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MATCHING THE THERAPIST'S INTERPERSONAL STANCE TO CLIENTS' CHARACTERISTICS: CONTRIBUTIONS FROM SYSTEMATIC ECLECTIC PSYCHOTHERAPY

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We briefly described the systematic eclectic psychotherapy approach by outlining its four levels of analysis and decisions: predisposing client variables, treatment contexts, relationship variables, and specific strategies and techniques. Within this model, the therapeutic stance is seen not as a static quality representing a theoretical model but as an integral part of a general plan of intervention tailored to a specific client, based on his/her motivational arousal, coping style, and reactance potential. The therapeutic stance comprehends the therapist's degree of directiveness, formality, and self-disclosure, the focus on behavioral or unconscious levels, and the emphasis on symptoms or conflicts. A case illustration is presented.

Purveyors of psychotherapy research literature, in the last decade and a half, have frequently reiterated Luborsky et al.'s verdict that there are no meaningful differences in outcome among the major systems of psychotherapy (Luborsky, Singer, & Luborsky, 1975). Unfortunately, this conclusion has been retained at the expense of a careful inspection of the clinically appealing possibility that there are subtypes of clients, who if disaggregated from pooled samples, may in fact respond with varying levels of benefit to different psychotherapies (*see* Beutler et al., 1991; Cooney et al., 1991). Virtually all of the reviews either base their conclusions on an assessment of treatment main effects, consistently omitting an analysis of how clients with different characteristics might respond differentially to different psychotherapies or apply an *ex post facto* search for client correlates that have little theoretical or logical basis for assuming their importance in this process. Indeed, the perpetuation of the conclusion of "no differences" ignores an accumulating body of research indicating that all psychotherapies may be successful, but with different types of clients (Beutler, 1991). Technical eclectic approaches, such as systematic eclectic psychotherapy (s.e.p.), are founded on the assumptions that all psychotherapies are not equally effective for all clients and that a client who does poorly with one type of psychotherapy may do well with another. S.e.p. applies empirical research to the task of identifying qualities of the client, the therapy, and the therapist that can be used to select treatments which best fit the needs of clients and that improve the likelihood of benefit, the longevity of improvement, and the speed of recovery (Beutler & Clarkin, 1990; Beutler & Consoli, in press).

S.e.p. begins with identifying and assessing the client characteristics that predispose responsiveness to different aspects of treatment. These treatment aspects, in turn, are arranged to allow a sequence of increasingly fine-grained decisions. Four levels at which decisions are made are defined, the decisions at each level evolving from the cumulative effects of those made at prior ones.

1. *Predisposing client variables*—Selecting those initial characteristics of clients that relate to

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treatment planning. These characteristics include diagnosis, problem severity, coping styles, client expectations, and stressors and resources in clients' living environments and backgrounds.

2. *Treatment contexts*—Selecting those qualities of the setting, the treatment mode and format (medical and/or psychosocial; individual, family or group), and the planned intensity (frequency and length) that characterizes the treatment environment which best fit client needs.

3. *Relationship variables*—Selecting those qualities of the treatment that are to be applied by the therapist either to prepare clients for the type of treatment to be used or to adjust treatment to meet clients' expectations. This focus on planned relationships includes efforts to selectively assign clients to compatible therapists.

4. *Specific strategies and techniques*—Selecting those strategies of influence and specific procedures that will maximally focus on relevant problems, manage levels of client motivation, overcome obstacles to successful resolution of problems, achieve treatment objectives, consolidate treatment gains, and prevent or reduce relapse.

S.e.p. does not distinguish the therapeutic stance from the general plan of psychotherapy. We view the therapist's stance as an interpersonal posture which varies in formality and visibility, and that is informed not only by an explicit knowledge of the therapist's values and attitudes, but also by a specific understanding both of a client's background and the specific dynamics of the therapist–client dyad. Hence, the stance represents a multitude of continua, some aspects of which are selected as part of the therapeutic strategy and others of which are constant reflections of the therapist's own values, response dispositions, and personality. S.e.p. does not view the therapeutic stance as a static quality that mirrors or inherently represents any given theoretical framework or philosophy. It is part of a general plan of intervention (Goldfried, 1980).

In our view, the therapeutic stance is embedded in the clinical strategies or plans that, as therapists, we choose to apply and tailor to a given client: the degree of directiveness or nondirectiveness, the focus on a behavioral or an unconscious level, the discussion of in-therapy or out-of-therapy material, the degree of formality and informality established, the kind and quality of therapist self-disclosure, and the relative emphasis given to symptomatic and conflictual problems. The nature of the stance is conveyed through the use of specific therapeutic techniques that are employed with a given client, and that convey an indistinguishable amalgamation of personal and theory-driven beliefs and values.

The Questions and Our Answers

The three questions address the first, third, and fourth levels of the s.e.p. model (the relationships among predisposing client variables, the qualities of the therapeutic relationship, and the efficacy of specific strategies and techniques). However, these questions can only be adequately addressed if one also considers the nature of the treatment context (the second level of the s.e.p. model), since therapeutic strategies are likely to be affected by the setting, mode, format, and intensity of treatment. To maintain consistency with other articles in this series, we will base our answers on the assumption that the context of our discussion is outpatient, individual psychotherapy, at a frequency of once or twice per week over at least 20 sessions, and that this context is consistent with the client's expectations and needs.

#1. S.e.p. recognizes that the preponderance of psychotherapeutic benefit is the product of a caring and respectful attitude of listening, support, empathy, and acceptance on the part of the therapist. However, s.e.p. also acknowledges that the therapist is not the only contributor to the quality of the therapeutic relationship, and that characteristics of the match between therapist and client will shape the enduring quality of the helping alliance. There may be individuals with whom the common qualities are not particularly helpful. Indeed, we hold open the possibility that even therapists who are nonempathic and critical of their clients may be effective with and "fit" the needs of some clients. For example, there is some suggestion in the literature (*e.g.*, Kolb et al., 1985) that empathy and warmth on the therapist's part may invoke distrust among suspicious clients. Such situations require a willingness on the part of the therapist to consider his/her interpersonal stance, both as a malleable therapeutic force and as behaviors over which one can acquire planned control. This stance needs to be adjusted to client qualities that are inadequately captured by formal diagnostic labels.

The only universal pattern of interpersonal behaviors expected of the s.e.p. therapist is the presence of a respectful, receptive attitude, and the flexibility to adjust to the changing therapeutic

environment. Therapists convey these attitudes by adhering to their professional role (Strupp & Binder, 1984), by not minimizing the client's problems nor diminishing their importance, by accepting the legitimacy of client's concerns and beliefs, and by considering the client worthy of their attention.

#2. Selecting intervention strategies occurs as the last step in the treatment planning sequence, and is both the most specific and the most reliant upon a combination of traits and situational, or moment-to-moment experiences that occur within the psychotherapy session. The selection of intervention strategies and techniques progresses through four levels of specificity: (a) selecting a focal objective by which to judge outcome efficacy; (b) selecting the level at which changes are initiated; (c) working toward specific mediating goals; and (d) employing the maximally effective procedures within individual sessions to implement this plan.

The question of selecting relational styles is addressed at the fourth level of intervention and is applied at two points. Interventions are selected, first, within a general plan of treatment, based upon certain trait-like indicators presented by the client.These general plans consist of the construction of a set of therapeutic strategies and associated menus of relevant procedures which fit the client's presentation. This general plan is then adjusted and tempered by the moment-to-moment states that occur within individual sessions. In each case, therapists adjust their styles along a minimum of three interpersonal dimensions in order to fit various client presentations: (a) the degree to which the therapist designs to increase or decrease client distress; (b) the degree to which the therapist attempts to modify the client's external behavior versus internal experiences (*i.e.*, insight); and (c) the level of directiveness the therapist brings to bear in guiding the client's in-session and extra-session activities (Lazarus, Beutler, & Norcross, 1992).

More specifically, s.e.p. accepts the probable motivational value of maintaining some optimal level of distress on the part of clients (Frank & Frank, 1991). Hence, the therapist must systematically employ procedures that either distract the client from or confront the client with feared objects in order to maintain this optimal level of arousal and distress. Likewise, directing attention to internal experiences tends to foster insight, while directing attention to changing external behaviors tends to foster adaptation. S.e.p. recognizes that procedures are not equivalent in the degree to which they promote insight (emotional awareness and uncovering unconscious experiences) and behavioral change, and that different clients may benefit to different degrees from these various foci. Therapeutic procedures also vary in the degree of active direction required of the therapist for their implementation. Roughly, interventions can be viewed as either directive (therapist guided) or evocative (therapist stimulated; (London, 1986), and each type may, again, be more or less suited to the needs of different people.

#3. There are a large number of client and problem qualities that are used for defining a treatment package within the s.e.p. model. These include such things as diagnosis, problem severity, problem complexity, coping style, reactance (resistance) potential, and level of readiness for change. For the purpose of simplicity, the current discussion will focus on those client qualities that correspond to making decisions along the three interpersonal dimensions previously described, and from which the therapist's stance is adjusted. These variables are *motivational arousal*, *coping style*, and *reactance (or resistance) potential*.

The decision to employ either confrontational or distraction procedures follows from an assessment of client *motivational arousal*, which, in turn, is a function of the intensity of distress and the degree to which this distress affects the client's motivation for change. Among clients with low motivation, the therapist employs procedures to confront the client with feared events and concepts as a means of both maintaining a relevant focus in therapy and raising the level of arousal to motivational levels. If arousal and distress are assessed to be too high to allow for effective functioning and information processing, supportive and distracting procedures are used to reduce tension; the feared focus is then gradually reintroduced.

The decisions arising from an assessment of client motivational distress are interdigitated with information about the other two client predisposing variables to set and adjust the therapist's stance. Specifically, client *coping style* is assessed along a dimension of externalization to internalization, largely relying on scores from standard personality tests. While s.e.p. has postulated the presence of nominal groupings or "client types" which exist along this dimension, most of

our research has treated the dimension of coping style as a continuum. Research on this dimension has been quite consistent in suggesting its value as an indicator for the use of interventions which vary in their level of influence, from behavioral manifestations to insight and emotional awareness. For example, we have found that a therapeutic stance that focuses on the management of external behavior is best suited to clients who tend to cope by acting out, projecting their fears, and otherwise externalizing their conflicts (Beutler, Engle et al., 1991; Beutler, Mohr et al., 1991; Calvert, Beutler, & Crago, 1988). Clients who tend to be intropunitive, to compartmentalize their conflicts, and otherwise to exhibit internalizing strategies, do well with procedures that foster either insight or emotional awareness. Similar findings have been reported by other investigators. For example, Kadden and collaborators (Cooney et al., 1991; Kadden et al., 1990) have determined that alcoholic clients who presented high scores on a measure of antisocial acting out benefited from a behaviorally oriented treatment, while those with low scores on this measure did better with a therapeutic program that emphasized interpersonal awareness and insight.

Finally, *reactance potential*, or the tendency to react against external influence, is considered in s.e.p. to be an indicator for a therapeutic stance that is either relatively nondirective or that utilizes paradoxical interventions. Highly reactant clients are seen as being likely to respond in an oppositional fashion to interventions which threaten their sense of personal control. Accordingly, s.e.p. has postulated that these clients would be responsive to a therapeutic stance in which the therapist remains quite non-authoritative and nondirective. In support of this contention, a post-hoc study of anxious and depressed clients at the University of Bern (Beutler, Mohr et al., 1991) revealed that nondirective therapy was uniformly more effective among those whose intake evaluations indicated a high potential for resisting external influence. On the other hand, a directive, behavioral intervention was most effective for those with low levels of this form of defensiveness. A prospective extension of this study among clients with major depression went further to reveal that a largely self-directed intervention conducted by graduate student therapists had a strikingly more positive effect among individuals who have high levels of defensive anxiety than did either of two professionally led, directive interventions (Beutler, Engle et al., 1991). As in the earlier study, the latter one also found that those with low levels of defensive resistance responded best to the directive, professionally led interventions. Other studies have further extended these findings to provide support for the proposition that paradoxical interventions are useful in the treatment of highly resistant-prone clients (Shoham-Salomon, Avner, & Neeman, 1989; Shoham-Salomon & Jancourt, 1985).

These three client indicators are initially evaluated as relatively stable traits before beginning psychotherapy, and then re-evaluated within each session in order to achieve greater precision in the management of the therapeutic interventions.

Measures of the three client variables reviewed here include objective and subjective procedures. Some of these client dimensions are assessed both as stable traits and as in-session states. To the degree that coping style and reactance potential can be defined as traits and be measured before treatment begins, we have relied on formally established measurements of personality. We have found the MMPI and MMPI-2 to be useful in providing empirical indices of these two variables (Beutler, Engle et al., 1991; Beutler & Mitchell, 1981; Calvert et al., 1988).

By comparison, the measurement of motivational distress is more complicated and combines measures of interpersonal conflict and psychiatric symptom severity. Formal psychological tests and symptom checklists are used to determine the level and nature of distress, with cut-off points being established from empirical work to indicate the point at which maintenance in treatment is optimal (Mohr et al., 1990). Combinations of scales from the SCL-90R (Derogatis, Rickels, & Rock, 1976) and the Inventory of Interpersonal Problems (Horwitz et al., 1988) are promising for defining criteria for motivational arousal levels that predict likelihood of response in psychotherapy.

Some client predisposing characteristics, however, are not readily susceptible to measurement with current instruments. In our clinical work we have relied on clinical judgment as exercised through process diagnostic procedures within the session. Concepts like *resistance potential*, or *reactance level* as we have often called it, are especially difficult to measure because they include both state and trait qualities. Shoham-Salomon and her colleagues have successfully experimented with content-filtered speech qualities taken within treatment sessions as indices of resistance states (Shoham-Salomon et al., 1989). We

also use "Reactance Challenges," relatively easy but therapist-directed homework assignments, as a means of directly observing the degree of compliance expressed by the client within sessions.

Case Illustration

Jim is a 38-year-old divorced white man employed as a laboratory technician. He has come to counseling referred by the court following a divorce and custody battle. The court has ordered Jim to attend weekly counseling sessions in order to maintain visitation rights of his three children, who are currently in his ex-wife's custody. Jim has a 20-year history of drug abuse (marijuana, alcohol, and cocaine). He has been sober for the last year, after attending a highly structured, inpatient, aversion treatment for ten days under court stipulation.

Client Predisposing Variables

Jim appears as an angry man who blames his ex-wife for the divorce, the court system for taking his children away, and the court-appointed psychological evaluator for the pathological findings described in his mental health evaluation. This style of accusatory blaming characterizes Jim as an individual whose coping style can be best described as externalizing. Jim's level of motivational distress is low. He presents few symptoms of psychic anxiety. Yet, his interpersonal distress is high, a combination we believe suggests a poor prognosis, and requires the evocation of psychic distress. Although Jim comes across as well socialized, he is socially isolated and without friends and intimate relationships. He is oversensitive and suspicious, presents an interpersonal style of control and manipulation, and feels threatened when this perceived control is in jeopardy, He tries to assert himself in a direct manner but when others offer resistance, he resorts to passive–aggressive means of getting his way. Jim hardly ever compromises. He typically resists control while asking for direction, an ambivalence that typifies a passive–aggressive response to authorities. All of these characteristics suggest a person whose reactance potential is high. Finally, MMPI-2 results (a 6-3 code type) correspond with the suggestion of an externalizing coping style and reveals the presence of chronic feelings of hostility that are indirectly, rather than directly, expressed. When aware of his anger, he justifies it in terms of the behavior of others. He denies serious psychological problems, and an elevated MAC-R subscale (27) confirms Jim's substance abuse problems.

Treatment of Choice

A general plan with an individual presenting highly reactant and externalizing characteristics is to put relatively strong emphasis on behaviorally and cognitively oriented procedures. Behavioral control and emotional stability are the first goals, and take priority over either insight or emotional awareness. His low level of personal distress argues for exposure to feared events, undermining destructive defensive patterns, and confrontation with the social consequences of his behavior in order to raise his arousal to motivating levels.

Relationship of Choice

Due to Jim's high reactance levels and externalizing defenses, he is predisposed to respond negatively to a therapist who is seen as a credible, authoritative expert. He is likely to respond in an oppositional fashion to interventions that threaten his personal and interpersonal control. Yet, he needs to control his impulsive behavior. Jim is likely to benefit most from a therapeutic relationship with an equal, someone who listens, responds and suggests choice alternatives, and who endures the oppositional choices made in situations. The most appropriate therapeutic stance is that of a therapist who exerts little direct control, and who works on the establishment of a collaborative relationship in which jointly created exercises are developed. Behavioral exchange and contingency focused interventions may be especially helpful.

Treatment

The recommended treatment, then, is broad band, behaviorally oriented, with low directive procedures for inducing perceptual change and behavioral control (reducing external behavior, passive–aggressiveness, violent acts, confrontation with authorities, drug abuse, and fostering relapse prevention). Rather than symptom removal alone, the treatment focuses upon resolving interpersonal conflicts and inducing interpersonal awareness of oppositional themes. When Jim becomes aware of feelings of hopelessness about himself, he becomes angry and attacks available outside sources. The treatment task is not to change him but to open up the possibilities for change providing a model and benign guide. He benefits from some observations about how he is free to change, able to change in ways that aren't catastrophic. As treatment proceeds, it is becoming increasingly insight oriented, with more emphasis on emotional awareness and self-responsibility (an internal focus).

Concluding Comment

Research continues on the principles of s.e.p. and to date has largely been supportive. While confirmation of the model in its entirety is unlikely, at least certain dimensions are emerging as consistent indicators for the selection of specific treatments for specific clients. Based upon currently available research, the most promising dimensions of treatment matching proposed by s.e.p. are the three that have been explicated here. However, numerous other dimensions are proposed by s.e.p. but are still poorly researched. These bear on such aspects of treatment selection as the setting, mode, and format through which treatment will be conducted, and on the use of homework assignments, the selection of focal themes, and the role of therapist–client similarity, as applied specifically to psychotherapy. These variables, too, are in need of research to define their limits of applicability.

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