Psychotherapy Volume 31/Summer 1994/Number 2

APPLYING OUTCOME RESEARCH: INTENTIONAL UTILIZATION OF THE CLIENT'S FRAME OF REFERENCE

BARRY L. DUNCAN DOROTHY W. MOYNIHAN
Dayton Institute for Family Therapy
Centerville, Ohio

The percentage of outcome variance attributable to extratherapeutic and common factors, and the superiority of client's predictions of outcome, challenges an emphasis on theoretical frames of reference and offers a compelling argument for allowing the client to direct the psychotherapeutic process. This article suggests that therapists intentionally utilize the client's frame of reference for the explicit purpose of influencing successful outcome. A proposal for a client-directed process is offered that de-emphasizes theory and seeks deliberate enhancement of common factor effects and maximum collaboration with the client through all phases of intervention.

A review of the outcome research (Lambert, Shapiro & Bergin, 1986) suggests that 30% of outcome variance is accounted for by the common factors (variables found in a variety of therapies regardless of the therapist's theoretical orientation). Techniques (factors unique to specific therapies) account for 15% of the variance, as do expectancy/placebo effects (improvement resulting from the client's knowledge of being in treatment) (Lambert, 1992). Accounting for the remaining 40% of the variance are the extratherapeutic change variables (factors that are part of the client and his/her environment that aid in recovery) (Lambert et al., 1986).

Lambert (1992) suggests that most of the success gleaned from intervention can be attributed to the common factors. Common factors have been conceptualized in a variety of ways. A recent analysis of the common factors literature (Grencavage & Norcross, 1990) revealed that the most frequently addressed commonality was the development of a collaborative therapeutic relationship/alliance.

Supportive of the Lambert et al. (1986) review is Patterson's (1984) report that empathy, respect, and genuineness account for from 25% to 40% of outcome variance. Patterson (1989) concludes that the outcome research undercuts the view that expertise in methods and techniques is the critical factor in promoting change; rather, the evidence suggests that therapists' influence lies in providing the conditions under which the client engages in change (Patterson, 1989).

The outcome literature challenges the inherent and invariant validity of a specific orientation, given that specific technique seems largely insignificant when compared with common factors and extratherapeutic variables. Another empirical challenge to the therapist's frame of reference is provided by research demonstrating that client perceptions of therapist-provided variables are the most consistent predictor of improvement (Gurman, 1977; Horowitz et al., 1984). More recently, the therapist-provided variables have been studied in terms of the therapeutic alliance, which includes both therapist and client contributions to the therapeutic climate, and emphasizes collaboration between therapist and client in achieving the goals of therapy (Marmar et al., 1986).

A recent study by Bachelor (1991) explored the contribution to improvement of three alliance measures and focused on the perceptions of the client and therapist. Confirming and adding em-

Correspondence regarding this article should be addressed to Barry L. Duncan, 747 Hidden River Drive, Port St. Lucie, FL 34983.

phasis to many previous findings regarding common factors and the client's perceptions, Bachelor (1991) found that client perceptions yield stronger predictions of outcome than therapists, and that from the client's view, the most salient factors are therapist-provided help, warmth, caring, emotional involvement, and efforts to explore relevant material.

The significance of client (extratherapeutic) and common factors as well as the superiority of clients' perceptions in predicting outcomes offer a compelling argument for more attention to the client's resources and experience of the psychotherapeutic process (Rogers, 1957). As an attempt to further apply outcome research, this article proposes an intentional utilization of the client's frame of reference for the explicit purpose of influencing successful outcome. The client's frame of reference is discussed in terms of: 1) the client's perceptions and experience of the therapeutic relationship; and 2) the client's perceptions and experience of the presenting complaint, its causes, and how therapy may best address the client's goals, *i.e.*, the client's informal theory (Held, 1991). A client-directed process in psychotherapy is presented that de-emphasizes theoretical frames of reference and seeks deliberate enhancement of common factor effects and maximum collaboration with the client through all phases of intervention.

The Client's Frame of Reference: The Therapeutic Relationship

One way of enhancing common factor effects is to extend the definitions of therapist-provided variables to include the client's perception of the therapist's behavior. Another way is to examine therapist assumptions critically and eliminate those that may undermine the client's positive perceptions of the relationship. Consider the therapist behavior of empathy, which is defined by Carkhuff (1971, p. 266) as "the ability to recognize, sense, and understand the feelings that another person has associated with his behavior and verbal expressions, and to accurately communicate this understanding to him." While this definition describes the therapist's expressed empathy, it does not address the client's idiosyncratic interpretation of the therapist's behavior.

In a recent study examining client perceptions of empathy, Bachelor (1988) found that 44% of clients perceived their therapist's empathy as cognitive, 30% as affective, 18% as sharing, and 7% as nurturant. Bachelor concluded that empathy has different *meanings* to different clients and should not be viewed or practiced as a universal construct.

The potential for positive enhancement of common factor effects will not occur in those situations in which the therapist's empathic response does not fit the empathic needs of the individual client. Regardless of how empathic a therapist may be by the standards of a chosen theoretical orientation, an empathic response may have little or no positive impact on certain clients, or may be interpreted by some clients as having negative impact. The therapist's reliance on stand-by responses to convey empathy will not be equally productive in terms of the client's perception of being understood (Bachelor, 1988).

Empathy, then, is not an invariant, specific therapist behavior or attitude (*e.g.*, reflection of feeling is inherently empathic), nor is it a means to gain a relationship so that the therapist may promote a particular orientation or personal value, nor a way of teaching clients what a relationship should be. Rather, empathy is therapist attitudes and behaviors that place the client's perceptions and experiences above theoretical content and personal values (Duncan, Solovey & Rusk, 1992); empathy is manifested by therapist attempts to work within the frame of reference of the client. When the therapist acts in a way that demonstrates consistency with the client's frame of reference, then empathy may be perceived, and common factor effects enhanced. Empathy, therefore, is a function of the client's unique perceptions and experience and requires that therapists respond flexibly to clients' *needs*, rather than from a particular theoretical frame of reference or behavioral set.

Respect

Respect, according to Rogers (1957), is the ability to prize or value the client as a person with worth and dignity. Central to conveying respect is a nonjudgmental attitude, the avoidance of condemnation of the client's actions or motives, and acceptance of the client's experience (Rogers, 1957). Demonstrating respect may entail embracing a nonpathological and nonpejorative perspective of people that assumes that *all* clients can make more satisfying lives for themselves and have the inherent capacity to do so. Diagnostic categories or attributions of pathology that connote a poor prognosis are perhaps disrespectful

and discount the complexity and beauty of human variation, masking the idiosyncratic strengths that individuals may utilize to live more satisfying lives. Such diagnoses may also undermine two other common factors identified by the Grencavage & Norcross' (1990) review, *i.e.*, the client's positive expectations and therapist qualities that cultivate hope.

Challenging pathology-oriented, diagnostic frames of reference and advocating an abiding faith in client resources seems unpopular, but well-founded. Client contribution to outcome (extratherapeutic factors), regardless of diagnosis, is the single most important factor to successful outcome (Lambert, 1992).

Respect is also conveyed by therapists' flexibility regarding their interpretations or views of clients or their circumstances. Interpretations made to clients, or therapist views imposed on clients despite the clients' lack of acceptance, are disrespectful and may undermine common factor effects. Kuehl, Newfield & Joanning (1990) found that clients who viewed their therapist as not rigidly adhering to a particular point of view were more likely to be satisfied with therapeutic experiences. Kuehl et al. (1990) conclude that therapists should proceed cautiously when trying to convince a client of the utility of an approach the client does not readily accept. Perceived respect may be assured when therapists discard their approaches if the client views them as unhelpful.

Respect is demonstrated in therapist attitudes and behaviors that place the value of the client as a person with worth and dignity above pathological, theoretical, or pejorative perspectives; respect is manifested by therapist sensitivity to the acceptability of *any* therapist behavior to the client's frame of reference (Duncan et al., 1992).

Genuineness

Genuineness means being oneself without being "phony" (Rogers, 1957). Therapists who do not overemphasize their role, authority, or status are more likely to be perceived as more genuine by clients (Cormier & Cormier, 1991). Genuineness may be further operationalized by the therapist's cautiousness and tentativeness about approaching the client, conceptualizing his or her concerns, and intervening to address those concerns. Tentativeness conveys to the client that the therapist claims no corner on reality and is not the deliverer of truth, but rather is a collaborator who, because of training and experience, can hopefully offer productive input. The therapist, therefore, is not an expert who champions an objective truth about the etiology and treatment of client problems or the way life should be lived. Rather, *the client is the expert* from a perspective that places the client's frame of reference and the client's input in a superior position to the therapist's orientation or input.

Phoniness may be exemplified by the position that equates theories of psychotherapy with "truth", rather than empirical/conceptual approximations of reality. Being genuine with clients may necessitate a humbling acceptance of the nondefinitive nature of psychotherapy theory and application, as well as the inherent complexity of human beings. While theories of psychotherapy are obviously of great value to clinicians and clients, there has been no demonstrated superiority of one over another. This equivalence of outcome findings has been documented in several reviews (Bergin & Lambert, 1978; Klein et al., 1983; Orlinsky & Howard, 1986; Luborsky, Singer & Luborsky, 1975; Sloane et al., 1975; Smith, Glass & Miller, 1980), and more recently in the NIMH multisite study of depression (Elkin et al., 1989). Perhaps it is time to reflect such findings in the way clients are approached.

The failure to find differential outcomes in studies comparing therapies that use highly divergent techniques also supports the importance of common factors to positive outcome (Arkowitz, 1992; Lambert, 1992). These findings, however, may be interpreted in other ways (Beutler, 1991; Butler & Strupp, 1986; Stiles, Shapiro & Elliott, 1986). For example, the apparent equivalence of outcome may reflect that different therapies can achieve similar goals through different processes, or that different outcomes do occur but are not detected by past methodological designs and strategies (Arkowitz, 1992; Kazdin & Bass, 1989; Lambert, 1992). The common factors explanation has received the most attention, and is supported by other research aimed at discovering the active ingredients of psychotherapy (Lambert, 1992).

Validation

Common factors may also be expressed through a therapist's verbal behavior called *validation*. Validation is a therapist-initiated process in which the client's thoughts, feelings, and behaviors are accepted, believed, and considered completely understandable, given the client's subjective experience of the world. Validation

represents a combined expression of empathy, respect, and genuineness that is individually tailored to the idiosyncracies of the client's experience.

The therapist genuinely accepts the client's presentation at face value and holds the belief that the client is doing the best that he or she can. The therapist respects the client's experience of the problem by emphasizing its importance, and empathically offers total justification of the client's experience. The therapist, therefore, verbally legitimizes the client's frame of reference and in the process may replace the invalidation that may be a part of it (Duncan et al., 1992). Validation represents a logical application of common factors research as well as studies documenting the significance of client perceptions to outcome.

Client's Frame of Reference: Informal Theory

Another dimension of the client's frame of reference encompasses the client's thoughts, beliefs, attitudes, and feelings about the nature of what served as the impetus for therapy (the problem or situation), its causes, and how therapy may best address the client's goals for treatment. Held's (1991) elaboration of the content/process distinction provides a framework for understanding this dimension.

Content versus Process

Held (1991), building on the work of Prochaska & DiClemente (1982), defines process as the activities of the therapist that promote change or develop coping solutions (*i.e.*, methods, techniques, interventions, strategies). Process embodies one's theory of how change occurs (Held, 1991). Content is the object of the change involving the aspects of the client and his or her behavior, upon which the therapist decides to focus the interventions (Held, 1991).

Content is defined at both formal and informal theoretical levels (Held, 1991). Formal theory consists of either general notions regarding the cause of problems (*e.g.*, symptoms are surface manifestations of intrapsychic conflict; symptoms are homeostatic mechanisms regulating a dysfunctional subsystem) or predetermined and specific explanatory schemes (*e.g.*, fixated psychosexual development; triangulation), which must be addressed across cases to solve problems. Cause and effect are either specific or implied by way of theoretical constructs of formal theory. Those constructs provide the content, which become the invariant explanations of the problems that bring clients to therapy.

Although variation exists in the degree to which content is emphasized and elaborated (Held, 1991), most therapies tend to fall to the content-oriented pole of the content–process continuum. The client presents with a complaint, and the therapist will overtly or covertly recast the complaint within the language of the therapist's formal theory. The therapist's reformulation of the complaint into a specific preconceived theoretical content will enable treatment to proceed down a particular path flowing from the formal theory.

In content-oriented approaches to psychotherapy, the formal theoretical reality of the therapist exists in a hierarchically superior position to the frame of reference of the client. This formal theory necessarily structures problem definition as well as outcome criteria. The more content-oriented the approach, the more content-directed the goals become. Conversely, intentionally utilizing the client's frame of reference requires that the content focus of the therapeutic conversation emerge from the *informal theory* of the client.

Informal theory involves the specific notions held by clients about the nature and causes of their particular problems and situations (Held, 1991). Informal theory is revealed through clients' articulations and elaborations of their concerns and is necessarily highly idiosyncratic. Recall the Bachelor (1991) study, which indicated the importance of not only the therapist-provided variables, but also the therapist's efforts to explore material that the client perceived as relevant. Clients seem to want therapists to explore their informal theories.

Rather than reformulating the informal theory into the language of the therapist's formal theory, it is suggested that therapists accommodate their formal theories to the client's informal theory by elevating the client's perceptions and experiences above theoretical conceptualizations, thereby allowing the client's informal theory to dictate therapeutic choices. Understanding the client's subjective experience and phenomenological representation of the presenting problem, and placing that experience above the theoretical predilection of the therapist seems consistent with the notion of enhancing common factor effects. Adopting the client's informal theory also provides a significant step in securing a strong therapeutic alliance.

The Informal Theory and the Therapeutic Alliance

Such an accommodation to the client's informal theory appears warranted given the importance of client perceptions to outcome (Gurman, 1977; Bachelor, 1991; Horowitz et al., 1984) and the large body of evidence demonstrating that the therapeutic alliance, as rated by client, therapist, and third-party perspectives, is the best predictor of psychotherapy outcome (Alexander & Luborsky, 1986; Marmar et al., 1986; Marziali, 1984; Suh, Strupp & O'Malley, 1986).

Bordin (1979) formulated three interacting components of the alliance: 1) agreement on the goals of psychotherapy; 2) agreement on the tasks of psychotherapy (specific techniques, topics of conversation, interview procedures, frequency of meeting); and 3) the development of a relationship bond between the therapist and client. While the bonding dimension reiterates the importance of the relationship and the therapist-provided variables, the agreement on goals and tasks refers to the congruence between the client's and the therapist's beliefs about how people change in therapy (Gaston, 1990).

Adopting the client's informal theory may ensure the development of a strong therapeutic alliance. By allowing the client's idiosyncratic content focus to direct the therapeutic process, there is necessarily an agreement regarding goals and tasks because the therapist always accommodates formal theory(s) to the informal theory of the client. The therapist attends to what the client thinks is important, addresses what the client indicates as significant, and accommodates both in- and out-of-session intervention to accomplish goals specified by the client.

Each client, therefore, presents the therapist with a new theory to learn and a different therapeutic course to pursue. Emerging from the process of unfolding the client's frame of reference, the therapist, an active participant, draws upon theoretical frames of reference and adds input, leading to the evolution of a new theory or frame of reference. Clients reconceptualize their informal theories by combining aspects of their experience with alternative views that arise from therapeutic dialogues. The alternative views are only perspectives that the client achieves in the process. Psychotherapy can be conceptualized as an idiosyncratic, process-determined synthesis of ideas, formulated by the client, that culminates in a new theory with explanatory and predictive validity for the client's specific circumstance.

Intervention and Common Factor Effects

Although it is useful to examine common factors separate from specific technique, relationship and intervention factors are interdependent aspects of the same process. Butler and Strupp (1986) argue:

> The complexity and subtlety of psychotherapeutic process cannot be reduced to a set of disembodied techniques, because the techniques gain their meaning, and in turn, their effectiveness, from the particular interaction of the individuals involved (p. 33).

The interactional context that creates meaning for intervention are the characteristics, attitudes, and behaviors of the therapist that provide the core conditions as perceived by the client. Common factors may be enhanced by specific interventions that *convey* or *implement* the therapist's understanding and acceptance of, as well as respect for, the client's frame of reference. Intervention, then, becomes another behavioral manifestation of the relationship. Intervention in the form of tasks or assignments extends the interpersonal context defined in session to the client's social environment and offers another opportunity to enhance common factor effects and maximize a positive therapeutic alliance.

The expert therapist role is therefore de-emphasized in the current proposal. From an expert position, the therapeutic search is for interventions reflecting objective truths that promote change via the process of validating the therapist's theoretical point of view. The therapeutic search, from a position seeking to deliberately influence successful outcome, is for interventions reflecting subjective truths that promote change via the process of validating the client's frame of reference. Three general steps extend the common factors and strong alliance context to the intervention process.

Dependence on the Client's Resources

People who enter therapy, except in certain compulsory situations, do so because the experience of their lives or some specific circumstance has become so painful that a change of some kind is perceived as necessary. Clients may initially appear frustrated and helpless, creative energies may be at a low ebb, and the perception may exist that they have tried everything possible only to have experience failure time after time. The client's frustration and helplessness should be re-

spected by the therapist and not considered as a reflection of any deficits or psychopathology.

Such a perspective is critical because the therapist is counting on the existent resources and strengths of the client. Interventions offer opportunities for change that promote clients' utilization of their own inherent capacities for growth. A pathology perspective may undermine the therapist's confidence in the resources of clients and, therefore, limit the range of interventions from which to choose. An initial step, then, is the recognition that interventions *depend* upon the resources of clients for success. *Therapist* dependence may perhaps hierarchically align the therapeutic relationship in a way that promotes the alliance and enhances relationship effects.

What the Client Wants

The next general step is that intervention must address what the client defines as problematic and what the client indicates as the goal for therapy. Rather than an imposition of the therapist's theoretical (or personal) frame of reference, the intervention is a response to the client's formulation of the problem experience. The client's desires, therefore, set the focus and structure of the intervention process.

Intervention begins by accepting the client's presentation at face value, without any reformulation, and then accommodating the intervention to that general presentation of the problem situation via rationales and treatment options available to the therapist. This aspect of intervention is limited only by the therapist's resources and knowledge base. The second step, then, is characterized by an explicit therapist acceptance of what the client wants and a start of a general search for intervention options that directly address the client's desires.

Collaborative Exploration

The final step involves the recognition that intervention is a collaborative exploration process that emerges from the therapist–client conversation and the clients' articulation of their content-rich frame of reference. As clients tell their problem stories, they elaborate the idiosyncracies of their experiences, their views of the problem itself and perhaps how it may be best approached, and what they have tried to do previously to solve the problem.

The client, then, collaborates in the intervention process during the interview by virtue of his or her description of, and dialogue about, the problem experience. The therapist continuously evaluates the multiple options and begins to rule out choices that are obviously antithetical to the client's informal theory. Differential therapeutics gleaned from the literature serve as a guide to the intervention process. However, the therapist depends upon the client's receptivity to ideas generated regarding views and actions about the client's concerns. Interventions evolving from collaborative exploration demonstrate the therapist's acceptance and validation of the client's frame of reference each time the client enacts the intervention. The common factors context of the relationship is therefore extended outside the session to the client's social environment. Out-of-session validation may encourage clients to utilize their resources to resolve problems.

Discussion and Conclusion

Recall the percentages of outcome variance attributable to four therapeutic factors: extratherapeutic change accounts for 40% of outcome variance, common factors account for 30%, while placebo and specific technique each contribute to 15% of the variance (Lambert et al., 1986). The differential percentages of the four factors reflect their differential emphasis in the current proposal.

Client-specific variables that result in change speak to clients' inherent resources, as well as their ability to utilize out-of-therapy events (*e.g.*, social support, fortuitous events) as opportunities for change. Given that this factor is percentage-wise the most powerful, the therapeutic process may be viewed as empowering a context that enables clients to access their own capacities for growth. From this perspective, intervention attempts to create opportunities for extratherapeutic change.

This article proposed to maximize the effects of therapist-provided variables by intentionally utilizing the client's frame of reference (experience of the relationship and informal theory) and extending a strong alliance into the intervention process by *depending* on the client's resources, *addressing* what the client wants, and *collaboratively exploring* intervention options. It was suggested that intervention represents another behavioral manifestation of the therapeutic relationship that offers the opportunity for clients to experience validation of their frame of reference each time they enact the intervention.

Last place in terms of significance to outcome is shared by placebo and specific technique fac-

tors. Placebo or expectancy effects include improvement that results from the client's knowledge of being in treatment, and consists of variables such as therapist credibility and the use of encouragement, persuasion, and reassurance (Lambert, 1992). The selection of the content for conservation, as well as technique based upon the client's frame of reference, explicitly addresses and, therefore, enhances client expectancies regarding therapy. Meeting the client's expectations regarding the goals and tasks of therapy would appear to enhance placebo effects by creating a cognitive set which expects change. Discussion of the applicability of a particular interpretation or intervention with a client may empower placebo by enhancing the intervention's credibility, as well as conveying the therapist's encouragement and reassurance. Expectancy may also be enhanced and hope cultivated by the therapist's cognitive set which conveys that change is inevitable given the client's resources and abilities.

Since technique only represents 15% of outcome variance, techniques may be viewed only as formal content areas that may or may not prove useful in the unique circumstance of the client. The selection of technique or content, therefore, must go beyond the mere prescriptive matching of client problems with research-demonstrated techniques. It seems that outcome depends far more on the client's resources and enactment of the technique, the therapist's style, attitude, and interpersonal relationship with the client, and the congruence of the technique with the client's frame of reference.

Biased by three decades of investigation of the factors accounting for successful outcome and the recent findings regarding the therapeutic alliance, this article suggested a more intentional utilization of the client's frame of reference and a deliberate promotion of a client-directed process in psychotherapy. Empowering extratherapeutic change, enhancing common factor effects, and building a strong alliance are not passive therapist postures, but rather are proactive initiatives that require a planned, focused effort to conduct psychotherapy within the context of the client's frame of reference. The outcome research suggests that psychotherapy devote itself more to a process directed by the individual client's construction of what constitutes success in therapy. Such a client-directed process may only enhance the value of empirically demonstrated differential therapeutics.

References

Alexander, L. B. & Luborsky, L. (1986). The Penn helping alliance scales. *In* L. S. Greenberg and W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 325-366). New York: Guilford.

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

Bachelor, A. (1988). How clients perceive therapist empathy. *Psychotherapy*, **25,** 227-240.

Bachelor, A. (1991). Comparison and relationship to outcome of diverse dimensions of the helping alliance as seen by client and therapist. *Psychotherapy*, **28,** 534-549.

Bergin, A. E. & Lambert, J. J. (1978). The evaluation of outcomes in psychotherapy. *In* S. L. Garfield and A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change: An empirical analysis* (pp. 139-189). New York: John Wiley.

Beutler, L. E. (1991). Have all won and must all have prizes? Revisiting Luborsky et al.'s verdict. *Journal of Consulting and Clinical Psychology*, **59,** 226-237.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy*, **16,** 252-260.

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

Carkhuff, R. R. (1971). *The development of human resources*. New York: Holt, Rinehart & Winston.

Cormier, W. H. & Cormier, L. S. (1991). *Interviewing strategies for helpers* (3rd Ed.). Pacific Grove, CA: Brooks/Cole.

Duncan, B., Solovey, A. & Rusk, G. (1992). *Changing the rules*: A client-directed approach to therapy. New York: Guilford.

Elkin, I., Shea, T., Watkins, J. T., Imber, S. D., Sotsky, S. M., Collins, I. F., Glass, D. R., Pilkonis, P. A., Leber, W. R., Dockerty, J. P., Fiester, S. J. & Parloff, M. B. (1989). National Institute of Mental Health treatment of depression collaborative research program: General effectiveness of treatments. *Archives of General Psychiatry*, **46,** 971-982.

Gaston, L. (1990). The concept of the alliance and its role in psychotherapy: Theoretical and empirical considerations. *Psychotherapy*, **27,** 143-152.

Grencavage, L. M. & Norcross, J. D. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychotherapy: Research and Practice*, **21,** 372-378.

Gurman, A. S. (1977). Therapist and patient factors influencing the patient's perception of facilitative therapeutic conditions. *Psychiatry*, **40,** 16-24.

Held, B. S. (1991). The process/content distinction in psychotherapy revisited. *Psychotherapy*, **28,** 207-217.

Horowitz, M., Marmar, C., Weiss, D., DeWitt, K. & Rosenbaum, R. (1984). Brief psychotherapy of bereavement reactions: The relationship of process to outcome. *Archives of General Psychiatry*, **41,** 438-448.

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

Klein, D., Zitrin, C., Woerner, M. & Ross, D. (1983). Treatment of phobias: II. Behavior therapy and supportive

psychotherapy: Are there any specific ingredients? *Archives of General Psychiatry*, **40,** 139-145.

KUEHL, B. P., NEWFIELD, N. A. & JOANNING, H. (1990). A client-based description of family therapy. *Journal of Family Psychology*, **3,** 310-321.

LAMBERT, M. (1992). Psychotherapy outcome research. In J. C. Norcross and M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94-129). New York: Basic.

LAMBERT, M. J., SHAPIRO, D. A. & BERGIN, A. E. (1986). The effectiveness of psychotherapy. *In* S. L. Garfield and A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 157-212). New York: John Wiley.

LUBORSKY, L., SINGER, B. & LUBORSKY, L. (1975). Comparative studies of psychotherapies: Is it true that "everybody has won and all must have prizes"? *Archives of General Psychiatry*, **32,** 995-1008.

MARMAR, C., HOROWITZ, M., WEISS, D. & MARZIALI, E. (1986). The development of the Therapeutic Alliance Rating System. *In* L. Greenberg and W. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 367-390). New York: Guilford.

MARZIALI, E. (1984). Three viewpoints on the therapeutic alliance: Similarities, differences, and associations with psychotherapy outcome. *Journal of Nervous and Mental Disease*, **172,** 417-423.

ORLINSKY, D. E. & HOWARD, K. I. (1986). Process and outcome in psychotherapy. *In* S. L. Garfield and A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change* (3rd ed., pp. 311-381). New York: John Wiley.

PATTERSON, C. H. (1984). Empathy, warmth, and genuineness in psychotherapy: A review of reviews. *Psychotherapy*, **21,** 431-438.

PATTERSON, C. H. (1989). Foundations for a systematic eclectic psychotherapy. *Psychotherapy*, **26,** 427-435.

PROCHASKA, J. O. & DICLEMENTE, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy* **19,** 276-288.

ROGERS, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, **21,** 95-103.

SLOANE, R. B., STAPLES, F. R., CRISTOL, A. H., YORKSTON, N. J. & WHIPPLE, K. (1975). *Psychotherapy versus behavior therapy.* Cambridge, MA: Harvard University Press.

SMITH, M. L., GLASS, G. U. & MILLER, T. J. (1980). *The benefits of psychotherapy.* Baltimore: Johns Hopkins University Press.

STILES, W. G., SHAPIRO, D. A. & ELLIOTT, R. (1986). "Are all psychotherapies equivalent?" *American Psychologist*, **41,** 1-8.

SUH, C., STRUPP, H. & O'MALLEY, S. (1986). The Vanderbilt process measures: The Psychotherapy Process Scale (VPPS) and the Negative Indicators Scale (VNIS). *In* L. Greenberg and W. Pinsof (Eds.), *The psychotherapeutic process: A research handbook*, (pp. 285-323). New York: Guilford.