goldfried, 1994; Goldfried & Norcross, 1995). I will briefly review of these three categories.

Theoretical integration. This approach to theoretical rapprochement is generally defined as a combination of theoretical concepts into a unitary and consistent theory of psychopathology and change. The goal of such an undertaking is to satisfy perceived shortcomings of theories through the incorporation of concepts from other theories, without becoming contradictory. Therefore, the ultimate achievement of such a process would be to create a theory that is comprehensible, able to guide therapists to more efficacious therapy than traditional single school models, and flexible enough to allow future accommodation (Arkowitz, 1997; Castonguay & Goldfried, 1994; Goldfried & Norcross, 1995). In sharp contrast to technical eclecticism, the primary focus remains on theory instead of focusing predominantly on techniques, which integrationists would say come out of and are critically linked to theory.

Not all attempts at theoretical integration take the same approach. In fact, three different types of theoretical integration have been identified (Arkowitz, 1997). A *translation model* simply draws parallels between concepts in theories. A *complementary model* uses different theoretical approaches with different stages in therapy or different presenting issues. A *synergistic model* combines two or more theories to simultaneously work on the same presenting issues, with the expectation that these theoretical concepts interact producing a more efficacious approach.

Early approaches at theoretical integration were criticized as simply using a translation model to bridge the gap between theories, primarily between psychodynamic and behavioral theories (Arkowitz, 1997; Castonguay & Goldfried, 1994; Goldfried & Norcross, 1995). Contemporary attempts at theoretical integration, however, concentrate more on the latter two types of theoretical integration. An example of a complementary model of theoretical integration can be found in Carkhuff's Human Technology (Aspy, Aspy, Russel, & Wedel, 2000). In Human Technology, the therapeutic process is broken down into three sequential phases beginning with Humanistic/Existential approaches to explore issues, followed by Psychodynamic approaches to promote understanding, culminating in the use of Behavioral approaches to promote action (Aspy et al., 2000).

The most discussed example of theoretical integration, Wachtel's integration of psychodynamic and behavioral theories (Arkowitz, 1997; Castonguay & Goldfried, 1994; Goldfried & Norcross, 1995), is an example of the synergistic model of integration. Stricker and Gold's (1996) approach to psychotherapy integration is another example of the synergistic model. The central aspect of this approach is an evolving, theoretical base that combines theoretical concepts from psychodynamic and interpersonal theories,

which allows for further innovation and provides a perspective of reciprocal relationships between behavior, cognition and affect, and unconscious mental processes.

Technical eclecticism. Technical eclecticism in general refers to any system of psychotherapy that utilizes techniques from varying theoretical orientations, without importing the theoretical assumptions that lead to their origination. Instead, techniques are gathered and used based solely on the criteria of empirical support. It is often estimated that this approach is absent of theory, but atheoretical technical eclecticism is just one variation within this approach. Other approaches, commonly termed assimilative eclecticism (Smith 1999), are centered on a unifying theory, allowing clinicians to conceptualize presenting issues and unify the techniques that are implemented based on the central theory. Lazarus' Multimodal therapy, for example, is centered on social learning theory (Lazarus, 1996). The promise of such an approach appears to be spreading to other theoretical orientations, such as psychodynamic (Fonagy, 1999). This is illustrated in Fonagy's (1999) call for the development of a technical eclectic approach centered around Psychodynamic therapy when he states that psychodynamic therapists should "make use of advances in other fields to optimize the effectiveness of their technique" (p. 519).

Currently, the literature typically discusses two predominant subtypes of technical eclecticism: Lazarus' Multimodal therapy and Beutler's Systematic Psychotherapy (Arkowitz, 1997; Castonguay & Goldfried, 1994; Goldfried & Norcross, 1995). Lazarus' Multimodal therapy (Lazarus, 1995, 1996), as discussed above, is centered on Social Learning theory, yet as Lazarus states "I am free to draw on effective techniques from virtually any discipline" (Lazarus, 1996, p. 66). In his estimation, it is wrong to assume

that the use of techniques from varying theoretical orientations directly implies that the associated theory is being applied or that the practitioner is being inconsistent to his/her primary theoretical orientation.

Instead, "treatments of choice" (Lazarus, 1995, p. 6), which are defined as empirically validated techniques for specific issues, should and can be employed irrespective of the theoretical origination of the technique. These techniques are assimilated into the theoretical context of the psychologist and take on meaning from that theoretical orientation. With this, it is the practitioner's goal to address the client's issues holistically by focusing on seven key components of the individual that are posited by Lazarus to encompass the personality (Beutler, Consoli, & Williams, 1995; Lazarus, 1992). These components are summarized with the acronym BASIC ID, which stands for behavior, affect, sensation, imagery, cognition, interpersonal relationships, and drug/biology.

Beutler's Systematic Psychotherapy, more recently termed Prescriptive Therapy, (Beutler & Consoli, 1993; Beutler, Consoli, & Williams, 1995; Beutler & Martin, 2000; Groth-Marnat, Roberts, & Beutler, 2001) is similar to the Multimodal therapy in that they both promote the use of empirically validated treatments. Each also places relatively little emphasis on theories of psychopathology, but the attention they do give is quite distinct from one another. While Lazarus promotes the use of traditional theory as a guiding and unifying force in therapy, Beutler limits the influence of traditional theory to the content of psychotherapeutic messages and uses his theory of "decisional processes", Systematic Treatment Selection (STS), (Beutler et al., 1995, p. 276; Beutler & Martin, 2000) to guide therapy.

In its current form this decision making process is highly operationalized consisting of four steps, which each have well-defined sub-steps. This process allows the therapist to work sequentially through assessing relevant client characteristics (e.g. problem complexity), considerations of the treatment context (e.g. modality), evaluation of client-therapist relational factor (e.g. therapist-client matching), and formulating the strategies of therapy (e.g. objectives). Specific assessment tools are suggested and prescriptive approaches are recommended based on the information gathered. Of particular note, is the consideration that this approach places on the use of manipulated relationship styles, to better match the client and bolster the prescribed technique's effects (Beutler & Consoli, 1993; Beutler et al., 1995; Mahoney & Norcross, 1993; Norcross, 1993).

Prescriptive Therapy (PT) is informed by the STS process and is guided by ten principles of therapeutic change (Beutler & Martin, 2000). It is held that these principles provide a flexible framework within which techniques from varying schools of thought may be utilized. Therapist's "use their own array of techniques and their own imagination to develop a treatment plan that is consistent with these principles" (Beutler & Martin, 2000, p.13). Therefore, STS provides an empirically supported method of individualizing treatment in the context of the client, therapist, and presenting issue, while PT provides a framework therapists use to organize their therapeutic approach.

Common factors. The common factors approach varies significantly from both theoretical integration and technical eclecticism, in that instead of being based on concepts and techniques that are specific to different theories, it is based on the components of theory that are common to all theories (Weinberger, 1993; 1995). The goal of such an approach is to allow for the determination of what is truly beneficial from

therapy, since most theories produce equitable results across presenting issues. With such a discovery, it would then be possible to concentrate more specifically on the effective components of therapy, while minimizing the potentially unnecessary specific factors that may not significantly impact the therapeutic process.

Researchers from the common factors camp has consistently found that specific factors account for a small amount of the therapeutic change. In a meta-analysis of component studies, Ahn and Wampold (2001) report that the specific factors purported by the theories of origin to be critical to the treatment actually accounted for a non-significant amount of therapeutic change. Instead, all treatments achieved "approximately equal benefits generally" (p.254). In a separate meta-analysis, Wampold (2001) concludes that common factors account for 70% of the variance in the therapeutic outcome, while specific factors account for only 8% of the variance. Therefore, common factors such as the healing context, belief in the rationale and efficacy of therapy, the therapeutic alliance, use of approaches consistent with the client's understanding of his or her issues, increased self-efficacy, and remoralization are held to be at the heart of therapeutic efficacy and the explanation for the approximate equivalency of psychotherapies (Ahn & Wampold 2001).

As discussed by Weinberger (1995), however, the term common factors may be a misnomer in that not all theories attend to each factor equally. In fact, the equality of therapies in research may be as much a result of the disuse of these factors as it is the common use of them. Therefore, the examination of the effective factors of therapy and the consistent use of them in therapy is posited to be able to increase the efficacy of psychotherapy. To illustrate this point, Weinberger (1995) discusses five factors that are

common to one school and only tangentially considered by other schools, yet they appear to be related to outcome research. These proposed factors include the therapeutic relationship, expectations of therapeutic success, confronting or facing the problem, providing an experience of mastery or cognitive control over the problematic issue, and an attribution of therapeutic success or failure (Weinberger, 1995). Thus, the future of this approach appears to rest on the ability to utilize outcome research to identify common factors, instead of relying on the examination of theories to identify factors that are purported to be influential in each.

Common factors or principles of change may be identified through an encompassing system meant to summarize the entire therapeutic interchange, but may also be identified through a focus on an isolated principle of change. Wiser and Arnow (2001) and Greenberg and Bolger (2001) for example, provide a useful review of the utility of emotional experiencing regardless of theoretical affiliation. Together these articles provide a rationale for clients who might benefit from emotional experiencing and articulate process sequences that might guide this experiencing in therapy regardless of theoretical orientation.

Contradictions in Psychotherapy Integration. When comparing psychotherapy integration to traditional single schools of therapy, there is a general consensus among contributors to this field that, as stated by Goldfried and Norcross (1995), "the ultimate outcome of integration and eclecticism, not yet fully realized, is to enhance the efficacy efficiency, and applicability of psychotherapy" (p. 254). Further, as discussed above, there are strong reactions to single school approaches centered on their purported inability to fully account for the complexity of the therapeutic situation. When

examining intra-psychotherapy integration debates, however, this consensus falls by the wayside.

Contributors to the different styles of integration ardently defend their position often at the expense of the others. For example, as Lazarus (1996) states, "it cannot be overstated that the effectiveness of specific techniques may have no bearing on the theories that spawned them" (p. 60). Another critique from technical eclecticism aimed at both theoretical integration and common factors comes from Beutler et al. (1995) when they state, "we do not believe that therapists will, can, or should agree on a common theory of psychopathology and change. To do so would signal that growth of new knowledge and creativity of thought have been stifled" (p. 276).

Arguments against technical eclecticism center on the separation of theory and technique as illustrated by Mahoney's (1993) comment that "technical eclectics may be fundamentally wrong in thinking that techniques can somehow be removed from theory, as well as thinking that personal processes and tacit theories of psychopathology/therapy play no significant role in the practice of eclectic psychotherapy" (p. 6). A further critique of technical eclecticism takes away the identity of this approach by asserting that it is essentially a form of theoretical integration, due to its use of an organizing system of psychotherapy (Beitman, 1989).

Compromises in Psychotherapy Integration. Contradicting these critiques is the prevalence of approaches to psychotherapy integration that are difficult to categorize in only one of these three categories. I will delineate three such approaches that contain elements of more than one of the above approaches. The first two to be reviewed have been discussed as both examples of theoretical integration and common factors.

First, transtheoretical therapy (Arkowitz, 1997; Castonguay & Goldfried, 1994; Goldfried & Norcross, 1995; Prochaska & DiClemente, 1982; Prochaska & DiClemente, 1992), developed by Prochaska and DiClemente, was created in response to work with addictions, however, it has come to be recognized as an approach with wider appeal. Their transtheoretical therapy has received a great deal of attention in review articles. It has been reviewed as one of the dominant common factors approaches (Arkowitz, 1997) and as an example of theoretical integration (Castonguay & Goldfried, 1994; Goldfried & Norcross, 1995).

Prochaska and DiClemente (1992) presented their theory in a chapter of the Handbook of Psychotherapy Integration (Norcross and Goldfried, 1992) as an example of theoretical integration. The creation of this approach followed a review of 18 leading systems of therapy, generating an initial five basic processes of change (Prochaska & DiClemente, 1982) and later expanded to ten processes of change (Goldfried & Norcross, 1995; Prochaska & DiClemente, 1992). These processes of change are used within a stage system of therapy, in which therapy is described in an invariable sequence of stages (precontemplation, contemplation, preparation, action, and maintenance). So, transtheoretical therapy combines processes of change, or common factors, and an outline for the sequential use of different theories to match the client's current stage.

Second, Beitman's model (1989) is presented as a form of complementary theoretical integration. The model is organized with the concept that "the individual psychotherapeutic relationship recapitulates the historical development of psychotherapy" (p. 264). In such, the therapeutic process progresses through the use of Psychodynamic theories, Behavioral theories, Humanistic theories, and concludes with

the use of multiple contemporary theories (e.g. cognitive, family systems) in order to progress through four identified stages in therapy (engagement, pattern search, change, and termination).

However, in his discussion in the Handbook of Psychotherapy Integration (Norcross & Goldfried, 1992) Beitman (1992) describes his approach as a common factors approach. At this time, he reports relying on eight guiding principles that he views as common to all theories as well as highlighting useful pieces of theories that are unique to that theory. Therefore, while Beitman's model seemingly changed from theoretical integration to common factors, the final product is written as including eight guiding principles, or common factors, as well as the synergistic integration of components of different theories.

The third approach to transcend the types of psychotherapy integration was presented above as an example of theoretical integration. The creators (Stricker & Gold, 1996) identify their approach as theoretical integration due to the incorporation of psychodynamic and interpersonal theories to provide a structure to therapy. This approach also, however, incorporates concepts from technical eclecticism in that "when indicated, either on the basis of clinical experience or research evidence" (Stricker & Gold, 1996, p. 51) there may be an assimilative use of techniques from outside of either psychodynamic or interpersonal therapy.

In summary, prototypical approaches to psychotherapy integration may fall into one of three categories (theoretical integration, technical eclecticism, and common factors), which have specific and varying goals. These goals could be summarized in that theoretical integration attempts to create a theory of psychopathology/personality,

technical eclecticism attempts to develop objective strategies to guide therapy, and common factors attempts to develop a theory of psychotherapeutic process. As can be seen from the examples, however, in practice these goals may not be as at odds as it would appear from debates within the field of psychotherapy integration.

In addition to the approaches, which appear to transcend the categories of psychotherapy integration, a number of authors have begun to attempt compromises among the narrow-band schools of psychotherapy integration. The most notable at this time is Messer's assimilative integration (1992). Messer's assimilative integration is purported to be a middle ground between a possibly unattainable (accommodative) theoretical integration and an incomplete technical eclecticism. In this approach therapists are encouraged to maintain their affiliation with their primary theoretical orientation, yet assimilate theoretical concepts and techniques that might address the original theories weaknesses. Lampropoulos (2001) discussed two main advantages of this perspective. First, "therapists can transcend limitations of their original theory, using highly effective, but previously "forbidden" techniques" (p.12). Second, therapist's retain a theoretical framework to guide his or her therapeutic practice.

Even for this compromise, however, there are critiques available. For example, Wolfe (2001) warns that models of assimilative integration may "remain an inconsistent hybrid of theoretical purism and eclectic practice" (p.127). The most common critique of the approach, however, is that alone it would contribute to the ever-expanding number of theoretical approaches, because it promotes the creation of new approaches through the incorporation of concepts and techniques into pre-existing theories (Carere-Comes, 2001; Lampropoulos, 2001; Wolfe, 2001). However, it might be a critical component of future

growth in the field when paired with (accommodative) theoretical integration (Carere-Comes, 2001; Wolfe, 2001). Therefore, accommodative approaches will attempt to create a unitary theory, which might become stagnate without the critical perspective of the assimilative approach.

A well-respected approach to assimilative integration can be found in the work of Safran and Segal (1990). The authors begin by discussing the limited attention that cognitive and cognitive-behavioral theorists have given to the therapeutic relationship, despite empirical evidence illustrating that these common factors account for a significant amount of therapeutic change. The author's suggest remediation of these perceived shortcomings in cognitive therapy through the incorporation of interpersonal and humanistic concepts.

A second compromise focuses on the struggle between common factors and empirically validated treatments (EVT's), which are at the heart of technical eclecticism (Chwalisz, 2001). Viewing the current state of affairs of both common and specific factors research as incomplete, the author suggests that it is entirely too early for a revolutionary change in the focus of psychotherapy research and practice to the exclusion of either approach. Instead, the focus should be a compromise where both common and specific factors are acknowledged and examined, so as to not ignore areas that both appear to have therapeutic value.

A third resolution focuses on addressing perceived shortcoming in the practicality of common factors and so discusses the consecutive use of common factors and theoretical integration (Castonguay, 2000). Specifically aimed at addressing training in psychotherapy integration, the author discusses the limitations of common factors as an

applied approach. These limitations include the inability of research to identify a succinct and consistent list of common factors, the inability to link common factors to etiology, and the potential inability to address specific concerns with the same common factors. To address these issues it is proposed that common factors be used within a guiding framework of either pure-form theory or theoretical integration with the incorporation of technical eclecticism for addressing specific therapeutic issues. In this respect common factors are placed at a meta-theory level and seen as principles that all approaches should abide by. In addition, common factors may serve as a common language to unite varying approaches.

A comment on the status of Psychotherapy Integration. Taking a lesson from the interaction of traditional schools of therapy and Kuhn's model of scientific revolution (Leahey, 2000), it is evident that psychology is still in the preparadigm phase and that strict adherence to one approach or theory may detract from the advancement of the field. Given the prevalence of psychotherapy integration, it appears that the majority of practicing psychologists are now open to transcending school lines (Norcross, 1995). Care should be taken that this openness to the advancement of psychology is not lost to a new type of partisanship, an outcome that would be particularly contradictory to the goal of psychotherapy integration. The difficulty with this openness, however, is that attempts of classifying psychotherapy integration in terms of theoretical integration, technical eclecticism, or common-factors may not accurately portray the approach used in therapy.

Classification Systems for Theoretical Orientation

The most common way to describe and classify the theoretical orientation of psychologists is the use of explicit theoretical orientation, wherein psychologists indicate

by self-report their preferred theory of psychotherapy and change (Najavits, 1997; Poznanski & McLennan, 1995a; Smith, 1999). There are two critical issues with this method, however, that question the utility of the use of explicit theoretical orientation as the only classification system. The first issue relates to the inability of research to distinguish between theoretical orientations in terms of treatment efficacy (Poznanski & McLennan, 1995a). This result questions the utility of explicit theoretical orientation in psychotherapy outcome research and promotes the use of additional or alternative classification systems to add specificity. The second issue relates to the popularity of psychotherapy integration in clinical practice and the relative inability to describe the practice of psychotherapy integration. Since "simply asking counselors to endorse the one self-ascribed theoretical perspective which informs their practice is unlikely to provide a comprehensive account of practitioners' theoretical preferences" (Poznanski & McLennan, 1998), more detail is needed on the use of psychotherapy integration than the primary theoretical influence.

A developing approach aimed at allowing for the assessment of more detail than explicit theoretical orientation has to do with the assessment of psychologists' underlying beliefs (Najavits, 1997; Poznanski & McLennan, 1995a; Smith, 1999). Such underlying beliefs have been labeled with such terms as latent theoretical orientations (Smith, 1999), implicit theories (Najavits, 1997), epistemological beliefs (Poznanski & McLennan, 1995b), and second order dimensions of theoretical orientation (Gelso, 1995). For consistency, I will refer to this concept from this point on as latent theoretical orientation. It is contended that individual latent theoretical orientations significantly influence the selection of explicit theoretical orientations (Poznanski & McLennan, 1995b; Smith,

1999). Also, latent theoretical orientation is hypothesized to directly and indirectly, through explicit theoretical orientation, effect therapeutic practices and the selection of therapeutic techniques (Najavits, 1997; Smith, 1999).

Given the role that latent theoretical orientations are believed to have, it is important to be able to assess such beliefs accurately and reliably. In a review of available assessments that have been purported to measure these underlying beliefs, Poznanski and McLennan (1995) determined that only two of fifteen instruments reviewed had adequate reliability and validity to support their use. Together, these instruments measured two dimensions of latent theoretical orientation, rational-intuitive and objective-subjective, which were later combined into one instrument, the Counselor Theoretical Position Scale (CTPS) (Poznanski & McLennan, 1998, 1999). The rational-intuitive dimension determines the degree of emphasis on either conscious or unconscious cognitive processes. The objective-subjective dimension examines the degree to which the respondent prescribes to the belief that human nature and behavior are influenced by perceived events or subjective experience. Utilizing the CTPS, Poznanski and McLennan (1998, 1999) were able to demonstrate that these two dimensions were successfully able to discriminate between respondents whose explicit theoretical orientation was Cognitive-Behavioral, Psychodynamic, Experiential, or Family Systemic.

While this approach shows promise in providing detail in the assessment of single school theoretical orientations, there has yet to be any attempts to use this classification strategy with psychologists who select an approach within psychotherapy integration as their primary theoretical orientation. Speculating on such a research study, Smith (1999) discusses potential results and their implications. One such result may be the discovery

of differences between Eclectic/Integrative and traditional single school therapist's on the basis of latent theoretical orientation. This difference may illustrate the reasons for the use of approaches to psychotherapy integration instead of traditional single school theories. An example of this might be that therapists who subscribe to psychotherapy integration may not favor either extreme on the dimensions, demonstrating openness to diverse perspectives that is distinct from the latent theoretical orientations of single school therapists. On the other hand, however, therapists who prescribe to psychotherapy integration may not cluster on these dimensions indicating a continued inability to further define the selection of Eclectic/Integrative approaches as the primary theoretical orientation.

Summary

It appears to be a safe prediction that given the current popularity and use of approaches to psychotherapy integration and the influence of factors that appear to support their use, psychotherapy integration will maintain its status as the most often chosen primary explicit theoretical orientation. Yet research on theoretical distribution offers very little in the way of illustrating the approaches used by those that label themselves as using eclectic, integrative, or common factors approaches. The label theoretical orientation is a global concept that often fails at providing adequate detail to discriminate between orientations of single school theories and has less of a chance at adequately defining what it is to practice psychotherapy integration, given the range of approaches within this broad-band approach.

Attempts at gaining more detailed information by asking for explicit reports of particular models of psychotherapy integration have contributed very little due to

therapists' apparent reliance on personal models and relative lack of use of formal models. Further, there are questions as to whether the current distinctions used (i.e. theoretical integration, technical eclecticism, and common-factors) can accurately classify approaches to psychotherapy integration. Therefore, given the apparent promise of assessing at the level of latent theoretical orientation, researchers need to examine approaches to psychotherapy integration using the rational-intuitive and the objective subjective dimensions, as compared to single school theories.

Purpose of Study

My primary purpose in this study was to examine any differences in latent theoretical orientation between psychologists who report practicing psychotherapy integration versus those who report practicing a single school therapy. A secondary purpose was to determine whether or not approaches to psychotherapy integration could be classified into distinct categories using latent theoretical orientation. In completing these two objectives, I also examined the distribution of theoretical orientations among practicing psychologists, with attention given to the distribution of narrow-band approaches to psychotherapy integration. Finally, I explored the factors that contribute to the use of psychotherapy integration.

My intentions for this study were explicitly stated in several guiding research questions. Is there an identifiable difference in the latent theoretical orientations of practicing psychologists who report practicing psychotherapy integration versus those who report practicing a single school therapy? Are approaches to psychotherapy integration capable of being categorized effectively by differences in latent theoretical orientation? What is the current distribution of theoretical orientations among practicing

psychologists? Of those practicing psychologist who practice psychotherapy integration, what is the distribution of formal narrow-band approaches to psychotherapy integration? What are the perceived factors that influence the use of psychotherapy integration?

CHAPTER II

METHOD

Participants

Participants were selected through requesting a randomly selected mailing list of 1000 doctoral level members of The National Register of Health Service Providers in Psychology. The National Register of Health Service Providers in Psychology generally sells randomized lists of members for research purposes. This source was selected to minimize criteria for inclusion and to focus on the target group, who are doctoral level psychologists actively involved in the provision of therapeutic services.

The provided list had 1006 doctoral level psychologist members; a minimum of 1000 names is given to students. The list included Ph.D. and Psy.D. members separated with a clear majority of Ph.D. candidates (928 and 78 respectively). The National Register assured me that the provided list was selected randomly, but then organized by type of doctoral degree. Therefore, proportionate numbers of Ph.D. and Psy.D. members were selected to represent the ratio from the entire list. A total of 800 practicing psychologists (the first 738 Ph.D. and 62 Psy.D. names of the list) were mailed the Professional Issues in Applied Psychology Survey and a letter, which conveyed information about the study for informed consent. A reminder postcard was sent to 300 psychologists (the first 277 Ph.D. and 23 Psy.D.), who previously received surveys, at approximately 2-months post survey mailing.

Of the originally mailed 800 surveys a total of 199 completed surveys were returned, for a return rate of 24.88 percent. The majority of respondents were male, Caucasian, Ph.D. recipients, trained in clinical psychology, and work in private practice. The gender distribution was 136 (68.3%) male and 63 (31.7%) female respondents. The ethnicity distribution was 187 (94.0%) Caucasian, 2 Hispanic, 1 African-American, 1 Asian American, 2 Native American respondents, 2 choosing "other", and 3 choosing not to respond. The distribution of type of doctoral degree was 163 (81.9%) Ph.D., 13 (6.5%) Psy.D., and 23 (11.6%) choosing not to respond. The distribution of psychology subfield was 155 (77.9%) clinical, 29 (14.6%) counseling, 13 (6.5%) selecting "other" or more than one, and 2 (1%) choosing not to respond. The primary work setting for 147 (73.9%) was independent practice with the remainder being distributed between hospital (9%), "other" (7%), community mental health center (4.5%), university counseling center (3%), medical school (2.0%), and school (.5%).

Procedures

The above-mentioned potential participants were mailed the Professional Issues in Applied Psychology Survey with a postage paid pre-addressed return envelope. The survey was estimated to take approximately fifteen minutes to complete, and consists of requests for demographic data, questions regarding the clinical use of theoretical orientations, and the Counsellor Theoretical Position Scale (CTPS) (Poznanski & McLennan, 1998). The CTPS is a 40-item questionnaire used to assess meta-theoretical beliefs. A letter accompanied the survey informing the participants how they were selected for this study, the study's general purpose, steps taken to ensure confidentiality, risks and benefits, and contact information. Participants were notified that their name

and address were secured from The National Register of Health Service Providers in Psychology. The general purpose of the study was presented generally as an examination of the clinical use of theoretical orientation and how this is related to underlying beliefs. Potential participants were notified that participation was voluntary, that no identifying data was required on the survey, and that the return of the survey implied consent to participate. The benefits of participation were limited to supporting the completion of this research, with no known risks. Participants were to understand that if they have any questions or concerns they were welcome to contact this researcher, my supervisor, or the Institutional Review Board for the protection of Human Subjects at the University of North Dakota. Appropriate contact information was provided. As reported above, reminder postcards were sent to the first 300 participants, all of whom had previously received a survey approximately 2 months prior to the postcard, in an attempt to increase the return rate. Completed surveys are to be kept for a minimum of 3 years following the end of the study in a locked and secure filing cabinet. While on internship the surveys were kept in my home office in DeKalb, IL and following my defense they were transported to the third floor of Montgomery Hall for the remainder.

Materials

Each questionnaire, the Professional Issues in Applied Psychology Survey, is composed of three particular sections. The first section requests demographic information related to gender, ethnicity, age, years of clinical experience, type of doctoral degree, sub-field within applied psychology, primary therapeutic setting, work time distribution, and theoretical orientation. This information was primarily used to ascertain whether the sample was representative of the population being studied, as compared to

demographic data provided in The National Register of Health Service Providers in Psychology. The second section consists of questions related to the clinical use of psychotherapy theories and techniques. In particular, this section asked participants to rate the influence of individual theoretical orientations on the theories and techniques used in therapy. Participants responded to questions regarding the acknowledged use of psychotherapy integration and use of formal frameworks of psychotherapy integration. Participants were asked to report whether their use of theory and technique related to provided definitions, which are definitions of approaches to psychotherapy integration. Finally, participants were asked to rank order factors that they identify as influential to their theoretical approach. The third section consists of the Counsellor Theoretical Position Scale (CTPS) (Poznanski & McLennan, 1998).

Counsellor Theoretical Position Scale. The CTPS is a 40-item instrument designed by Poznanski and Mclennan (1998, 1999) to measure two dimensions of latent theoretical orientation: Rational-Intuitive and Objective-Subjective. Each dimension is comprised of twenty questions requiring a response on a 7-point Likert scale, with 1 meaning completely disagree and 7 meaning completely agree. Poznanski and McLennan (1998, 1999) reported the internal consistency for the two dimensions as being acceptable, Rational-Intuitive= 0.87 and Objective-Subjective= 0.81. Construct validity is supported by factor analysis of the two dimensions, results of which show that all factor loadings, following varimax rotation, are greater than .30 for the predicted dimension (Poznanski & McLennan, 1999). Criterion-related validity is supported by correlations between scores on the dimensions of the CTPS and explicit reports of theoretical orientation, which are all in the predicted direction.

Hypotheses

Hypothesis 1: Psychotherapy integration was the most prominent broad-band theoretical orientation utilized by the practicing psychologists sampled.

Hypothesis 2: Psychologists reporting use of a single school theory cluster together on the dimensions of latent theoretical orientation, according to their respective theoretical orientation, while psychologists reporting use of an approach to psychotherapy integration do not produce a meaningful cluster, reflecting the diversity of approaches to psychotherapy integration.

Hypothesis 3: Psychologists reporting use of an approach to psychotherapy integration cluster into groupings based on the two dimensions of latent theoretical orientation, reflecting commonalities among approaches.

Hypothesis 4: The majority of practicing psychologists who report using an approach to psychotherapy integration did not report using a formal approach.

Hypothesis 5: Respondents would choose "client needs" as the most prominent influence on their use of theory and techniques.

Analyses of Data

All data analyses were computed utilizing the SPSS software package for Windows version 10.0. The analyses used consist of descriptive, hypothesis testing, and exploratory procedures. Descriptive analyses of the data were used to describe the sample of psychologists in the study, as well as to illustrate the distribution of theoretical orientations. Measures of central tendency and variation, as well as frequency and percentages were used in this description of the data.

Hypothesis testing analyses.

Hypothesis 1: A Chi-Square Goodness of Fit Test was computed to test the underlying hypothesis that theoretical orientation was not distributed evenly. Descriptive statistics were used to illustrate the stated hypothesis that psychotherapy integration was the most prominent broad-band orientation reported.

Hypothesis 2: A discriminant analysis was computed to test the hypothesis that latent theoretical orientation of psychologists reporting a single school orientation cluster by respective theoretical orientation and that latent theoretical orientation of psychologists reporting psychotherapy integration did not produce a meaningful cluster.

Hypothesis 3: A Heirarchical Cluster Analysis was computed to test the hypothesis that latent theoretical orientation among psychologists reporting psychotherapy integration cluster into distinct and meaningful groups, which represent different approaches to psychotherapy integration.

Hypothesis 4: A Chi-Square Goodness of Fit Test was computed to test the underlying hypothesis that formal approaches to theoretical orientation will not be distributed evenly. Descriptive statistics were used to illustrate the stated hypothesis that "no formal approach" will be the most common approach.

Hypothesis 5: A Chi-Square Goodness of Fit was computed to test the hypothesis that psychologists would report "client needs" as the most prominent influence on their use of theory and techniques.

CHAPTER III

RESULTS

In examining potential group differences of the 199 practicing psychologists who completed surveys, gender, psychology sub-field (limited to clinical vs. counseling), and type of doctoral degree (Ph.D. vs. Psy.D.) were examined on primary theoretical orientation, rational/intuitive dimension scores, and objective/subjective dimension scores. The factor of ethnicity was not examined statistically, because of the small number of respondents who self-reported as a member of an ethnic group other than Caucasian. An alpha level of .05 was used for all statistical tests.

To test the distribution of primary theoretical orientation, a Chi-Square was run for each factor. There were no differences on any factor in the distribution of primary theoretical orientation. For gender, $X^2(8, N=177)= 9.849$, $p=.276$; for Psychology Subfield $X^2(8, N=160)= 6.767$, $p=.562$; and for Type of Doctoral Degree $X^2(8, N=152)= 3.215$, $p=.920$. To examine group differences on the dimension scores, independent samples t-tests were performed for each factor. No group differences were found on either dimension. On the Rational/Intuitive Dimension for gender the $t(197)= 1.587$, $p= .114$; for Psychology Subfield the $t(182)= .769$, $p= .443$; and for Type of Doctoral Degree the $t(174)= .260$, $p= .795$). On the Objective/Subjective Dimension for gender the $t(197)= 1.918$, $p= .057$; for Psychology Subfield the $t(182)= .059$, $p= .953$; and for Type of Doctoral Degree the $t(197)= .147$, $p= .883$. Therefore, despite the uneven distribution

distribution of these factors among the sample, these factors do not appear to be confounding grouping variables that might effect further analyses.

Hypothesis 1. Theoretical orientation was assessed in three different ways. First, participants were simply asked to report their theoretical orientation, overt theoretical orientation. Each participant's first three orientations, when applicable, were collected as data. Analyses and reported percentages are based on valid responses only, with 171, 67, and 21 valid responses for primary theoretical orientation, secondary theoretical orientation, and tertiary theoretical orientation, respectively. Reported theoretical orientations were categorized into eight broad-band categories, including behavioral, cognitive, eclectic/integrative, humanistic/existential, interpersonal, "other", psychodynamic, and systems. Due to the number of responses, the narrow-band category of cognitive-behavioral was also used.

The distribution of the respondents' primary theoretical orientation is represented in Table 2. The three most reported primary explicit theoretical orientations were psychodynamic (29.8%), eclectic/integrative (26.9%), and cognitive-behavioral (16.4%). Results of a Chi-Square Goodness of Fit Test on primary theoretical orientation indicate that theoretical orientation was not distributed evenly, $X^2(8, N=171)= 143.053$, $p=.000$. As can be seen from the distribution within primary theoretical orientation, the most often reported theoretical orientation was not eclectic/integrative as hypothesized, but psychodynamic. However, if cognitive-behavioral were to be subsumed by the broad-band category of eclectic/integrative, due to the integrative nature of cognitive-behavioral theory, approaches to psychotherapy integration would be the most often reported primary theoretical orientation accounting for 43.3% of respondents.

Table 1

Distribution of Primary Theoretical Orientation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Psychodynamic	51	25.6	29.8	29.8
	Eclectic/Integrative	46	23.1	26.9	56.7
	Cognitive-Behavioral	28	14.1	16.4	73.1
	Behavioral	16	8.0	9.4	82.5
	Humanistic/Existentia	9	4.5	5.3	87.7
	Cognitive	8	4.0	4.7	92.4
	Other	6	3.0	3.5	95.9
	Systems	5	2.5	2.9	98.8
	Interpersonal	2	1.0	1.2	100.0
	Total	171	85.9	100.0	
Missing	System	28	14.1		
Total		199	100.0		

The distribution of secondary theoretical orientation is presented in Table 2. Results of a Chi-Square Goodness of Fit Test for secondary theoretical orientation indicate that it is not evenly distributed, $X^2(9, N=67)= 24.791$, $p= .003$. The most often reported secondary theoretical orientation was cognitive-behavioral, accounting for 23.9% of valid responses, and cognitive, psychodynamic, and systems each accounting for 13.4% of valid responses. The distribution of tertiary theoretical orientation is presented in Table 3. Results of a Chi-Square Goodness of Fit Test for tertiary theoretical orientation indicate that there is no evidence to reject the null hypothesis that theoretical orientations are evenly distributed, $X^2(8, N=21)= 6.000$, $p= .647$.

Table 2

Distribution of Secondary Theoretical Orientation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Cognitive-Behavioral	16	8.0	23.9	23.9
	Cognitive	9	4.5	13.4	37.3
	Psychodynamic	9	4.5	13.4	50.7
	Systems	9	4.5	13.4	64.2
	Eclectic/Integrative	7	3.5	10.4	74.6
	Humanistic/Existentia	5	2.5	7.5	82.1
	Interpersonal	4	2.0	6.0	88.1
	Other	4	2.0	6.0	94.0
	Behavioral	3	1.5	4.5	98.5
	Feminist	1	.5	1.5	100.0
	Total	67	33.7	100.0	
Missing	System	132	66.3		
Total		199	100.0		

Table 3

Distribution of Tertiary Theoretical Orientation

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Systems	5	2.5	23.8	23.8
	Humanistic/Existentia	3	1.5	14.3	38.1
	Interpersonal	3	1.5	14.3	52.4
	Eclectic/Integrative	3	1.5	14.3	66.7
	Cognitive	2	1.0	9.5	76.2
	Psychodynamic	2	1.0	9.5	85.7
	Behavioral	1	.5	4.8	90.5
	Other	1	.5	4.8	95.2
	Cognitive-Behavioral	1	.5	4.8	100.0
	Total	21	10.6	100.0	
Missing	System	178	89.4		
Total		199	100.0		

Second, implicitly reported theoretical orientation was examined by asking participants to indicate their use of theory and technique in clinical practice through assigning percentages for both theory and technique to nine broad-band categories, including behavioral, cognitive, feminist, humanistic/existential, interpersonal, "other", psychodynamic, psychotherapy integration, and systems. In order to classify responses into an implicit primary theoretical orientation, I created a decision rule for inclusion. To be classified in a broad-band category other than psychotherapy integration a respondent would have needed to indicate the use of one theory more than 50% of the time and this score would be at least 20% greater than the next closest percentage; if, however, percentages were 50% or below, or within 20% points the participant was classified in the psychotherapy integration category. This decision rule was created in order to be less stringent than past research, which classified all participants reporting use of more than one theory as psychotherapy integration (Hollanders & McLeod, 1999), because this rule would have resulted in all but a small minority of participants being classified as using psychotherapy integration. The decision rule used in this study was chosen in order to allow those participants who reported using one theory the majority of the time to be classified as using pure theory.

When I used this classification system, psychotherapy integration was by far the most often used broad-band theoretical orientation, accounting for 70.1% of valid responses. The second highest broad-band theoretical orientation was Psychodynamic, which accounted for 17.0% of valid responses. The distribution for use of technique closely follows the distribution by theory with psychotherapy integration accounting for 64.1% of respondents, while psychodynamic techniques were reported as the next most used,

accounting for 14.8% of respondents. Tables 4 and 5 represent the distribution of respondents by theory and technique, respectively, using this classification system. Of note, a small minority of respondents who were classified as psychotherapy integration indicated use of only two broad-band categories, 15 for theory and 12 for techniques, leaving the majority endorsing three or more broad-band categories.

Table 4

Distribution of Primary Theoretical Orientation from Implicit Report

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Integration	136	68.3	70.1	70.1
	Psychodynamic	33	16.6	17.0	87.1
	Cognitive	9	4.5	4.6	91.8
	Behavioral	6	3.0	3.1	94.8
	Other	5	2.5	2.6	97.4
	Humanistic/Existential	3	1.5	1.5	99.0
	Interpersonal	2	1.0	1.0	100.0
	Total	194	97.5	100.0	
Missing	System	5	2.5		
Total		199	100.0		

Table 5

Distribution of Primary Techniques by Theory from Implicit Report

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Eclectic	117	58.8	64.3	64.3
	Psychodynamic	27	13.6	14.8	79.1
	Cognitive	16	8.0	8.8	87.9
	Behavioral	9	4.5	4.9	92.9
	Other	5	2.5	2.7	95.6
	Interpersonal	4	2.0	2.2	97.8
	Humanistic/Existentia	3	1.5	1.6	99.5
	Systems	1	.5	.5	100.0
	Total	182	91.5	100.0	
Missing	System	17	8.5		
Total		199	100.0		

The third and final attempt at assessing the use of theory was to ask the respondents to confirm or disconfirm the use of psychotherapy integration through responding to whether the definition of psychotherapy integration identified their use of theory and technique. I found that 89.8% of valid responses endorsed the use of some form of psychotherapy integration.

Hypothesis 2. I used a discriminant analysis using Fisher's classification function coefficients to test the hypothesis that psychologists reporting a theoretical orientation other than psychotherapy integration would cluster on the dimensions of latent theoretical orientation, while those reporting psychotherapy integration would not. Self-reported primary theoretical orientation was used as the grouping variable and the scores on the rationale-intuitive and objective-subjective dimensions were used as the independent variables. Due to the large number of psychologists indicating cognitive-behavioral as their primary theoretical orientation, approaches to psychotherapy integration were split between eclectic/integrative and cognitive-behavioral.

To check for the assumption of equality of covariances, I performed a Box's M test of equality of covariance matrices. No evidence was found to reject the null hypothesis that there are no differences among covariances, Approximate $F(21, 3833.102) = 1.466$, $p = .078$. I used the Kolmogorov-Smirnov Test to check univariate normality as part of the assumption of a multivariate normality. Both dependent variables, rational/intuitive and objective/subjective, were normally distributed (rational/intuitive $D(199) = .045$, $p = .200$; objective/subjective $D(199) = .051$, $p = .200$).

Two functions were created in this discriminant analysis. The Wilks' Lambda Test of Function indicated that functions 1 through 2 were significant, $\Lambda(16) = .483$, $p = .000$, but

that function 2 was not, $\Lambda(7)= .949$, $p= .287$. Function 1 had a Cononical Correlation of .701, thus function 1 accounted for approximately 49.1% of the overall variance, while function 2 had a Cononical Correlation of .225, accounting for only approximately 5.1% of the overall variance. Therefore, only function 1 will be interpreted in considering the results of the discriminant analysis.

Both dimensions appeared to contribute to the formation of function 1, with the direction of the contribution being positive for both the rational-intuitive and the objective-subjective dimensions. Therefore, a group with a high score on function 1 will have a high score on both the rational-intuitive and the objective-subjective dimensions. Between the two dimensions, however, Rational-Intuitive contributed more to the formation of the function and is more highly correlated with it. Function 1 discriminated most between the groups of behavioral (1.427), cognitive (1.221), and cognitive-behavioral (1.156), and the group of psychodynamic therapists (-1.151). The behavioral, cognitive, and cognitive-behavioral therapists would generally be described as relatively more rational and focused on objective data, psychodynamic therapists would generally be described as relatively more intuitive and more focused on subjective data. Humanistic/existential (-.663), interpersonal (-.403), and therapists selecting an uncategorized orientation (-.433), such as transpersonal, were relatively more intuitive and focused on subjective data, but to a lesser extent than psychodynamic therapists. Systems therapists (.538) were relatively rational and focused on objective data, but to a lesser extent than behavioral, cognitive, and cognitive-behavioral therapists. Eclectic/integrative therapists (.008) were as a group approximately equally rational and intuitive and open to both objective and subjective data .

Classification results are based on Fisher's classification function coefficients with assumed equal prior probabilities for all groups using with-in group covariance matrix. Leave-one-out classification (Jackknife) was also performed. The discriminant analysis based on both functions correctly classified 32.2% of the original cases. Using Leave-one-out classification, 27.5% of cases were correctly classified.

I followed up the discriminant analysis with a MANOVA in order to further analyze group differences on the dependent variables, rational/intuitive and objective/subjective. The descriptive statistics for primary theoretical orientation by latent theoretical orientation is provided in Table 6.

Table 6

Descriptive Statistics of Latent Theoretical Scores by Primary Explicit Theoretical Orientation

	THEORY	Mean	SD	N
Rational/ Intuitive	behavioral	3.978	.9452	16
	cognitive	3.831	.5719	8
	humanistic/existential	2.922	.5783	9
	interpersonal	2.825	.6718	2
	psychodynamic	2.508	.4743	51
	systems	3.590	.7326	5
	other	3.041	.8003	6
	eclectic/integrative	3.137	.5786	46
	cognitive-behavioral	3.743	.5132	28
	Total	3.155	.7852	171
Objective/ Subjective	behavioral	4.085	.7719	16
	cognitive	4.081	.5656	8
	humanistic/existential	3.183	.6042	9
	interpersonal	3.750	.2828	2
	psychodynamic	3.304	.5469	51
	systems	3.580	.4453	5
	other	3.275	.7751	6
	eclectic/integrative	3.720	.5470	46
	cognitive-behavioral	4.162	.5940	28
	Total	3.672	.6725	171

The multivariate test of significance using Pillai's Trace was significant, $F(16.000, 324.000) = 7.522$, $p = .000$, $\eta^2 = .271$. Follow-up F-tests of univariate significance were

significant for both rational/intuitive, $F(8, 162)=16.607$, $p= .000$, $\eta^2= .451$, and objective/subjective, $F(8, 162)= 7.591$, $p=.000$, $\eta^2= .273$). Post-Hoc analyses were conducted using Tukey's HSD. The results of Tukey's HSD are summarized in Tables 7 and 8, but generally parallel the results of the discriminant analysis.

Table 7

Homogeneous Subsets for Rational/Intuitive Dimension

Tukey HSD [a,b,c]

		Subset			
THEORY1	N	1	2	3	4
psychodynamic	51	2.5087			
interpersonal	2	2.8250	2.8250		
humanistic/existential	9	2.9222	2.9222	2.9222	
other	6	3.0417	3.0417	3.0417	3.0417
eclectic/integrative	46	3.1370	3.1370	3.1370	3.1370
systems	5		3.5900	3.5900	3.5900
cognitive-behavioral	28		3.7431	3.7431	3.7431
cognitive	8			3.8313	3.8313
behavioral	16				3.9781
Sig.		.539	.082	.088	.069

Note. Means for groups in homogeneous subsets are displayed.

a. Uses Harmonic Mean Sample Size = 7.244.

b. The group sizes are unequal. The harmonic mean of the group sizes is used. Type I error levels are not guaranteed.

c. Alpha = .05.

Hypothesis 3. I conducted three Hierarchical cluster analyses using Between-groups Linkage and Squared Euclidean Distance to test hypothesis three that psychologists reporting use of an approach to psychotherapy integration would cluster into groupings based on the two dimensions of latent theoretical orientation. I performed one cluster analysis for each method used to discern the use of psychotherapy integration, as discussed in reporting results for hypothesis I. For each analysis the dependent measures were rational/intuitive and objective/subjective. Also, for each analysis a range of solutions, two through ten, was saved for further analysis. Frequencies were then

calculated on each saved cluster solution in order to determine the most appropriate cluster solution for each analysis. A cluster solution was chosen when the addition of further clusters failed to delineate the largest clusters.

Table 8

Homogeneous Subsets for Objective/Subjective Dimension

Tukey HSD [a,b,c]

		Subset	
THEORY1	N	1	2
humanistic/existential	9	3.1833	
other	6	3.2750	3.2750
psychodynamic	51	3.3043	3.3043
systems	5	3.5800	3.5800
eclectic/integrative	46	3.7204	3.7204
interpersonal	2	3.7500	3.7500
cognitive	8	4.0813	4.0813
behavioral	16	4.0854	4.0854
cognitive-behavioral	28		4.1625
Sig.		.083	.095

Note. Means for groups in homogeneous subsets are displayed.

a. Uses Harmonic Mean Sample Size = 7.244.

b. The group sizes are unequal. The harmonic mean of the group sizes is used. Type I error levels are not guaranteed.

c. Alpha = .05.

The first cluster analysis performed was meant to cluster those respondents who had explicitly reported a primary theoretical orientation of either eclectic/integration or cognitive/behavioral. A total of 74 valid responses was used for this analysis, 46 eclectic/integrative and 28 cognitive-behavioral. The eight clusters solution was chosen for further interpretation. Of the eight clusters, four contained fewer than 5 percent of the respondents and so were dropped from further interpretation. The four largest clusters are represented in Figure 2 and descriptive statistics are provided in Table 9.

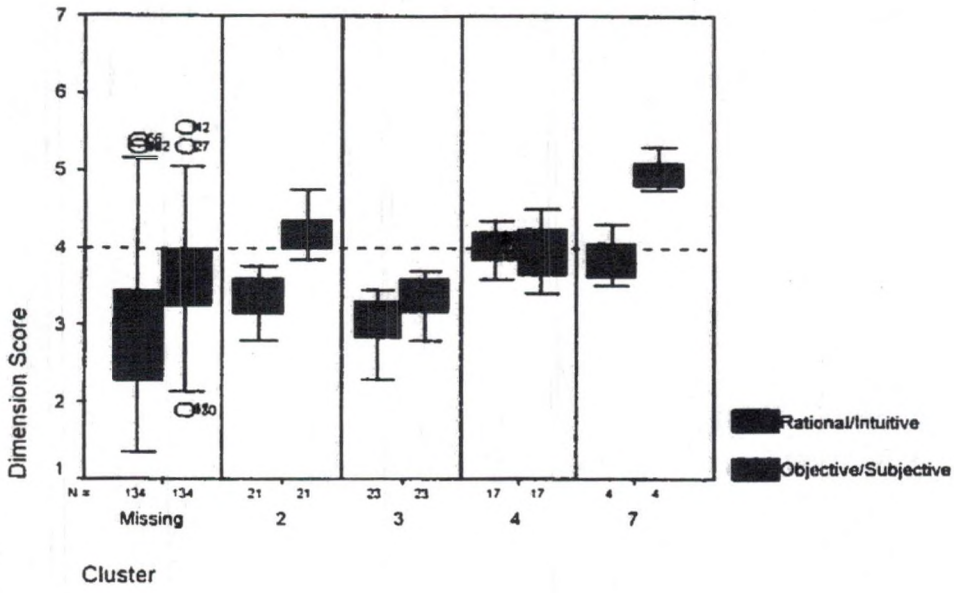


Figure 2. Rational/Intuitive and Objective/Subjective Dimension Scores by Cluster from Heirarchical Cluster Analysis of Psychologists who Explicitly Reported Psychotherapy Integration.

Note. The dimension scores are on a 7 point scale (1= Completely Intuitive or Subjective, 7= Completely Rational or Objective).

Table 9

Distribution by Cluster for Psychologists who Explicitly Report Psychotherapy Integration

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	3	4.1	4.1	4.1
	2	21	28.4	28.4	32.4
	3	23	31.1	31.1	63.5
	4	17	23.0	23.0	86.5
	5	3	4.1	4.1	90.5
	6	1	1.4	1.4	91.9
	7	4	5.4	5.4	97.3
	8	2	2.7	2.7	100.0
	Total	74	100.0	100.0	

I conducted a MANOVA with the dependent variables rational/intuitive and objective/subjective and the fixed factor being the cluster numbers for the four clusters chosen for interpretation, Pillai's Trace $F(6.000, 122.000) = 37.113$, $p = .000$, $\eta^2 = .646$. Univariate F tests were significant for both rational/intuitive, $F(3, 61) = 43.308$, $p = .000$, $\eta^2 = .680$, and objective subjective, $F(3, 61) = 58.723$, $p = .000$, $\eta^2 = .743$. Post Hoc analysis was performed with Tukey's HSD for each dependent variable. For rational/intuitive, all clusters were found to be different except for clusters four and seven, which had a mean difference of .1862, $p = .643$. For objective/subjective, all clusters were found to be different except clusters two and four, which had a mean difference of .1772, $p = .235$.

I conducted Crosstabs for primary theoretical orientation by cluster affiliation. The crosstabulation is shown in Table 10. A Chi-Square on the data was significant, $X^2(8, N=74) = 15.467$, $p = .030$, indicating that the distribution of primary theoretical orientation was not distributed evenly across clusters.

Table 10

Crosstabulation of Form of Explicit Psychotherapy Integration by Cluster Affiliation from Hiercharchical Cluster Analysis

Count

		Average Linkage (Between Groups)								
		1	2	3	4	5	6	7	8	Total
Primary Theoretcial Orientation	Eclectic/ Integrative	2	13	18	8	3	--	--	2	46
	Cognitive-Behavioral	1	8	5	9	--	1	4	--	28
Total		3	21	23	17	3	1	4	2	74

In the second cluster analysis I intended to group those respondents who were classified as using psychotherapy integration using the classification system described in

reporting the results of hypothesis I, where respondents were classified based on their estimated affiliation with nine broad-band theories. A total of 136 valid responses were used for this analysis. The eight clusters solution was chosen for further interpretation. Of the eight clusters, four contained less than 5 percent of the respondents and so were dropped from further interpretation. The four largest clusters are represented in Figure 3 and descriptive statistics for the eight-cluster solution are provided in Table 11.

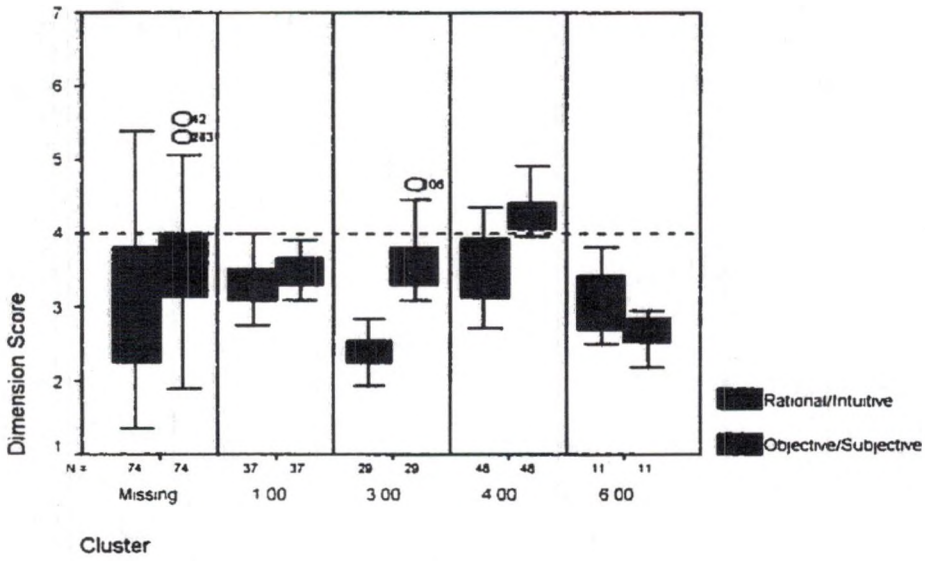


Figure 3. Rational/Intuitive and Objective/Subjective Dimension Scores by Cluster from Hierarchical Cluster Analysis of Psychologists who Implicitly Reported Psychotherapy Integration.

Note. The dimension scores are on a 7 point scale (1= Completely Intuitive or Subjective, 7= Completely Rational or Objective).

Table 11

Distribution by Cluster for Psychologists who Implicitly Report Psychotherapy Integration

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	37	27.2	27.2	27.2
	2	4	2.9	2.9	30.1
	3	29	21.3	21.3	51.5
	4	48	35.3	35.3	86.8
	5	2	1.5	1.5	88.2
	6	11	8.1	8.1	96.3
	7	4	2.9	2.9	99.3
	8	1	.7	.7	100.0
	Total	136	100.0	100.0	

I performed a MANOVA with the dependent variables rational/intuitive and objective/subjective and the fixed factor being the cluster numbers for the four clusters chosen for interpretation, Pillai's Trace $F(6.000, 242.000) = 72.298$, $p = .000$, $\eta^2 = .642$. Univariate F tests were significant for both rational/intuitive, $F(3, 121) = 60.349$, $p = .000$, $\eta^2 = .599$ and objective/subjective, $F(3, 121) = 114.630$, $p = .000$, $\eta^2 = .740$. Post Hoc analysis was performed with Tukey's HSD for each dependent variable. For rational/intuitive, all clusters were found to be different except cluster one, which did not differ from either cluster four or six. The mean difference between cluster one and four was -.2079, $p = .054$. The mean difference between cluster one and six was .2969, $p = .095$. For objective/subjective all clusters were found to be significantly different except clusters one and three, which had a mean difference of -.1378, $p = .204$.

I conducted Crosstabs for primary theoretical orientation by cluster affiliation. The crosstabulation is shown in Table 12. A Chi-Square on the data was significant, $X^2(56,$

N=136)= 105.259, p= .000, indicating that the distribution of primary theoretical orientation was not distributed evenly across clusters.

Table 12

Crosstabulation of Primary Theoretical Orientation by Cluster Affiliation from Hierarchical Cluster Analysis with Implicitly Reported Psychotherapy Integration

Count

		Cluster								
		1	2	3	4	5	6	7	8	Total
Primary Theoretical Orientation	missing	3	--	6	7	--	--	--	--	16
	Behavioral	1	2	1	1	2	1	1	--	9
	Cognitive	1	--	--	4	--	--	1	--	6
	Humanistic/ Existential	2	--	1	1	--	1	--	--	5
	Interpersonal	1	--	1	--	--	--	--	--	2
	Psychodynamic	4	--	12	3	--	4	--	1	24
	Systems	3	1	--	--	--	1	--	--	5
	Other	2	--	--	--	--	--	--	--	2
	Eclectic/ Integrative	14	1	7	15	--	4	--	--	41
	Cognitive-Behavioral	6	--	1	17	--	--	2	--	26
Total		37	4	29	48	2	11	4	1	136

With the third cluster analysis, I intended to group those respondents who affirmed that the definition of psychotherapy integration represented their use of theory and technique in practice. A total of 177 valid responses were used for this analysis. I chose the eight clusters solution for further interpretation. Three of the eight clusters contained less than 5 percent of the respondents and so were dropped from further interpretation. The 5 largest clusters are represented in Figure 4 and descriptive statistics for the eight-cluster solution are provided in Table 13.

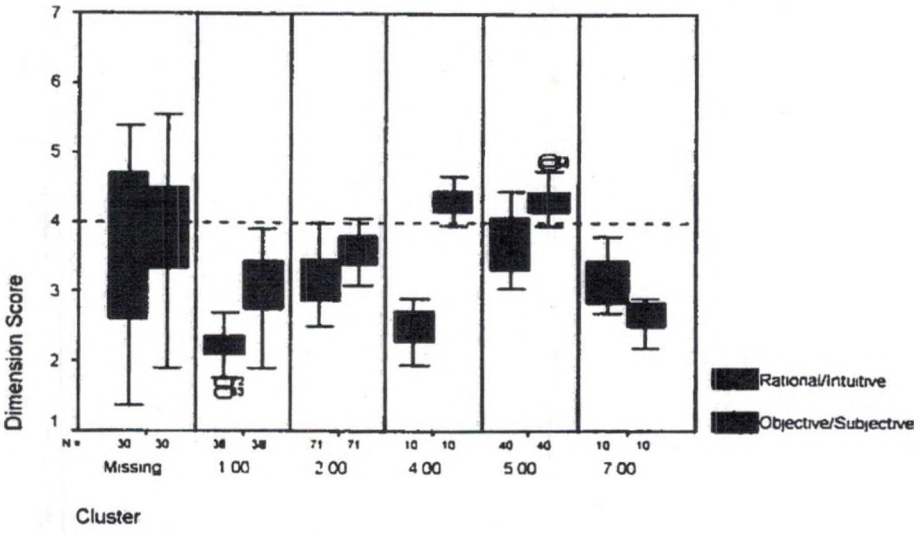


Figure 4. Rational/Intuitive and Objective/Subjective Dimension Scores by Cluster from Hierarchical Cluster Analysis of Psychologists who Implicitly Defined Personal Use of Psychotherapy Integration.

Note. The dimension scores are on a 7 point scale (1= Completely Intuitive or Subjective, 7= Completely Rational or Objective).

Table 13

Distribution by Cluster of Psychologists who Implicitly Defined Personal Use of Psychotherapy Integration

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	38	21.5	21.5	21.5
	2	71	40.1	40.1	61.6
	3	4	2.3	2.3	63.8
	4	10	5.6	5.6	69.5
	5	40	22.6	22.6	92.1
	6	1	.6	.6	92.7
	7	10	5.6	5.6	98.3
	8	3	1.7	1.7	100.0
	Total	177	100.0	100.0	

I conducted a MANOVA with the dependent variables rational/intuitive and objective/subjective and the fixed factor being the cluster numbers for the five clusters chosen for interpretation, Pillai's Trace $\underline{F}(8.000, 328.000)= 70.273$, $\underline{p}= .000$, $\eta^2= .632$. Univariate F tests were significant for both rational/intuitive, $\underline{F}(4, 164)= 92.627$, $\underline{p}=.000$, $\eta^2= .693$, and objective/subjective, $\underline{F}(4, 164)= 109.261$, $\underline{p}= .000$, $\eta^2= .727$. Post Hoc analysis was performed with Tukey's HSD for each dependent variable. For rational/intuitive, two pairs of clusters were not different from the paired cluster, while the remaining clusters were different from each other. The mean difference between cluster two and seven was -.0233, $\underline{p}= 1.000$. The mean difference between cluster one and four was -.2717, $\underline{p}= .226$. For objective/subjective all clusters were significantly different except clusters four and five, which had a mean difference of .0075, $\underline{p}= 1.000$.

I conducted Crosstabs for primary theoretical orientation by cluster affiliation. The crosstabulation is shown in Table 14. A Chi-Square on the data was significant, $X^2(63, \underline{N}=177)= 129.620$, $\underline{p}= .000$, indicating that the distribution of primary theoretical orientation was not distributed evenly across clusters.

Table 14

Crosstabulation of Primary Theoretical Orientation by Cluster Affiliation from Hierarchical Cluster Analysis with Self-Defined Use of Psychotherapy Integration

Count

		Cluster								
		1	2	3	4	5	6	7	8	Total
Primary Theoretical Orientation	missing	8	10	1	4	5	--	--	--	28
	Behavioral	--	2	1	--	3	1	1	1	9
	Cognitive	--	2	1	--	3	--	--	1	7
	Humanistic/ Existential	3	5	--	--	--	--	1	--	9
	Interpersonal	--	1	--	1	--	--	--	--	2
	Psychodynamic	20	15	--	1	2	--	4	--	42
	Systems	--	3	1	--	--	--	1	--	5
	Other	1	3	--	--	1	--	--	--	5
	Eclectic/ Integrative	6	22	--	3	11	--	3	--	45
	Cognitive-Behavioral	--	8	--	1	15	--	--	1	25
Total		38	71	4	10	40	1	10	3	177

Hypothesis 4. This hypothesis was that the majority of practicing psychologists who report using an approach to psychotherapy integration did not report using a formal approach. The analyses and interpretations made for Hypothesis IV are limited to those 177 respondents who affirmed the use of psychotherapy integration through responding that the definition applied to their use of theory and technique. Only 27 respondents reported the use of a formal approach to psychotherapy integration, with 26 providing a name or description of the formal approach, while 147 reported not using a formal approach. Table 15 shows the frequencies for reported use of formal approaches to psychotherapy integration.

Table 15
Psychologists' Reported Use of Formal Approaches to Psychotherapy Integration

		Frequency	Percent	Valid Percent
Valid	Personal	11	5.5	37.9
	Psychodynamic	2	1.0	6.9
	Prochaska and DiClemente	2	1.0	6.9
	Multimodal	2	1.0	6.9
	missing	1	.5	3.4
	Health	1	.5	3.4
	Wholistic	1	.5	3.4
	Social Learning Theory- Julian Rotter	1	.5	3.4
	Wachtel's	1	.5	3.4
	Cognitive-Behavioral	1	.5	3.4
	Prochaska & DiClemente plus CBT	1	.5	3.4
	Rogers	1	.5	3.4
	Systems	1	.5	3.4
	EMDR	1	.5	3.4
	Neurobiopsychosocial	1	.5	3.4
	Behavioral	1	.5	3.4
	Total	29	14.6	100.0
Missing	System	170	85.4	
Total		199	100.0	

To test the hypothesis that formal approaches to theoretical orientation will not be distributed evenly, I computed a Chi-Square Goodness of Fit Test for respondents who provided a formal approach. The distribution of formal approaches was not equal, X^2(14, N=26)= 43.231, p= .000, with the majority of respondents describing use of a personally derived approach. I computed a second Chi-Square to test the significance of the distribution for reported use of a formal approach. More respondents reported not using than using a formal approach to psychotherapy integration, X^2(1, N=177)= 82.759, p= .000.

In regards to types of psychotherapy integration used, I performed a Chi-Square to examine the reported use of different types of psychotherapy integration. Definitions of three approaches to psychotherapy integration (theoretical integration, eclecticism, and common factors) were provided, with both theoretical integration and eclecticism having sub-definitions to choose from. The frequency of reported use by form of psychotherapy integration is reported in Table 16. The results of the Chi-Square, X^2(10, N=177)= 77.419, p= .000, indicated that respondents were not evenly distributed on type of psychotherapy integration. The most commonly reported types of psychotherapy integration identified with were three forms of theoretical integration (different theory for different presenting issues (complimentary), simultaneous use of multiple theories (synergistic), and a general use of theoretical integration not further defined or with more than one subcategory checked) and two forms of eclecticism (eclecticism with a core theory (technical eclecticism) and a general use of eclecticism that was not further defined).

Table 16

Psychologists' Reported Use of Form of Psychotherapy Integration

		Frequency	Percent	Valid Percent
Valid	Integration- Analogous	7	3.5	3.7
	Integration- Stages	3	1.5	1.6
	Integration- Issues	29	14.6	15.2
	Integration- Simultaneous	31	15.6	16.2
	Integration- General	26	13.1	13.6
	Eclectic- Atheoretical	3	1.5	1.6
	Eclectic- Core Theory	34	17.1	17.8
	Eclectic- General	24	12.1	12.6
	Common Factors	10	5.0	5.2
	Other	15	7.5	7.9
	More Than One	9	4.5	4.7
	Total	191	96.0	100.0
Missing	System	8	4.0	
Total		199	100.0	

In order to examine the ability of type of psychotherapy integration to account for the variance in scores on the dimensions of latent theoretical orientation, I conducted an ANOVA with the dimension scores as the dependent variables and type of psychotherapy integration as the grouping variable. There were no differences between types of psychotherapy integration on either dimension score. For the rational/intuitive dimension, $F(10, 180) = 1.424$, $p = .173$, and for the objective/subjective dimension, $F(10, 180) = 1.482$, $p = .149$.

Hypothesis 5. This hypothesis stated that respondents would choose "client needs" as the most prominent influence on their use of theory and techniques. First, I conducted cross-tabulations and Chi-Square analyses for the first four ranks of ranked influences (ranks 5 through 10 were omitted because only 20 or less respondents ranked influences at these ranks) on the use of theory and technique grouped by use of explicitly reported

psychotherapy integration, defined as a self-reported primary theoretical orientation of either eclectic/integrative or cognitive-behavioral, or primary identification with a pure theory. On rank 1 ($X^2(6, N=189)= 6.733$, $p= .346$), rank 2 ($X^2(8, N=162)= 11.407$, $p= .180$), and rank 4 ($X^2(8, N=61)= 6.539$, $p= .587$), there were no differences in distribution between those psychologists who explicitly report use of psychotherapy integration and those who explicitly report the primary use of pure theory. For rank 3, however, there was a difference in distribution with $X^2(8, N=98)= 17.675$, $p= .024$.

Therefore, ranks1, 2, and 4 were examined for the sample, while rank 3 was reviewed for both those whose primary theoretical orientation reflects psychotherapy integration and those whose primary theoretical orientation reflects pure theory. In order to examine the distribution within each rank, I conducted a Chi-Square analysis for each. For rank 1, $X^2(6, N=189)= 230.370$, $p= .000$, indicating that the distribution of influences was not equal, with "client needs" receiving the most endorsements, followed by "critical perspective" and "Empirically-Validated Treatments". The distribution for rank1 is represented in Table 17.

Table 17

Rank 1 Influences on Use of Theory and Technique

	Observed	Expected	Residual
Number of Theories	1	27.0	-26.0
Perceived Equality of Theories	3	27.0	-24.0
Critical Perspective	40	27.0	13.0
Short-Term Therapy	5	27.0	-22.0
EVTs	30	27.0	3.0
Client Needs	92	27.0	65.0
other	18	27.0	-9.0
Total	189		

For rank 2, $X^2(8, N=162) = 150.333$, $p = .000$, indicating the distribution of influences was not equal, with "client needs" receiving the most endorsements, followed by "Empirically-Validated Treatments", and then "critical perspective". The distribution for rank 2 is represented in Table 18. For rank 4, $X^2(8, N=61) = 25.311$, $p = .001$, indicating the distribution was not equal. In rank 4 "Short Term Therapy", "Empirically-Validated Treatments", and "Managed Care" were the most endorsed influences with 13, 12, and 10 endorsements, respectively. The distribution for rank 4 is represented in Table 19.

Table 18

Rank 2 Influences on Use of Theory and Technique

	Observed	Expected	Residual
Number of Theories	2	18.0	-16.0
Perceived Equality of Theories	9	18.0	-9.0
Critical Perspective	31	18.0	13.0
Short-Term Therapy	13	18.0	-5.0
EVTs	45	18.0	27.0
Managed Care	5	18.0	-13.0
Medicalization	2	18.0	-16.0
Client Needs	48	18.0	30.0
other	7	18.0	-11.0
Total	162		

Table 19

Rank 4 Influences on Use of Theory and Technique

	Observed	Expected	Residual
Number of Theories	2	6.8	-4.8
Perceived Equality of Theories	6	6.8	-.8
Critical Perspective	9	6.8	2.2
Short-Term Therapy	13	6.8	6.2
EVTs	12	6.8	5.2
Managed Care	10	6.8	3.2
Medicalization	1	6.8	-5.8
Client Needs	7	6.8	.2
other	1	6.8	-5.8
Total	61		

For rank 3, I ran a Chi-Square for each sub-group, those indicating use of psychotherapy integration and those indicating use of pure theory. In regards to psychologists reporting use of psychotherapy integration, $X^2(8, N=50)= 30.640$, $p= .000$, indicating the distribution of influences across respondents was not equal. These psychologists selected "Critical Perspective" and "Short Term Therapy" most often. The distribution for rank 3 of psychologists reporting psychotherapy integration is represented in Table 20. In regards to psychologists reporting use of pure theory, $X^2(6, N=48)= 8.583$, $p= .198$, indicating that the distribution did not differ from equal. The distribution for rank 3 of psychologists reporting use of pure theory is represented in Table 21.

Table 20

Rank 3 Influences for Psychologists Explicitly Reporting Psychotherapy Integration

	Observed	Expected	Residual
Number of Theories	1	5.6	-4.6
Perceived Equality of Theories	3	5.6	-2.6
Critical Perspective	13	5.6	7.4
Short-Term Therapy	13	5.6	7.4
EVTs	7	5.6	1.4
Managed Care	5	5.6	-.6
Medicalization	3	5.6	-2.6
Client Needs	4	5.6	-1.6
other	1	5.6	-4.6
Total	50		

Table 21

Rank 3 Influences for Psychologists Explicitly Reporting Pure Theory

	Observed	Expected	Residual
Perceived Equality of Theories	9	6.9	2.1
Critical Perspective	10	6.9	3.1
Short-Term Therapy	3	6.9	-3.9
EVTs	11	6.9	4.1
Managed Care	4	6.9	-2.9
Client Needs	6	6.9	-.9
other	5	6.9	-1.9
Total	48		

CHAPTER IV

DISCUSSION

Summary of Findings

Hypothesis 1. The hypothesis that psychotherapy integration would be the most prominent broad-band theoretical orientation utilized by the practicing psychologists sampled was supported by the results. In this study, use of psychotherapy integration was defined in three different ways, yet consistently across definitions the use of psychotherapy integration was the most prominent perspective endorsed by psychologists, when cognitive-behavioral was subsumed within eclectic/integrative. The second most endorsed primary theoretical orientation was psychodynamic. These results are consistent with past research, which has reliably found that psychologists endorsed eclectic/integrative and psychodynamic approaches as the two most prominent primary theoretical orientations (Garfield & Kurtz, 1974; Norcross & Prochaska, 1982; Smith, 1982; Norcross, et al., 1993; Milan et al., 1994; Stone & Yan, 1997). I believe that these findings indicate the high prevalence of use of psychotherapy integration by psychologists across samples.

The findings are also consistent with past literature that implicit measures of use of psychotherapy integration indicate a higher percentage of psychologists endorsing this approach in their clinical work than is reported in explicit reports of primary theoretical orientation (Hollanders & McLeod, 1999). There are at least two possible interpretations for this. First, the stigma of syncretism, an uninformed and unsystematic approach to

psychotherapy integration, appears to remain prominent in the field. This stigma may negatively influence a psychologist's likelihood of reporting use of psychotherapy integration.

Second, the difference may exist due to the manner in which implicit and explicit measures of theoretical orientation are approached. Explicit theoretical orientation has been consistently operationalized as the primary theoretical orientation reported (Garfield & Kurtz, 1974; Norcross & Prochaska, 1982; Smith,1982; Norcross, et al., 1993; Milan et al.,1994; Stone & Yan, 1997). Implicit theoretical orientation, on the other hand, has been operationalized as the mere reporting of a secondary explicit theoretical orientation (Hollanders & McLeod, 1999). In the current study, implicit theoretical orientation was operationally defined in two ways, affiliation with more than one theory so that no theory was clearly prominent and endorsement of the provided definition of psychotherapy integration. Explicit measures, therefore, are notably restricted in their focus compared to implicit measures and so essentially are measuring different criteria. Further, when psychologists are asked to report their explicit theoretical orientation and allowed to provide more than one response, there may be a presumption that defining their approach with specific theories would be more informative than reporting eclectic, integrative, or common factors. Thus, more psychologists may endorse psychotherapy integration than is exhibited through focus on explicit primary theoretical orientation.

Hypothesis 2. The hypothesis that psychologists reporting use of a single school theory would cluster together on the dimensions of latent theoretical orientation, according to their respective theoretical orientation, while psychologists reporting use of an approach to psychotherapy integration do not produce a meaningful cluster was

partially supported. Of note, due to the large number of psychologists reporting the use of cognitive behavioral as their primary theoretical orientation, approaches to psychotherapy integration are split between eclectic/integrative and cognitive-behavioral.

I found, using both a discriminant analysis and MANOVA, that particular theoretical orientations could be differentiated using the dimensions of rational/intuitive and objective/subjective, while others could not. In summary, using the two dimensions distinctions can best be identified between psychologists endorsing behavioral, cognitive, cognitive-behavioral, or systems approaches from psychologists endorsing psychodynamic, humanistic/existential, or interpersonal approaches.

Psychologists endorsing eclectic/integrative fell approximately in the middle between the two groupings described above. Smith (1999) suggested two potential interpretations that need further exploration. Are psychologists who endorse a general eclectic/integrative approach open to both ends of the dimensions equally, so that they fall in the middle? Or, are psychologists who endorse a general eclectic/integrative approach unable to be classified by the scores on these two dimensions, due to with-in group variability that simply has a group mean that falls in the middle? I explore these questions further in the interpretation of hypothesis three.

I think it is important to exert some caution here that while there were differences between some theoretical orientations, this implies nothing about the clinical utility of these differences. My discussion to this point has considered relative differences, but it is also important to compare differences against the range of potential responses on the Likert-type scale. On the rational-intuitive dimension the most extreme scores were for psychologists who had explicitly reported a primary theoretical orientation of

psychodynamic and behavioral theories. Psychodynamic therapists' average response was between "Moderately Disagree" and "Somewhat Disagree", while behavioral therapists' average responses were approximately "Equally Agree and Disagree", where high agreement would mean high rational. On the objective-subjective dimension, the most extreme scores were for humanistic/existential and cognitive-behavioral therapists. Humanistic/existential therapists' average response was approximately "Somewhat Disagree", while cognitive-behavioral therapists' response was approximately "Equally Agree and Disagree", where high agreement would mean high objectivity.

Therefore, while the differences may be statistically significant, the relatively close scores out of the entire range of potential responses may call into question the utility of latent theoretical orientation as a predictor of primary theoretical orientation. I see three possible interpretations, which I will briefly introduce and further discuss in the limitations section below. First, this may be limitation of the assessment. For both dimensions the highest level of agreement fell between "Somewhat Agree" and "Moderately Agree". This may indicate a poor ability to assess the rational and objective ends of the dimensions. Second, due to the potentially restricted focus of primary explicit theoretical orientation, which ignores secondary, tertiary, etc. theoretical influences, the mean group-scores may not be meaningful, due to with-in primary theoretical orientation variance. Third, one potential limitation of Likert-type scales is the potential for respondents to avoid the extremes, which may artificially cluster groups within the mid-range of possible scores.

Hypothesis 3. I found support for the hypothesis that psychologists reporting use of an approach to psychotherapy integration would cluster into groupings based on the two

dimensions of latent theoretical orientation. Across the different methods of defining psychotherapy integration used, between 4 and 5 clusters were formed identifying different subgroups within psychotherapy integration based on the two dimensions. These clusters differed from each other on one or both dimensions. Therefore, it appears that Smith's (1999) observation that psychologists who endorse a general eclectic/integrative approach would have a mean for each dimension that places them in the middle of the groups is due more to with-in group variance rather than a true representation of openness on the dimensions of latent theoretical orientation.

Further, the distribution of explicitly reported primary theory across clusters indicates that certain clusters contain more of one theory than expected. This may help define these clusters, for example clusters with more psychologists who reported primary use of cognitive-behavioral consistently have higher scores on each dimension than clusters with more psychologists who reported primary use of psychodynamic theories.

However, the scatter of orientations across clusters may be interpreted as indicating that primary theoretical orientation fails to account for a good deal of variability. For example, one or more psychologists who endorse primary use of psychodynamic theory are distributed within each interpreted cluster, in the two cluster analyses that these respondents were included. Therefore, when focusing on psychologists who implicitly report use of psychotherapy integration, explicit primary theoretical orientation appears to provide some ability to define how group members would respond on the dimensions of latent theoretical orientation, however, this seems to be an oversimplification that fails to account for with-in primary theoretical orientation variance.

Hypothesis 4. The hypothesis that the majority of practicing psychologists who report using an approach to psychotherapy integration, through the endorsement of the definition of psychotherapy integration, did not report using a formal approach was supported. Only a few of the surveyed psychologists endorsed the use of a formal approach to psychotherapy integration, suggesting that most psychologists use personally defined approaches to psychotherapy integration. This is not entirely surprising when one considers the variance on the dimensions of latent theoretical orientation within explicitly reported theoretical orientations. It seems that the variance may be related to personal formulations of the clinical use of theory and technique. So, instead of using primary theoretical orientation as a classification system, it seems that use of latent theoretical orientation as a classification system may allow researchers the capability of better accounting for the personal influence on the use of theory.

In regards to types of psychotherapy integration (common factors, eclectic, and integrative), the most endorsed types were theoretical integration and eclecticism. However, there appears to be little clinical utility in examining the types of psychotherapy integration used, since types did not differ in regards to the scores on the dimensions of latent theoretical orientation. Therefore, while the use of types of psychotherapy integration may be a useful framework for discussing structural similarities and differences, these structural differences do not appear to relate to the clinical aspects assessed with latent theoretical orientation suggesting that more clinically useful narrow-band approaches should be defined.

Hypothesis 5. The hypothesis that respondents would choose "client needs" as the most prominent influence on their use of theory and techniques was supported. In rank

orders of the influences "client needs" was the most often endorsed influence both at rank 1 and rank 2. This finding is similar to the findings of Hollanders and McCleod (1999), who found that client needs was the most often reported influence on changing from pure theory to use of psychotherapy integration. However, in the Hollanders and McCleod (1999) study the influences for psychologists explicitly reporting pure theory were not examined, which may have kept them from seeing the similarity between these groups that was found in the current study. The endorsement of influences by rank did not differ between psychologists who explicitly reported use of psychotherapy integration and those who explicitly reported use of pure theory for ranks1, 2, and 4.

The similarity in endorsement of influences by all psychologists strongly supports that psychologists' main focus, as it probably should be, is on the needs of the client. Interestingly, both psychologists who endorse psychotherapy integration explicitly and those who do not equally endorse that they were influenced by "client needs" in shaping their use of theory and technique. I have two possibly relevant interpretations. First, consistent with cognitive schemas, it appears that psychologists' personal beliefs define what they view as the needs of the client. Psychologists who adhere to one theory strongly believe in the utility of that theory to address client needs, while psychologists who practice psychotherapy integration may hold the belief that multiple theories and techniques are required to address the diverse needs of clients. Second, as discussed above, explicit primary theoretical orientation may not accurately describe use of psychotherapy integration and so this comparison may be invalid. In this case the findings on the influences on use of theory and technique should be viewed for the entire sample rather than try to interpret meaning for separate groups.

Other influences that were highly endorsed were "Critical perspective toward available theories", "Empirically Validated Treatments", and "Short-Term Solution Focused Therapy". Each of these influences has been discussed as factors within psychology. This should be noted as a potential short-coming of survey research that relies on explicit report. Factors such as "Public opinion", "Medicalization of mental illness", and even "Managed Care" may be less likely to be reported due to the difficulty in identifying their effects compared to the more personally relevant factors.

Implications of Findings

Theoretical Implications. Theory in psychology appears to be going through a transformation from conceptual to pragmatic. In the continuing quest to make psychology more of a "hard" science, there seems to be a separation from its philosophical base. In one aspect of this transformation, psychotherapy integration, lines between traditional schools of thought are being crossed, leading to a decrease in theoretical partisanship. Traditional single school theories also appear to be influenced by the apparent trend toward pragmatism. Theories are, in general, amenable to change and re-interpretation (Smith, 1999). This ability to change speaks to the difficulty of disproving psychological theories. In the process of adapting to research findings there may be movement toward more efficacious therapeutic approaches within single school theories.

Past critiques about psychologists not following the scientific process were aimed at the deleterious effects of partisanship. By adhering to one theory that is seen as a "truth" the potential for further advancement is limited. Garfield (1994) commented on this ardent faith in one theoretical approach: "What has also been intriguing has been the

confidence and devotion that adherents to these approaches have manifested in the worth and validity of their approaches" (p. 123). Because psychologists have yet to agree on one model of psychotherapy and change, psychology remains in Kuhn's preparadigm phase of science (Leahey, 2000).

However, the finding in this study that psychologists for the most part incorporate more than one broad-band theoretical orientation in their clinical practice may be interpreted as a shift that is equally deleterious to the scientific process. The scientific process relies on both accommodation and assimilation to further scientific knowledge. The evidence suggests that psychologists are creating personally relevant assimilations and that attempts at accommodation (such as formal approaches to psychotherapy integration) are being ignored.

Broad-band primary theoretical orientation does not appear to have the explanatory power that latent theoretical orientation promises. Despite the drive to create theories, which accounts for having over four hundred theories (Karasu, 1986), interpretation of the results from this study may imply that broad-band theoretical orientation fails to explain the variance within primary theoretical orientation on dimensions of latent theoretical orientation. Plus, the majority of psychologists report being influenced by more that one broad-band theoretical orientation. To guide their use of theory and probably in-session behavior, it appears that psychologists are using their personal beliefs (latent theoretical beliefs), which they note are shaped by factors such as client needs, a critical perspective toward theory, empirically validated treatments, and short-term solution focused therapy. Smith (1999) pointed out that latent theoretical beliefs are also shaped by our values, life experiences, epistemology, and reading/training.

Latent theoretical orientation has the potential to allow researchers to guide psychology back to the scientific process. Latent theory can be used as a means to better define current theoretical orientations and provide a means to assess consistency with theory. Latent theory could also be used to create new and more clinically realistic orientations based on categorizing psychologists based on latent theory.

In regards to use with current theoretical orientations, latent theoretical orientation has important implications for training programs. The use of measures of latent theoretical orientation by training programs may ensure appropriate understanding and utilization of theoretical principles, potentially improving treatment efficacy. It is possible that the ability to ensure that psychologists' underlying beliefs are consistent with a specified theoretical approach may improve treatment efficacy, because this may help to reduce the potentially detrimental reliance on personally derived underlying beliefs (clinical intuition). More importantly, psychologists would be potentially more consistent with their explicit primary theoretical orientation allowing researchers to use the scientific process to improve treatment efficacy and scientific knowledge.

There are, however, two important concerns with this use of latent theoretical orientation. First, training psychologists to identify more closely with one theoretical orientation may create a situation in which psychologists as a whole develop tunnel-vision and are unable to view theories critically. Second, decreased intra-group differences and magnified inter-group differences are factors that lead to prejudice. Either of these concerns could potentially create a situation in psychology where partisanship is actually increased, thus potentially countering the current openness to

different perspectives and detracting from the benefits that might have come out of the use latent theoretical orientation.

Latent theoretical orientation may also be used to create distinct clinically-based orientations separate from overt theoretical orientation. The evidence from this study may be interpreted as suggesting that the attempt to create theories, which has recently been re-invigorated by attempts at psychotherapy integration, does not accurately address the clinical reality of the use of theory and technique. Instead of continuing the trend of flooding the field with different approaches, which may reinforce psychologists' critical perspective towards theory, it may be time for a paring down of the approaches to psychotherapy in order for the scientific process of psychology to work effectively. This may be best accomplished through clustering approaches to psychotherapy using latent theoretical orientation, a form of psychotherapy integration based on latent theory. When these clusters are created, researchers may use these as the basis of process and outcome research.

Theory to this point has been mainly created through top-down reasoning, however, theory could be created bottom-up based on the beliefs that psychologists are actually using to guide their clinical practice. This approach would be similar to the common factors approach, which entails researchers reviewing the components of the therapeutic process to identify commonalities that may account for therapeutic change. Specifically, using this approach, researchers would look for commonalities in latent theoretical orientation and cluster groups based on these, as done in this study. These groups could then be defined through qualitative processes, with the result being statistically and potentially clinically significant groups based on latent theoretical orientation. This

process would allow theories to be made that represent psychologists rather than training psychologists to fit into existing theories.

Research Implications. Currently outcome research is critically hampered by an inability to distinguish between psychotherapists based on theoretical orientation. A major contributing factor to this is the amount of intra-orientation variance (Poznanski & McLennan, 1995). In discerning significant inter-group differences, the variance-from-the-mean between the groups is compared with the variance-from-the-mean within the groups. Therefore, the amount of intra-orientation variance, due to the inability of explicit theoretical orientation to provide accurate and useful groupings, makes it difficult to recognize inter-orientation variation. Latent theoretical orientation is one possible solution to this, due to its ability to provide more detailed information and thus create groupings that are more internally consistent.

Maintaining traditional theoretical orientations, it is impossible to conduct meaningful outcome research without manualizing treatment in order to operationalize the theory and to reduce with-in group variance. This has been criticized, however, because it lacks ecological validity, unless psychologists are trained in and adhere to the manual outside of the research study. Also, in reviews of the literature, Wampold (1997) and Henry (1998) make the argument that most treatment variance when using treatment manuals is still found between therapists, and that strict adherence to a manual may actually decrease a therapist's efficacy. These issues call into question the utility of manualized treatment research.

If latent theoretical orientation were developed to more fully discern between approaches through the addition and refinement of dimensions, then this might allow for

more effective process and outcome research. Finding between-group differences relies heavily on limiting with-in group differences, so latent theoretical orientation should be used to identify psychologists whose underlying beliefs are consistent with the theory, with the hopes of decreasing the with-in group variance. Additionally, this would produce more valid results, because the participants would not have to alter their approach to therapy.

Latent theoretical orientation, along with other advances in psychotherapy outcome research, has the potential of improving researchers' ability to identify the most efficacious treatments available, whether the treatments are based on single school theories or approaches to psychotherapy integration. Improvement in the assessment of treatment efficacy with single school theories, will be made due to the increased ability to select a representative sample of psychologists who practice consistently with a given theory, thus reducing intra-orientation variance. Improvement in the assessment of treatment efficacy with approaches to psychotherapy integration, however, will need to begin with improving the classification of these approaches.

As seen in the results of the current study and the Hollanders and McCleod (1999) study, the majority of psychologists who practice psychotherapy integration do not use a formal model. Also, there appear to be limitations with the current classification system, which severely limit researchers' ability to categorize approaches in order to compare treatment efficacy. Therefore, as I did in this study, latent theoretical orientation can be used as a means to potentially distinguish between different approaches to psychotherapy integration, as well as provide for a selection process following the development of this classification system.

With improved research methodology in psychotherapy outcome research, such as the development of improved classification systems, researchers have the potential of demonstrating a potential superiority of psychotherapy integration over traditional schools of theory in treatment efficacy, thus justifying their use. Until this point, however, there needs to be a way to provide some description of what these psychologists are doing, in order to provide accountability. Currently, there are few restrictions in clinical practice for psychologists who report using an approach to psychotherapy integration, and there are no methods of determining in-session behavior.

The use of latent theoretical orientation has the potential for providing this accountability, through the assessment of more specific belief systems that directly influence therapeutic decision-making. Research may then focus on the relationship between these more specific components of latent theoretical orientation and treatment efficacy, with the potential of identifying therapist belief systems that might be associated with better treatment outcomes. Since the information gathered would be at a level that all therapists can relate to, separated from the potential partisanship of theoretical orientation, it is probable that this information could be more readily integrated into existing theories and approaches to psychotherapy, thus benefiting all approaches to therapy.

The assessment of latent theoretical orientations may be an important step in providing more information than explicit theoretical orientation alone, and may play a part in holding therapists accountable for their practice. It should be addressed, however, that since therapists' in-session behavior is what these classification systems try to represent, future researchers should focus on incorporating these classification systems in

psychotherapy process research. This will allow research to move beyond survey research and the inherent limitations associated with explicit reporting, and, instead, directly observe therapist behavior in relation to latent theoretical orientations. The end result may be the development of a more encompassing and accurate assessment tool of latent theoretical orientation, allowing researchers, educators, and psychologists in general to gather more detailed information about the working framework of an individual psychologist. Despite the ultimate concern with observed clinical behavior, latent theoretical orientation is a necessary step, due to the impracticality of observing clinical behavior for a large sample of clinicians. Thus, latent theoretical orientation may be used as a practical alternative.

Applied Implications. At present, psychotherapy researchers are unable to determine differences between theories in the outcome of treatment across presenting issues. Research has been consistent, however, in being used to support the utility of psychotherapy, with a common conclusion that all theories are effective (Norcross & Prochaska, 1982). The main implication of this is that those practitioners who affiliate with one theoretical orientation would appear to be practicing effectively. A limitation of this conclusion, however, is illustrated with the use of latent theoretical orientation. It appears that even when guided by a formal theoretical orientation, there is room for interpretation and possibly misinterpretation, which might significantly alter the utility of theoretical orientations (Smith, 1999). Therefore, simply claiming adherence to a theoretical orientation is not evidence of providing effective therapeutic services. Instead, clinicians should be able to demonstrate adherence to principles of theoretical orientation on measures of latent theoretical orientation.

The current inability of researchers to distinguish between therapeutic approaches has even more significant implications on the practice of psychotherapy integration. This inability may contribute to the growth of psychotherapy integration, in that some psychologists seek to create approaches that are able to distinguish themselves as more efficacious. It also, however, has the potential of being misinterpreted as supporting the idea that there are no actual differences between therapeutic approaches. Such a belief may be directly related to the sole reliance on clinical intuition in the practice of psychotherapy.

Psychologists, who report using psychotherapy integration and do not subscribe to a formal model of psychotherapy integration, have relatively few guidelines and restrictions on their therapeutic practice. Claiming artistic freedom, many psychologists appear to be basing their therapeutic services on clinical intuition alone, which may be fraught with personal biases, detracting from the provision of effective treatment. This type of service is counter to the APA ethics code, which states in code 1.06 that "psychologists rely on scientifically and professionally derived knowledge when making scientific or professional judgments" (Canter, et al., 1996, p. 36). Ignoring the ethics code, psychologists who base their practice solely on clinical intuition have the potential of ending up with an inconsistent assortment of therapeutic strategies and techniques, commonly referred to as syncretism.

The potential benefit of this line of research for therapy is to provide guidelines, which might result in more consistent and effective therapeutic services. Adherents to both psychotherapy integration and single school theories may utilize these potential benefits. In psychotherapy integration this research may contribute to the development of

formal approaches, which might demonstrate improved efficacy over current approaches. Formal approaches to psychotherapy integration, as well as single school theories, may then utilize latent theoretical orientation in their training programs to more accurately measure adherence and consistency of understanding. This improvement in training might then follow with improved treatment efficacy and the more ethical provision of services to the public.

Limitations of the Present Study

The main findings of this study may be interpreted as illustrating the potential clinical utility of using latent theoretical orientation as either a complement to or in replace of traditional theoretical orientation. However, these conclusions should be considered in light of several limitations in this study. Potential limitations include factors such as the use of survey research, clinical utility of the CTPS, and difficulty comparing overt and latent theoretical orientation.

There are two limitations of survey research that seem particularly applicable to this study. The data collected is dependent on the return rate, which as reported above, was 24.88 percent for this study. This may suggest that while the pool of subjects was random, the responding sample may be self-selected on some criteria that confounds the generalizability of the results.

Another limitation of survey research is that respondents may avoid extreme responses, which could drastically affect responses on likert-type scales, thus limiting the ability to accurately differentiate responses. As discussed above, psychologists' scores on the dimensions of the CTPS tended to fall within the midrange of possible responses.

This restricted range may simply be an artifact of using survey research that does not accurately represent clinical reality.

While responses may have been affected by the use of survey research, it is also possible that the CTPS does not adequately differentiate psychologists on the two dimensions. The CTPS was developed using an Australian sample, which may introduce cultural factors limiting its applicability in its current form to a U.S. population. However, results presented by Poznanski and McClennan (1998), using an Australian sample, similarly show that scores for respondents within the same theoretical orientation differ by less than one standard deviation from the mean. Therefore, one can question the ability of the CTPS to differentiate groups identified by primary theoretical orientation.

At this point in the discussion the relationship between explicit and latent theoretical orientation becomes twisted. The purpose of latent theoretical orientation is to eventually improve upon explicit theoretical orientation. However, in this and other studies latent theoretical orientation is judged on its ability to differentiate overt theoretical orientation, a construct that is viewed as flawed. Therefore, it is impossible to estimate whether any failure is within latent theoretical orientation, overt theoretical orientation, or both. Also, comparing overt to latent theoretical orientation is similar to comparing apples to oranges. Primary overt theoretical orientation is limited to one aspect of the individual's belief system, while latent theoretical orientation attempts to represent the entirety of the individual's belief system.

Future Directions

Given the findings of this study there appear to be two future directions for this research. In step with the initial purpose of latent theoretical orientation, assessments

could be further developed in order to better allow categorization of therapists into pre-existing theoretical orientations. This would affect training in that therapists could be monitored on their adherence and trained accordingly, thus potentially reducing with-in orientation variance and better providing an ability to determine between-group differences. Process and outcome research would be aided by the ability to more accurately assign therapists to groups again reducing with-in group/orientation variance.

Using latent theoretical orientation to create new categorizations representing the clinical use of theory may aid in the advancement of psychotherapy integration. Future studies should build upon the attempts in this study. Once groupings were established, researchers could use these groupings in process and outcome research to determine the ability of latent theoretical to truly represent clinical behavior of the therapist.

Either using latent theoretical orientation in addition to explicit theory or instead of explicit theory, the first step is to refine the assessment of the current dimensions and develop further dimensions that can discriminate underlying beliefs in a more holistic manner. The CTPS in its current form does not have the ability to detect differences between psychologists from more than a few theoretical orientations. This seems to be related to both a need for a better ability to differentiate psychologists on the current dimensions as well as the need to create dimensions that can pull groups apart.

A related area of interest for future researchers would be to use measures of latent theoretical orientation in a longitudinal design to explore any shifts in theoretical orientation that accompany increasing years of clinical experience. Such shifts may suggest that the use of theory in psychotherapy is a developmental process, as discussed by Cullari (1999) and Hollanders (1999). If it were found that these shifts in theoretical

perspective correlated with improved treatment efficacy, this would have important implications for training programs, licensure, and managed care.

APPENDIX

PROFESSIONAL ISSUES IN APPLIED PSYCHOLOGY SURVEY

1) Gender:
Male ____
Female ____

2) Age:_____

3) Ethinicity(ies):
Caucasian (Non-Hispanic) _____
Hispanic _____
African-American _____
Asian-American _____
Native American _____
Other_____ _____

4) Doctoral Degree:
Ph.D. _____
Psy.D. _____
Ed.D. _____

5) Applied Psychology Sub-field:
Counseling _____
Clinical _____
School _____
Community _____
Other _____

6) Years of Clinical Experience:
Years Full-Time _____
Years Part-Time _____

7) Primary Therapeutic Work Setting:
Community Mental Health Center _____
Hospital _____
Medical School _____
Independent Practice _____
University Counseling Center _____
School _____
Other_____ _____

8) Work Time Distribution:
Academic _____%
Therapeutic _____%
Research _____%
Administrative _____%
Consultation _____%
Supervisor _____%

9) Theoretical Orientation_____

For the next six questions. please respond in a manner that best describes your current clinical approach.

1) Theories and Techniques used in therapy:
*Please estimate and fill in percentages to reflect the influence each respective theory has on the theories and techniques used in your practice.

	Theory	Tech.		Theory	Tech.		Theory	Tech.
Behavioral	___%	___%	Cognitive	___%	___%	Humanistic/ Existential	___%	___%
Interpersonal	___%	___%	Psychodynamic	___%	___%	Systems	___%	___%
Feminist	___%	___%	Other_____	___%	___%	Other_____	___%	___%

2) Do you perceive yourself as practicing Psychotherapy Integration (Defined as, any method of combining theories, concepts, or techniques from more than one theory into one approach)?

Yes _____
No _____ (Please continue with questions regardless of response)

3) Would your theoretical approach meet any of these definitions: [Please check the one most appropriate primary category (A,B,C,D) if any, and subcategory within this (a,b)]

_____ A) A combination of theoretical concepts from more than one theory into a unitary and consistent theory.

____ a) different theories interpreted to be analogous
____ b) different theories for different stages of therapy
____ c) different theories for different presenting issues
____ d) different theories used simultaneously

_____ B) Utilization of techniques from varying theoretical orientations, without importing the theoretical assumptions that lead to their origination.

____ a) Atheoretical
____ b) with a core theory, which is _____
-and -
____ a) based on research findings
____ b) based on clinical judgement
*If both please rank order importance

_____ C) The use of components believed to be common to all theories.
_____ D) Other (Please describe):

5) Please rank order the factors that most influence your theoretical approach (reasons for use): [Rank only those thought to bear influence]

____ A) The number of available theories
____ B) Perceived equality of available theories
____ C) Critical perspective toward available theories
____ D) Short-Term Solution Focused Therapy
____ E) Empirically Validated Treatments
____ F) Managed Care
____ G) Medicalization of mental illness (competition with Medical Field)
____ H) Public opinion
____ I) Client needs
____ J) Other _____

6) In practicing Psychotherapy Integration do you subscribe to a formal framework?

Yes _____
No _____

If yes, which (e.g. Smith's approach or Multi-theory model)

_____

* Please provide more information than such descriptors as Eclectic, Integrative, or Common Factors.

For the following questions, please respond by circling the number 1-7 that best expresses your level of agreement with the respective statement. (1=Completely Disagree, 2=Moderately Disagree, 3=Somewhat Disagree, 4=Equally Agree and Disagree, 5=Somewhat Agree, 6=Moderately Agree, 7=Completely Agree)

		CD	MD	SD	E	SA	MA	CA
1)	Unconscious motives and intuitive processes should be considered as essential aspects of psychological theory	1	2	3	4	5	6	7
2)	Unconscious motivation is a very important aspect of human behavior	1	2	3	4	5	6	7
3)	The emotional process in psychotherapy is a vital agent of change	1	2	3	4	5	6	7
4)	Interpretation of symbolic meaning enables illumination of the depth of human experience	1	2	3	4	5	6	7
5)	The concept of unconscious processes is of limited therapeutic value	1	2	3	4	5	6	7
6)	I generally prefer to practice a goal-directed approach to psychotherapy	1	2	3	4	5	6	7
7)	Understanding of a client's childhood is crucial to therapeutic change	1	2	3	4	5	6	7
8)	Psychotherapy should focus on 'here and now' experiences: There is no need to focus on the client's past	1	2	3	4	5	6	7
9)	Human beings need to know meanings rather than simply factual information	1	2	3	4	5	6	7
10)	It is essential to focus on feeling and meaning as communicated by a client	1	2	3	4	5	6	7
11)	People can learn effective coping skills without necessarily having to go into the depths of their private experience	1	2	3	4	5	6	7
12)	Introspective and intuitive methods in psychotherapy are more useful than explanations which do not go beyond observable behavior	1	2	3	4	5	6	7
13)	Self knowledge deepens our understanding of life	1	2	3	4	5	6	7
14)	An effective psychotherapist demonstrates sensitivity and personal involvement towards the client	1	2	3	4	5	6	7
15)	Careful re-examination by a client of his/her personal history can alter the client's present emotional life	1	2	3	4	5	6	7
16)	It is important for a psychotherapist to feel strong personal and emotional involvement with a client	1	2	3	4	5	6	7
17)	Search for meaning and wholeness in life is the essence of human existence	1	2	3	4	5	6	7
18)	Establishing a client's awareness of his/her emotions and desires is a beneficial therapeutic outcome	1	2	3	4	5	6	7
19)	I believe psychotherapy is much more an art than a science	1	2	3	4	5	6	7
20)	As a psychotherapist I usually take an active role in structuring the interview	1	2	3	4	5	6	7

		CD	MD	SD	E	SA	MA	CA
21)	Emotional stability is a product of one's logical and consistent thinking behavior	1	2	3	4	5	6	7
22)	Cognition is the most powerful factor in determining experience	1	2	3	4	5	6	7
23)	An understanding of the reasons for one's behavior is crucial to behavioral change	1	2	3	4	5	6	7
24)	Knowledge is valid only if it is based on logic and/or reason	1	2	3	4	5	6	7
25)	Irrationality is the fundamental cause of psychological dysfunction	1	2	3	4	5	6	7
26)	Clients need to be guided and given information in order to achieve their therapeutic goals	1	2	3	4	5	6	7
27)	Improving the client's level of social adjustment ought to be the main therapeutic aim	1	2	3	4	5	6	7
28)	As a psychotherapist I maintain a detached and objective approach during psychotherapy interviews	1	2	3	4	5	6	7
29)	It is unwise for a psychotherapist to respond to a client in a spontaneous. not thought-through manner	1	2	3	4	5	6	7
30)	Any claimed mental process can be translated into a statement describing observable behavior	1	2	3	4	5	6	7
31)	Valid information comes only from empirical research	1	2	3	4	5	6	7
32)	Nothing is true if it is illogical	1	2	3	4	5	6	7
33)	The brain is the prime mover in human social development	1	2	3	4	5	6	7
34)	Logical analysis and synthesis of information is crucial to one's survival	1	2	3	4	5	6	7
35)	Emotional involvement by a therapist defeats the purpose of therapy	1	2	3	4	5	6	7
36)	Intense negative emotions are manifestations of unrealistic and non-logical cognitions	1	2	3	4	5	6	7
37)	It is preferable that a psychotherapist remains personally uninvolved in the therapeutic relationship	1	2	3	4	5	6	7
38)	Specific training in psychotherapy techniques is vital to therapeutic outcome	1	2	3	4	5	6	7
39)	Perceptions define human experience	1	2	3	4	5	6	7
40)	Higher intellectual processes over-ride more primitive functions of feeling and behavior	1	2	3	4	5	6	7

Thank you for your time!

REFERENCES CITED

Ahn, H. & Wampold, B. E. (2001). Where of where are the specific ingredients? A meta-analysis of component studies in counseling and psychotherapy. Journal of Counseling Psychology, 48 (3), 251-257.

Arkowitz, H. (1997). Integrative theories of therapy. In P. L. Wachtel & S. B. Messer (Eds.), Theories of Psychotherapy: Origins and Evolution (pp. 227-288). Washington, DC: American Psychological Association.

Aspy, D. N., Aspy, C. B., Russel, G., & Wedel, M. (2000). Carkhuff's human technology: A verification and extension of Kelly's (1997) suggestion to integrate the humanistic and technical components of counseling. Journal of Counseling and Development, 78, 29-37.

Beitman, B. D. (1989). Why I am an integrationist (not an eclectic). British Journal of Guidance and Counselling, 17 (3), 259-273.

Beitman, B. D. (1992). Integration through fundamental similarities and useful differences among schools. In J. C. Norcross & M. R. Goldfried (Eds.), Handbook of Psychotherapy Integration (pp. 202-230). New York: BasicBooks.

Beutler, L. E. (1989). The misplaced role of theory in psychotherapy integration. Journal of Integrative and Eclectic Psychotherapy, 8 (1), 17-22.

Beutler, L. E. & Consoli, A. J. (1993). Matching the therapist's interpersonal stance to client's characteristics: Contributions from systematic eclectic psychotherapy. Psychotherapy, 30 (3), 417-422.

Beutler, L. E., Consoli, A. J., Williams, R. E. (1995). Integrative and eclectic therapies in practice.

Beutler, L. E. & Martin (2000). Prescribing therapeutic interventions through strategic treatment selection. Cognitive and Behavioral Practice, 7 (1), 1-17.

Carere-Comes, T. (2001). Assimilative and accommodative integration: The basic dialectics. Journal of Psychotherapy Integration, 11 (1), 105-115.

Castonguay, L. G. (2000). A common factors approach to psychotherapy training. Journal of Psychotherapy Integration, 10 (3), 263-282.

Castonguay, L. G. & Goldfried, M. R. (1994). Psychotherapy integration: An idea whose time has come. Applied and Preventive Psychology, 3 (3), 159-172.

Chwalisz, K. (2001). A common factors revolution: Let's not "cut off our Discipline's nose to spite its face". Journal of Counseling Psychology, 48 (3), 262-267.

Cullari, S. (1999). Does every good behaviorist deserve favor? A reply to Neil Jacobsen. Journal of Psychotherapy Integration, 9 (3), 243-249.

Fonagy, P. (1999). Relation of theory and practice in In B. Bongar & L. E. Beutler (Eds.), Comprehensive Textbook of Psychotherapy: Theory and Practice (pp. 274-292). New York: Oxford University Press.psychodynamic therapy. Journal of Clinical Child Psychology, 28 (4), 513-520.

Garfield, S. L. (1994). Eclecticism and integration in psychotherapy: Developments and issues. Clinical Psychology: Science and Practice, 1 (2), 123-137.

Garfield, S. L. & Kurtz, R. (1974). A survey of clinical psychologists: Characteristics, activities, and orientations. The Clinical Psychologist, 28 (1), 7-10.

Gelso. C. J. (1995). Theories, theoretical orientation, and theoretical dimensions: Comment on Poznanski and McLennan (1995). Journal of Counseling Psychology, 42 (4), 426-427.

Gold, J. R. (1993). The sociohistorical context of psychotherapy integration. In G. Stricker & J. R. Gold (Eds.). Comprehensive Handbook of Psychotherapy Integration (pp. 3-8). New York: Plenum Press.

Goldfried, M. R. & Norcross, J. C. (1995). Integrative and eclectic therapies in historical perspective. In B. Bongar & L. E. Beutler (Eds.), Comprehensive Textbook of Psychotherapy: Theory and Practice (pp. 254-273). New York: Oxford University Press.

Greenberg, L. S. & Bolger, E. (2001). An emotion-focused approach to the overregulation of emotion and emotional pain. JCLP/In Session: Psychotherapy in Practice, 57 (2), 197-211.

Groth-Marnat, G., Roberts, R. I., & Beutler, L. E. (2001). Client characteristics and psychotherapy: Perspectives, support, interactions, and implications for training. Australian Psychologist, 36 (2), 115-121.

Henry, W. P. (1998). Science, politics, and the politics of science: The use and misuse of empirically validated treatment research. Psychotherapy Research, 8 (2), 126-140.

Hollanders, H. (1999). Eclecticism and integration in counseling: Implications for training. British Journal of Guidance and Counselling, 27 (4), 483-500.

Hollanders, H. & McLeod, J. (1999). Theoretical orientation and reported practice: a survey of eclecticism among counselors in Britain. British Journal of Guidance and Counselling, 27 (3), 405-414.

Honos-Webb, L. & Leitner, L. M. (2001). How using the DSM causes damage: A client's report. Journal of Humanistic Psychology, 41 (4), 36-56.

Lamproproulos, G. K. (2001). Bridging technical eclecticism and theoretical integration: Assimilative integration. Journal of Psychotherapy Integration, 11 (1), 5-19.

Lazarus, A. A. (1992). Multimodal therapy: Technical eclecticism with minimal integration. In J. C. Norcross & M. R. Goldfried (Eds.), Handbook of Psychotherapy Integration (pp. 231-263). New York: BasicBooks.

Lazarus, A. A. (1995). Different types of eclecticism and integration: Let's be aware of the dangers. Journal of Psychotherapy Integration, 5 (1), 27-39.

Lazarus, A. A. (1996). The utility and futility of combining treatments in psychotherapy. Clinical Psychology: Science and Practice, 3 (1), 59-68.

Lazarus, A. A., Beutler, L. E., & Norcross, J. C. (1992). The future of technical eclecticism. Psychotherapy, 29 (1), 11-20.

Mahoney, M. J. (1993). Diversity and the dynamics of development in psychotherapy integration. Journal of Psychotherapy Integration, 3 (1), 1-13.

Mahoney, M. J. & Norcross, J. C. (1993). Relationship styles and therapeutic choices: A commentary on the preceding four articles. Psychotherapy, 30 (3), 423-425.

Messer, S. B. (1992). A critical examination of belief structures in integrative and eclectic psychotherapy. In J. C. Norcross & M. R. Goldfried (Eds.), Handbook of Psychotherapy Integration (pp. 231-263). New York: BasicBooks.

Messer, S. B. & Wachtel, P. L. (1997). The contemporary psychotherapeutic landscape: Issues and prospects. In P. L. Wachtel and S. B. Messer (Eds.), Theories of Psychotherapy: Origins and Evolution (pp. 1-38). Washington, DC: American Psychological Association.

Milan, M. A., Montgomery, R. W., & Rogers, E. C. (1994). Theoretical orientation revolution in clinical psychology: Fact or fiction? Professional Psychology: Research and Practice, 25 (4), 398-402.

Moldawsky, S. (1995). The impact of damaged care on our practices. Psychotherapy in Private Practice, 14 (2), 35-41.

Najavits, L. M. (1997). Psychotherapists' implicit theories of therapy. Journal of Psychotherapy Integration, 7 (1), 1-16.

Norcross, J. C. (1993). Tailoring relationship stances to client needs: An introduction. Psychotherapy, 30 (3), 402-403.

Norcross, J. C. (1995). A roundtable on psychotherapy integration: Common factors, technical eclecticism, and psychotherapy research. Journal of Psychotherapy Practice and Research, 4 (3), 248-271.

Norcross, J. C. & Prochaska, J. O. (1982). A national survey of clinical psychologists: Affiliations and orientations. The Clinical Psychologist, 35 (3), 1-6.

Norcross, J. C., Prochaska, J. O., & Farber, J. A. (1993). Psychologists conducting psychotherapy: New findings and historical comparisons on the psychotherapy division membership. Psychotherapy, 30 (4), 692-697.

Poznanski, J. J. & McLennan, J. (1995a). Conceptualizing and measuring counselors' theoretical orientation. Journal of Counseling Psychology, 42 (4), 411-422.

Poznanski, J. J. & McLennan, J. (1995b). Afterthoughts on counselor theoretical orientation. Journal of Counseling Psychology, 42 (4), 428-430.

Poznanski, J. J. & McLennan, J. (1998). Theoretical orientations of Australian counseling psychologists. International Journal for the Advancement of Counselling, 20 (3), 253-261.

Poznanski, J. J. & McLennan, J. (1999). Measuring counsellor theoretical orientation. Counselling Psychology Quarterly, 12 (4), 327-334.

Prochaska, J. O. & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. Psychotherapy: Theory, Research, and Practice, 19 (3), 276-288.

Prochaska, J. O. & DiClemente, C. C. (1992). The transtheoretical approach. In J. C. Norcross & M. R. Goldfried (Eds.), Handbook of Psychotherapy Integration (pp. 300-334). New York: BasicBooks.

Russell, R. L. (1986). The inadvisability of admixing psychoanalysis with other forms of psychotherapy. Journal of Contemporary Psychotherapy, 16 (1), 76-86.

Safran, J. D. & Segal, Z. V. (1990). Interpersonal Process in Cognitive Therapy. New York: Basic Books, Inc.

Sammons, M. T. & Gravitz, M. E. (1990). Theoretical orientations of professional psychologists and their former professors. Professional Psychology: Research and Practice, 21 (2), 131-134.

Smith, D. A., (1982). Trends in counseling and psychotherapy. American Psychologist, 37 (7), 802-809.

Smith, D. A. (1999). The end of theoretical orientations? Applied and Preventive Psychology, 8 (4), 269-280.

Stone, G. L. & Yan, S. Y. (1997). Differences between psychologists working in counseling centers and independent practice. Journal of College Student Psychotherapy, 12 (2), 41-63.

Stricker, G. & Gold, J. R. (1996). Psychotherapy integration: An assimilative, psychodynamic approach. Clinical Psychology: Science and Practice, 3 (1), 47-58.

Vandenbos, G. R., Cummings, N. A., & DeLeon, P. H. (1992). A century of psychotherapy: Economic and environmental influences. In D. K. Freedheim (Ed.), History of Psychotherapy: A Century of Change (pp. 65-102). Washington DC: American Psychological Association.

Wampold, B. E. (1997). Methodological problems in identifying efficacious psychotherapies. Psychotherapy Research, 7 (1), 21-43.

Wampold, B. E. (2001). The great psychotherapy debate: Models, methods, and findings. Mahwah, NJ: Erlbaum.

Weinberger, J. (1995). Common factors aren't so common: The common factors dilemma. Clinical Psychology: Science and Practice, 2 (1), 45-69.

Wiser, S. & Arnow, B. (2001). Emotional experiencing: To facilitate or regulate? JCLP/In Session: Psychotherapy in Practice, 57 (2), 157-168.

Wolfe, B. E. (2001). A message to assimilative integrationists: It's time to become accommodative integrationists: A commentary. Journal of Psychotherapy Integration, 11 (1), 123-131.