How Integrative and Eclectic Therapists Make Treatment Selection Decisions:

A Qualitative Study

By

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ABSTRACT

Therapists with Integrative or Eclectic (I/E) theoretical orientations make up at least 30% of practitioners in the United States. Although several treatment selection models have been proposed and tested, little is known about the way I/E clinicians make decisions and choose among potential interventions in actual practice. Using a qualitative, collective, instrumental case study design, the current study explored how practicing I/E therapists make treatment selection decisions. Five licensed, currently practicing I/E psychologists consented to be interviewed individually during three audio taped meetings, using an in-depth-interviewing protocol. One participant withdrew after the first interview. Thus, four participants had complete data sets for Intra-case analyses: one man and three women, with 5-15 years of post-licensure experience, working in private practices, a university-affiliated counseling center, and an outpatient clinic. The fifth participant's partial data were included only in the final Cross-case analysis. Transcripts were first analyzed by the author and another researcher, and then further analyzed by the author alone. Intra-case analyses revealed nuanced accounts of each of the four therapist's approaches to treatment selection. Further, a Cross-case analysis yielded six Assertions: 1) Treatment decisions emerged from I/E orientations: What this orientation meant to therapists, why it was chosen, how it developed. 2) I/E therapists used stable theoretical or philosophical cores, plus ample flexibility to inform treatment. Participants reported similar core approaches: humanistic, relational, dynamic, or interpersonal. Flexibility was fundamental to I/E treatment selection. 3) The therapeutic relationship was inextricably linked to the treatment selection process, impacting it in complex and subtle ways. 4) Therapists' conflicted disavowal of Empirically Supported Treatments (ESTs) led them to feel like a silent majority. 5) Therapists based treatment selection on certain concrete, specific variables: timing, diagnosis, formal assessment, treatment goals, and

larger sociopolitical contexts. However, these were less salient than other factors. 6) Therapists'

treatment decision processes were experienced as primarily implicit. Based upon the results, a set

of Working Hypotheses about I/E treatment selection processes were generated as directions for

future research. Limitations are acknowledged, and implications for the research-practice gap,

and for therapist training are discussed.

CHAPTER ONE: STATEMENT OF THE PROBLEM

Treatment selection, the process of choosing theoretical approaches, strategies and technical interventions for use in psychotherapy, is an omnipresent task of clinical practice. Each time a therapist begins treatment with a new client, he or she is faced with the question of how to best assist the client using the psychological tools, training, and philosophies available to them. However, in many ways, the process of treatment selection remains poorly understood (Van Manen et al., 2008). Although a number of models of treatment selection have been proposed and tested, little is known about the way clinicians make decisions in actual practice. To illustrate, a recent appeal to researchers of Integrative psychotherapy pointed out:

> "The need for research on how psychotherapy is conducted by practicing clinicians was recently recognized in a NIMH workshop; likewise, a report by the National Advisory Mental Health Council's Treatment and Services Research Workgroup highlighted the importance of studying clinician decision making" (Schottenbauer, Glass & Arnkoff, 2005, p. 480).

The goals for this increased understanding of practice include improving current models of treatment selection, bridging the gap between research and practice, and improving training of beginning therapists. Consistent with these aims, the goal of the current study was to explore the following: How do practicing therapists who identify as Eclectic or Integrative make treatment selection decsions? What are the processes they use to arrive at a therapeutic approach? This question was addressed using a collective, instrumental case study design (Creswell, Hanson, Clark Plano, & Morales, 2007).

In this chapter, I begin by defining treatment selection, and the parameters of this construct within this investigation. Next, sections two and three focus on the importance of studying treatment selection, and briefly discuss the current state of the research. In a fourth section, I review the important gaps in knowledge about treatment selection, and the many calls

for more practice-focused research from the field. Specifically, I assert that some of the widest gaps relate to understanding the process by which practicing clinicians make treatment selection decisions. Lastly, in the final sections, I provide a rationale for the utility of qualitative research to address these missing links, and describe the present study.

Defining treatment selection

Although it is not common for qualitative studies to rely heavily on a priori definitions of terms (Creswell, 1998), it is important for researchers to present their own biases, and the background from which they are approaching the investigation. Thus, while the participants themselves constructed their own meanings of "treatment selection," providing this section can provide both a brief statement of my initial understanding of the topic, and a means to bracket, or suggest boundaries for, the specific process of interest. It seems that the term "treatment selection" refers to a process that (with notable exceptions) is not often explicitly defined in the literature that addresses it. This is perhaps for two reasons: first, on one hand, the issue of treatment selection is so commonplace and seemingly self-explanatory as to be nearly invisible. And second, on the other hand, it is so complex and multifaceted-- a core problem in research and practice--that it is difficult to consider it a discrete clinical action to be studied its own right. However, in direct terms, treatment selection "can be defined as the decision process resulting in ... a therapy proposal to the client" (p. 14, Beenan 1979, as cited by Bleyen, Vertommen & Van Audenhove, 1998), "that typically occurs as part of an intake process during which the clinician must consider: 'is treatment necessary for this client? If yes, is psychotherapy an efficient way of helping this client? What form of psychotherapy, which therapist, and which setting is most appropriate for this client? Which psychotherapy method or techniques should be used in this moment?'" (p.14, Bleyen et al.). Here, I focused my investigation on therapists' response to the

third question. Treatment selection can also be defined in terms of its goals. According to

Vervaeke and Emmelkamp (1998) there are two: to start treatment well, and to ultimately help

the client.

Defining treatment selection also requires operationalizing what is meant by "treatment."

Wampold (2001) differentiates three levels of abstraction that comprise what is referred to as

psychotherapy "treatment":

> "Therapeutic *techniques* (the specific ingredients/interventions used in therapy);
> *therapeutic strategies* ("heuristics that implicitly guide therapist efforts during the course
> of therapy" (Goldfried, 1980, as cited in Wampold, 2001); and *theoretical approaches*
> (the name-brand therapies such as CBT, Interpersonal, Psychodynamic, etc." (p. 9,
> Wampold 2001, italics added).

In addition, Wampold (2001) described a very important fourth level: meta-theoretical models,

which will be discussed later on.

Treatment selection decisions are generally made about the first three levels of

abstraction. "Therapeutic approaches" have attendant techniques that are advocated by, and that

follow logically from the philosophy of the approach. A "pure form" therapist would use one

therapeutic approach and its appropriate corresponding techniques, whereas an Eclectic or

Integrative therapist would work by incorporating more than one therapeutic approach, and/or

one or more techniques that were originally associated with different therapeutic approaches.

In the literature, treatment selection is most often discussed in the context of Integrative,

Common Factors-based, or Technically Eclectic practice. Approximately 30% of psychologists

in the United States identify as Eclectic or Integrative, with most preferring the term

"integrative" to describe their theoretical orientation (Norcross, Karpiak, & Lister, 2009). Thus,

Integrative/Eclectic is the most frequently named approach today. Logically, by not adhering to

one single therapeutic approach and its respective techniques, Integrative and technically

Eclectic therapists are more saliently faced with issues of treatment selection than are therapists who adhere to one theoretical approach and its attendant strategies and techniques. Of course, focusing on non-single-approach therapists does not imply that those who adhere to pure form therapies do not also have complex decisions to make about how to administer their treatment. To be most effective, all therapists, whether drawing from one or more than one approach, must adapt their treatments to their client's needs: for example, they must choose what components or techniques to stress or to downplay, evaluate the timing of particular interventions, consider adjunct referrals for medication or skills training groups, and so on. But it is particularly in the realm of Integrative and Eclectic psychotherapy that the number of treatment approaches and technique choices produces a unique need for a treatment *selection* decision, as opposed to a treatment tailoring or treatment adjustment decision.

Also, the question of how treatment selection decisions are made is not incompatible with a common-factors focus. Even when therapists acknowledge and focus upon known contextual predictors of outcome such as the therapeutic relationship, working alliance, and counteracting demoralization, they still must introduce some specific treatment with a logical rationale and in-therapy tasks in order to provide that necessary component of an effective psychotherapy (Nelson, 2002). Knowing that no one specific approach has been shown to be reliably more effective than any other (Wampold, 2001), therapists must still find a way to decide which one they will employ with which clients.

In summary, for the purposes of this study, "treatment selection" was understood to be the process by which therapists make choices about the three components that constitute psychotherapy "treatments:" therapeutic approaches, strategies, and techniques. And due to the special relevance of treatment selection issues to therapists who do not adhere to one single

approach, the study focused on Integrative and Eclectic psychotherapists.

Importance of studying treatment selection: Relation to therapy outcomes and historical context

Treatment selection decisions can affect the working alliance between therapist and client, and by doing so, affect the ultimate outcome of the therapy (Beutler & Clarkin, 1990; Duncan, Miller & Sparks, 2004; Vervaeke & Emmelkamp, 1998). Working alliance, which refers to the positive affective bond and degree of therapist-client agreement on the goals and tasks of therapy, is one of the strongest predictors of outcomes across modalities of psychological treatment and psychological treatment providers (Horvath & Bedi 2002). Treatment selection and working alliance are intertwined due to the fact that by choosing specific approaches and techniques, therapists are proposing the content of the "tasks" of therapy, and their rationale. Because a client may or may not resonate with these choices, it is important that the therapist either helps the client to understand and accept the logic behind the chosen treatment procedures, or to consult with them to determine which approaches will best fit their perspective before selecting a treatment (Wampold, 2001). Considered in this way, treatment selection processes and the resulting treatment selection decisions can be thought of as common factors present in all psychotherapies. That is, the choice of a particular treatment, while not being the primary cause of therapeutic change as advocated by a Medical Model, does play a supporting role in the overall context of the therapeutic endeavor. Specifically, treatment selection issues correspond to Frank and Frank's (1991) third and fourth category of such common factors:

> 1. Therapy involves an emotionally charged, confiding relationship with a helping person (i.e. the therapist)
> 2. The context of the relationship is a healing setting, where the client presents to a professional who the client believes can provide help and who is entrusted to work in his or her behalf.
> 3. There exists a rationale, conceptual scheme, or myth that provides a plausible explanation for the patient's symptoms and prescribes a ritual or procedure for resolving

them.

4. There is a ritual or procedure that requires the active participation of both client and therapist and is based on the rationale (it is believed to be a viable means of helping the client).

Further, evidence indicates that a strong early alliance is very important, and that measurements taken after as few as 1, 3, or 5 sessions are good predictors of therapy outcome (Horvath & Bedi, 2002). The fact that alliance is set early in therapy also corresponds to the importance of how treatments are selected, as this activity also occurs at the outset of therapy (although it can also change depending upon the progression of therapy later on). The timing issue is also relevant considering the problem of all too frequent early, premature termination in therapy (Garfield, 1994).

As noted above, selecting treatment approaches and techniques is a necessary, but not sufficient part of making psychotherapy work, akin to aspects of common factors such as working alliance. Stepping back a moment, it is possible to contextualize the importance of understanding treatment selection issues by looking to psychotherapy research history, and its cautionary tale of sorts (Beutler 2000).

In reviewing the history of Eclecticism and Integration, Beutler (2000) was concerned that the field of Eclecticism would recapitulate the missteps of "pure form" therapy adherents. He described a pattern that entailed the proliferation of different approaches; the gathering of allegiant proponents; the randomized control-trial competitions, and the resulting idealized manualization that individual brand-name therapy approaches had demonstrated. While he noted that it would be desirable for there to be some greater unification in the areas of integration and eclecticism, he did not want to see integration similarly repeat the pattern with proliferating approaches to integrating or approaches to Eclectic practice. In order to not likewise become

mired in specific-factors comparisons and reliance on a medical-model-type prescription list, there needed to be a new direction taken (Beutler, 2000).

At this point in history, we indeed seem to be in a phase at which models of treatment selection are proliferating. There are over 250 name-brand therapeutic approaches (as estimated by Goldfried and Wolfe, 1996, as cited in Wampold, 2001); and in parallel, "dozens of specific systems of eclectic/Integrative psychotherapy have appeared" (Norcoss, Karpiak, & Lister, 2005). If we are to draw lessons from the historic trends, then it is important now to acknowledge that there are likely many effective ways to make treatment selection decisions, and it is likely not profitable to focus research on pitting one specific method against another (Wampold, 2005). Instead, the problem of logically understanding, systematizing and organizing the areas of Integrative and Eclectic practice could be addressed by exploring what common themes and unique methods are present in the processes of treatment selection as practiced in real clinical settings.

Studies and conceptual frameworks to date: Theories and investigations of treatment selection

As noted above, there have been a number of different models of treatment selection with varying purposes, audiences, and levels of empirical testing published to date. Here, I outline examples of some of the primary methods and systems of treatment selection, provide an overview of the types of studies and the methods that have been used to examine what therapists actually do in practice, and mention other related areas of study pertinent to treatment selection decision-making.

Different models, frameworks or approaches to treatment selection were created with diverse intended goals. Some state their primary purpose as providing a scaffolding for therapists in training as they begin to engage the complexity of treatment selection (e.g. Nelson, 2002).

Others are created to actively prescribe what treatment selection process "should" look like. Such Perscriptive Psychotherapies are defined as models that "employ direct empirical evidence in tailoring interventions and do not limit to just a few orientations" (Bedi, 2001). These include Systematic Treatment Selection and Multimodal Psychotherapy (Beutler & Clarkin, 1990; Lazarus, 1989). Another category of models meant to prescribe is based upon the authors' experience with using the model as well as formally testing it in practice, as Duncan, Miller & Sparks (2004) have done with their Client Directed, Outcome Informed Therapy. Finally, still other proposed models are also based upon theory, but are in the earlier stages of collecting empirical data from their use in practice. These include, for example, Adaptive Counseling Therapy (ACT; Howard, Nance & Myers, 1987) and the Negotiation Model of Treatment Selection (Bleyen, Vertommen, & Audenhove, 1998).

In his review of the Handbook on integration, Wampold (2005) touched upon this question of the use of prescriptive integration/treatment selection models in actual practice: "Despite [these approaches] having great 'face validity' to the reader, I was left wondering, 'Who else uses this approach besides [its creator] and therapists he has trained or worked with?' Several studies have begun to respond to the question of what therapists are "using". They ask how their theoretical orientations, certain aspects of a given therapy, varying client characteristics, and the availability of research data about a particular treatment influence their treatment preferences and decisions. To date, most such studies of therapists in practice have used quantitative methodologies based upon survey data, open-ended written prompts, examining client records, or experimental manipulation. Few have used a qualitative method to study different specific facets of treatment selection.

In the realm of quantitative methods, Schottenbauer, Glass and Arnkoff (2007) provided a

review, and a rationale for the need for additional research in psychotherapy integration. They then provided the results of a study they conduced that addressed this need by comparing the treatment selection practicies of integrationists and "pure form" ahderents. Researchers have examined what treatment decisions therapists make when treatment reaches an impasse (Stewart & Chambliss 2008); the effects of client characteristics on choice of short or long-term therapy (Rabinowitz & Lukoff, 1995); and the role of up to 50 predictor variables in therapist treatment decisions (Rosenblum, Mannarno, Magnussen, & Jameson, 1981). In addition, research has been directed at treatment decisions for a specific disorder, GAD (Van Manen et al. 2008). Although they provide useful data at part of a multi-faceted exploration of this issue, Nelson and Steele (2008) noted a limitation of quantitative survey methods: "To better understand influences on practitioners' decision-making in action, research might examine practitioners' actual treatment decisions and identify important considerations in those decisions. Such methods would be less subject to the effects of socially desirable responding" (p. 176).

Researchers have not only focused on study of whole systems of treatment selection, or the behaviors of therapists in practice. Much of the current research on treatment selection has examined individual predictors of clinical decisions and their outcomes. Vervaeke and Emmelkamp (1998) reviewed research on such matching variables, including sociodemographic factors, degree of disturbance/severity, diagnosis, match of patient and therapist, personal or background characteristics, and matches for varying attitudes, values, and patient characteristics. Other brief examples are Duncan and Miller's work with clients' theory of change, and Berg, Sandhal and Clinton's (2008) investigation into the role of clients' treament preferences in therapy outcomes.

Approaching therapist's clinical decision-making from another angle, researchers have

also suggested that underlying cognitive processes that undergird all of decision-making, including treatment selection, should be investigated, and have conducted studies with clinicians in practice (e.g. Murdock & Fremont, 1989; Schottenbauer et al., 2007). Through all the above studies, we have come to rule out some of the hypothesized processes of treatment selection, and begun to speculate about others. For example, it seems that therapists do not use research evidence as a primary guide to treatment selection. Specifically, one recent study based upon a national survey of practioners concluded that even though research evidence is thought to be the appropriate basis for clinical decision-making, treatments with the best research are not widely implemented in clinical settings. It is in actuality, treatments with little or no research support, and those that emphasize the therapeutic relationship, which are more preferred by clinicians. (Nelson & Steele, 2008).

What is missing: Important gaps in understanding

Several researchers and organizations have independently called for a greater understanding of the way psychotherapists practice in actual therapy settings, with some specifically calling for research on clinical decision-making and therapy integration practices, as well as research using a diversity of methodologies.

A report from the 2000 NIMH workshop on promoting greater public health relevance for psychotherapy intervention research noted, "One of the most frequent comments expressed at the meeting concerned the paucity of existing research defining treatment as usual (TAU). Participants strongly recommended that descriptive data on the components of 'typical' clinical practice be collected," (p. 130, Street, Niedereche, & Lebowitz, 2008). Leading researchers from the area of psychotherapy integration suggested three hoped-for benefits of knowing more about therapists' in-practice treatment selection decisions: addressing the gap between research and

practice, better understanding complex clinical tasks, and gathering data that could be used to

support therapists in training (Eubanks-Carter, Burckell, & Goldfried, 2005).

Researchers whose focus is on training Integrative therapists have called for good models

of Integrative practice. For example, in the summary of contributors' responses to the question of

future directions in Integrative training, Eubanks-Carter et al. (2005) noted, "Several contributors

emphasized that students need faculty and supervisors who can model Integrative practice

(Feldman & Feldman; Pachankis & Bell). Halgin contended that the most effective way to teach

integration is for students to observe the work of Integrative therapists" (p. 515). If researchers

were to contribute to this effort of providing access to models, their work might take the form of

publishing case studies that focus on the perspectives of such potential mentors:

> "[Norcross & Halgrin, 2005] and others (e.g. Lampropoulos, 2002; Norcross & Beutler,
> 2000) emphasize the enormous value of demonstrating and modeling psychotherapy to
> trainees. Trainees should observe the work of clinical supervisors, conduct psychotherapy
> with more experienced peers, and watch videotapes of seasoned clinicians conducting
> psychotherapy. Trainees may also benefit by reading about how seasoned therapists
> themselves struggled in their early attempts to develop an integrated approach to therapy
> (Goldfried, 2001)" (p. 450).

There is a gap in the literature-- thus far, the field has primarily taken the top-down

approach of proposing theories of integration and treatment selection and begun to test them. But

we are missing the complementary approach of asking therapists about their current process of

treatment selection. One hope is that by bringing these two directions of study together, top and

bottom, we can also make progress towards bridging the gap between research and practice in

this area. This idea is reinforced in the following quote:

> "Therapists in the trenches are constantly making decisions to integrate therapies in an
> effort to improve service to their clients. Although it is a challenge to study their
> decision-making and link it to outcome, the field can benefit from the wisdom of those
> who spend the majority of their time providing services. Such 'bottom-up' research
> strategies can complement and ultimately inform the more standard 'top-down' strategy of

creating and studying manualized treatments" (p. 480, Schottenbauer, Glass & Arnkoff, 2005).

Reasons for using a qualitative methodology to contribute to narrowing the gap:

While a variety of research approaches to studying therapists' treatment selection processes have been advocated, it seems that the least utilized to date are qualitative methods. This is a notable absence, because qualitative research methods are particularly useful for exploring processes about which less is known (Creswell, Hanson, Clark Plano, & Morales, 2007), and as Schottenbauer, Glass and Arnkoff (2007) assert, "Research on clinical decision-making in psychotherapy is in its infancy" (p. 225). Another characteristic of qualitative research that makes it particularly well-suited to the question of how therapists make treatment selection decisions, is that qualitative research is designed to answer questions of "how" and "what," and to "explore" issues in a "naturalistic setting" (Cresswell, 1998).

A third reason qualitative methods were used is that this approach is especially useful for highlighting the perspectives of those whose voices are not always heard (Haverkamp & Young, 2007). And while this is not to imply that studying practicing therapists is comparable to working with participants who have been systematically oppressed in society, there is a mild parallel. The gap between research and practice is most frequently forded by researchers "bringing" theories and techniques for therapists to use, rather than by therapists bringing theories and techniques for researchers to study. Eubanks-Carter et al. (2005) suggested ways for future research to be more open:

> "In addition to basic research, we should draw on clinical wisdom when we develop new theories. The intuition of skilled clinicians is often years ahead of our research findings. But the tools of research can help us to access clinical wisdom in a systematic way. Instead of allowing the most forceful personalities to dominate the discussion, we can use systematic reviews of the literature, surveys of experts, and studies of master therapists to bring together the clinical wisdom of a diverse sample of therapists" (p. 513).

Two researchers have used qualitative methods to study the way therapists think about, and make decisions about the therapy they conduct. Williams and Levitt (2007) studied the process by which expert therapists negotiate values-- theirs and their clients'-- in psychotherapy, as part of a larger qualitative study concerned with therapists' understanding of the change process. This is relevant to the current study in that the rationale for the study of therapists' treatment selection process mirrored Wiliams and Levitt's rationale for studying therapists' values negotiation process. It seems that in both lines of investigation, the gap appeared in the same place. That is, that although a significant number of studies had proposed, tested, and advocated for theories about the process in question (values negotiation or treatment selection), and several quantitative studies had provided insight into the issue, questions still remained about what the process looked like in everyday practice. In their rationale for conducting a qualitative study, Williams and Levitt stated:

> "Instead of indicating sets of rules about value conversion, we could develop principles by first asking therapists about their practice of therapy, and then developing a comprehensive understanding of how values are actively negotiated within sessions rather than beginning with a theoretical foundation" (2007, p. 162).

In addition to calls for all types of studies on therapists' clinical decision-making and treatment selection processes, some in the field have suggested that case study methodologies are particularly warranted (Lazarus, 2005; Wolfe 2005). Lazarus (2005) advocated for their use because, "when properly implemented, single case studies can be carefully thought through, tied to relevant theoretical constructs, empirically measured, and described in sufficient detail for others to be able to appreciate, understand, and replicate the intricacies of the clinical situation" (p.418).

The present study

The question that guided the present study was: How do practicing therapists--particularly those who identify as Eclectic or integrationist-- make treatment selection decsions? To investigate this question, the study took the form of a collective, instrumental case study. "Collective," because I examined more than one case, and "instumental" because the cases were selected in the service of promoting insight and greater understanding of the issue of naturalistic practices of treatment selection (Creswell et al. 2007). I recruited experienced practicing therapists to particpate in interviews, and analyzed transcripts, observations, and (vicarious) documents from five cases. Although one defining feature of qualitative research is an "evolving design" that allows the investigator to be responsive to unfolding information (Creswell, 1998, p.19; Haverkamp & Young, 2007), a specific plan was initially necessary. This provided an initial structure for choosing participants of interest, methods of data collection, data analyis strategies, and guiding philosopies of science. The method for this study is elaborated in Chapter three.

Scope of the present study

One initial limitation of this study is that it does not address questions of the effectiveness or outcomes associated with using different methods of treatment-relevant decision-making. That issue remained outside the scope of the project. This project also shared the advantages and drawbacks of qualitative research methods compared to quantitative methods.

CHAPTER TWO: LITERATURE REVIEW

To provide a context for the following research and theory, I begin by locating treatment selection issues within the broader psychotherapy literature. Next, I call attention to the Psychotherapy Integration movement and its practitioners, whose decisional processes are the focus of this study. Disagreements and controversies, both among Integrative/Eclectic psychologists and between integrationists and single-therapy adherents are acknowledged. Following this contextual grounding, I overview: 1) published theories and models of treatment selection and the empirical evidence for these models, 2) studies of individual variables associated with treatment selection, and 3) research focused specifically on the process and content of treatment selection decisions made by practicing psychotherapists. Sections were organized with the aim of describing the current state of research on treatment selection through the lens of the Integrative psychotherapy movement.

Treatment selection and the broader context of psychotherapy research

Psychotherapy on the whole is highly effective (Glass & Miller, 1980; Lambert & Bergin, 1994; Shadish, Matt, Navarro, & Phillips, 2000; Shadish, Matt, Navarro, Siegle, Crits -Cristoph, Hazelrigg & et al., 1997; Smith & Glass, 1977), but research as to precisely why and how it is effective is still nascent. These primary questions have led to competing meta-models and divergent research foci: the search for specific factors/ingredients that make therapy effective, versus the search for factors common to all forms of psychotherapy that account for its effectiveness. At present, research evidence is steadily accumulating in favor of the contextual model.

Within the field of psychotherapy, partly in response to the proliferation of individual therapy approaches, the majority of research had followed the form and focus of that from

medicine (Wampold, 2001). In this type of Medical Model, specific treatment techniques based upon differing theoretical orientations had been studied to determine their absolute and relative efficacies. The focus was on testing specific "ingredients" of each therapy, under the assumption that just as medical conditions may require specifically matched interventions, it was the specific factors unique to each psychotherapy approach that were most important for clients' change and recovery. However, using meta-analytic statistical procedures, psychotherapy researchers (Wampold, Mondin, Moody, Stich, Benson & Ahn, 1997) tested and found support for another possibility, which is known as the Contextual Model. Instead of the specific differences in therapies accounting for healing, it was found that the general factors common across all forms of psychotherapy contributed to the largest proportion of variance in outcomes. This finding provided strong evidence for what others had been arguing for some time (i.e. Frank & Frank, 1991; Rosenzweig, 1936).

While each of the alternatives to a single theoretical approach vary in their consistency with the contextual model--from Theoretical Integration at the far end of the continuum, which at times suffers the issues of the integration becoming its own "new" single theoretical approach--to Technical Eclecticism, and finally to Common Factors Integration at the most closely affiliated end (Wampold, 2001), they may tend to be more consistent with the Contextual Model then are single "pure form" theoretical approaches with their prescribed technical interventions. This is so by virtue of the fact that the Medical Model, by definition, requires treatments to highlight the specific ingredients to the point of advocating the use of a manual to ensure adherence to these specifics. And while several Integrative Psychotherapies do have published manuals, the broader idea of psychotherapy integration allows more latitude for focus on factors common to many effective treatments.

Placing Integration and Eclecticism in the context of other psychotherapy movements, Anchin (2003) pointed out the co-evolving histories of Integrative psychotherapy and Brief psychotherapy. He argued, for example, that the aftermath of WW-II, the growth of inter-disciplinary VA hospitals, and the Community Mental Health Center Act each called for flexibility in treatment techniques that produced efficient results, and also allowed therapists to come into contact with variations in other practitioners' approaches. Thus, there was motive and opportunity for the development of Brief and Eclectic therapies.

Integrative and Eclectic (I/E) Theoretical Orientations

The proposed study is focused upon the treatment selection decisions of psychologists who identify with, and practice Eclectic and/or Integrationist approaches to psychotherapy. Beginning in the 1960s, studies have investigated the number of therapists practicing from more than one theory, and have consistently found that one quarter to one third of these practitioners identified as Integrative or Eclectic in their approach to psychotherapy (Norcross, Kariak, & Lister, 2005). In the most recent survey of psychologists, 29% of the 654 respondents identified as Integrative or Eclectic (Norcross et al., 2005), with most respondents preferring the term "Integration" as opposed to "Eclecticism". This self-identification seems to be consistent with an historical trend towards using the former term to encompass both styles. These data are a crucial part of understanding what practicing psychologists report doing during treatment as usual. But while they demonstrate the widespread use of Integrative approaches in practice, there is little known about what such actual practice looks like.

The Eclectic and Integrative psychotherapy movement: History and changing terminology

The distinctions between Integration, Eclecticism and their subtypes can be unclear, because their meanings and connotations have shifted over time and continue to evolve

(Garfield, 2000). Because of this evolution of terms, these approaches to psychotherapy are perhaps usefully described through tracing the history of their development. Although Psychotherapy Integration, as a formal movement, dates back only [25 years as of 2009] (Lampropoulos, 2001), it is based upon a much longer tradition of combining different aspects of "pure type" treatments.

In a sense, I/E psychotherapy can be traced back to Freud, who began by integrating techniques such as hypnosis with a relational approach to create psychoanalytic therapy (Anchin, 2003). Or, it can be traced to Freud in another way: perhaps because disagreements among ex-followers of Freud sparked the first rivalries among theoretical orientations (Beitman, Goldfried, and Norcorss, 1989). But most historians of Psychotherapy Integration and Eclecticism cite an article by French (1933) on the need for Psychoanalysis to account for Pavlov's findings in Classical Conditioning, as the seminal work in what would become the I/E movement (Garfield, 1994; 2000; Lazarus, 2000; Stricker & Gold, 2003).

Later, in the mid to late 1950s, journals frequently published debates pitting psychoanalysis against behaviorism. Meanwhile, the number of other single-systems of psychotherapy proliferated. It was this climate that led an unofficial "underground movement" of psychotherapists to question whether any one school had all the answers (Beitman et al, 1989; Lazarus 2000). "Eclectic" was the term for the use of more than one approach to psychotherapy. Another line of influence that contributed to the rise of Eclecticism was new insurance regulations, which did not favor the long-term therapy model of traditional psychoanalysis (Lazarus, 2000). Eclectic therapies were useful under these conditions because they could combine more active, brief therapy models with techniques from psychoanalysis. But the most prominent contributor to the growth of Eclectic and Integrative psychotherapy was outcome

research accumulating in the 1970s and 1980s. This research indicated that the many diverse

pure-form therapies, which had continued to proliferate, were equally effective (Anchin, 2003;

Garfield, 2000).

Thus, the late 1970s and early1980s was a time of great interest in Eclectic approaches to

therapy, because of the culmination of several factors. Stricker and Gold (2003) offered four

catalysts: First, it was recognition of evidence for the equivalence of outcomes between single-

school therapies. Second, because of the rise of biological models of psychopathology and the

new medications, talk therapies were required to defend their own effectiveness. To do so,

therapists from divergent schools began to, as it were, hang together or hang separately through

learning from one another. Another facilitating factor of integration was generational: because

the "pure form" therapies had established themselves and provided the raw materials, newer

generations of therapists were more free to experiment and attempt to make improvements.

Finally, the broader zeitgeist of the 1960s-1980s supported breaks with authority, and encouraged

social integration as well as intellectual integrations.

However, the 1970-to-mid-1980s period was also a time of differentiation within the

movement. The introduction and favoring of the term "Integration" in the early 1980s was partly

a response to critiques that Eclecticism was "haphazard", and partly in response to Wachtel's

(1977) well-received book, *Psychoanalysis and Behavior Therapy: Toward an Integration*, which

"opened the floodgates" (Stricker and Gold, 2003 p. 319) of psychotherapy integration. Garfield

(1994) further explained that, "what was evident during this period was both a continuing

interest in Eclectic approaches to psychotherapy, and the beginning development of a movement

for integration of two or more approaches to psychotherapy, particularly psychodynamic and

behavioral" (p. 126). In 1983, the Society for Exploration of Psychotherapy Integration (SEPI)

was founded (Lazarus, 2000; Stricker & Gold, 2003). As a concrete example of the shift in terminology and focus in the movement, from then on, second editions of several books and journals previously using the term "Eclectic" in their titles changed to using the term "Integration" even while maintaining the same essential content (Garfield, 1994). Technical Eclecticism was retained as a term, but was re-organized to be not a separate system, but as one of three sub-categories of Integration which included Theoretical Integration, Common Factors Integration, and Technical Eclecticism. Interestingly, from the perspective of one psychotherapist and researcher who was making treatment selection decisions during this time, Garfield (2000) noted that in the1995 edition, he himself had changed the title of his 1980 book to include the word Integration for social/political reasons: Despite being a proponent of Technical Eclecticism, and specifically of Common Factors Eclecticism, "[Garfield] accepted the fact that I was viewed also as an Integrationist."

Psychotherapy integration versus Integrative Psychotherapies

The evolution from the use of the term "eclectic" to the use of the term "integrative" was only one chapter in the story of labels shaping the Integrative psychotherapy movement. Stricker and Gold (2003) stressed the importance of recognizing the differences between two closely related constructs: psychotherapy integration: a process on one hand, and Integrative Psychotherapy/ies: the product of that process, on the other. More specifically, Psychotherapy Integration refers to a clinical orientation, philosophical approach, or general worldview of psychotherapy "defined by an openness to understanding areas of overlap or divergence among individual psychotherapies, interest in promoting dialogue among and learning from therapists from diverse orientations, and not declaring loyalty to one school or model of psychotherapy" (Stricker & Gold, 2003, p. 317). Integrative Psychotherapy, however, is the *product* of such a

process, which can then be packaged as a single unit and used "as yet another sectarian approach with all the limitations attendant upon that status" (p. 317).

This distinction is relevant to the present study because it juxtaposes what is theorized with what may or may not be practiced. It is not known whether practicing I/E psychotherapists view themselves as Psychotherapy Integrationists who maintain a general outlook that informs treatment decisions, or if they consider themselves to be users of one or more Integrative Psychotherapies, and adhere to more structured systems of drawing from more than one "pure form" therapy. Or, alternatively, if it could be that they vary between the two depending upon certain variables or contexts. Or as a final example, if this distinction is even "on the radar" as a dimension therapists use to conceptualize or to describe their work. It is also relevant in so far as the need for such a distinction provides information about the state of the I/E movement. On a broad scale, Integrationism is recapitulating some of the very things it was designed to avoid (Garfield, 2000). That is, I/E arose in part due to the proliferation of psychotherapy "packages", along with the belief that no one therapy could provide everything to every client in every situation. But in response to a similar proliferation of forms of integration, Stricker and Gold (2003) seem to be noting that there is once again a need to reaffirm that no one Integrative Psychotherapy can provide all things to all people.

Types of I/E: Primary categories and conceptualizations

Overall, Integrative Psychotherapies have been defined as "the result of an explicit attempt to synthesize theoretical constructs and clinical interventions that are drawn from two or more traditional schools of psychotherapy into one therapeutic approach [with the goal that these forms of therapy] will be more effective, and applicable to a wider range of clinical populations and problems than were the individual modes of psychotherapy that were integrated" (Stricker &

Gold, 2003, p. 317). There are a great many Integrative Psychotherapies, and likewise, a number

of different systems by which they have been organized. Anchin (2003) observed, "there are a

number of ways to slice the brief integrative therapy pie...[that are] by no means mutually

exclusive" (p. 227). One frequent organization is differentiating models of I/E treatment

selection by their primary type of integration. This breaks down into Theoretical Integration,

Technical Eclecticism, Assimilative Integration, and Common Factors Integration. Brief

descriptions of each follow.

Theoretical Integration (TI)

TI "is the most complex, sophisticated, and difficult mode of integration, and relies on a

process of synthesizing personality theories, models of psychotherapy, and mechanism of change

from two or more traditional systems" (Stricker & Gold, 2003, p. 321). It is an integration in

which "a clear theory drives the choice of techniques (which are not necessarily from only one

school of therapy" (Schottenbauer, Glass, & Arnkoff, 2005, p. 460), and in its ideal sense, bring

together two or more theories into one more explanatory, useful theory that is then used to guide

treatment.

Technical Eclecticism (TE)

TE is "an empirically based approach which advocates selectively combining the best

techniques, regardless of theoretical orientation, and applying them to efficiently address client

problems" (Lampropoulos, 2001, p. 7). This approach is one response to Paul's (1967) question:

what treatment, by whom.... is best (Wampold, 2001). Strategies and techniques from at least two

approaches can be applied serially or in combination, usually after extensive assessment of the

client to understand how techniques targeting different realms (affect, cognition, behavior,

systems) could best be combined to address the client's problems. Within this sub-category of

integration, treatment decisions are made on the basis of thorough assessment, clinical knowledge, and/or research findings (Stricker & Gold, 2003, p. 320).

Assimilative Integration (AI)

AI is a more recently introduced sub-type of integration (Messer, 1992), which was conceived as a means to combine the flexibility of Technical Eclecticism with the coherent scaffolding of Theoretical Integration (Norcross, Karpiak, & Lister, 2005). Case conceptualization and the majority of strategies and techniques are informed by one primary theoretical orientation, while selective techniques from other orientation are judiciously added. Ideally, Assimilative Integrationists use an empirically supported "home" therapy, incorporate empirically supported complementary techniques, and ensure that all components are compatible with the original rationale, therapeutic stance, and philosophical underpinnings of the home treatment (Lampropoulos 2001).

Common Factors Integration (CFI)

CFI "begins with an identification of effective ingredients present across all therapies" (Stricker & Gold, 2003, p. 320), and is at times categorized together with Technical Eclecticism as a sub-form because the curative factors can come from any system of therapy, regardless of the original theory involved. When Technical Eclecticism involves choosing from among strategies (as opposed to techniques or approaches) it represents a form of CFI (Wampold, 2001).

Types of I/E: Alternative classification systems

In addition to/in place of the three types integration discussed above, Carere-Comes (2001) proposed an alternative taxonomy that adds Accommodative Integration. Messer (2000) additionally suggested categorizing integrative techniques by their "visions of reality" which he described as potentially romantic, tragic, ironic, or comic (as cited by Anchin 2003). Integrative

psychotherapies have also been categorized by the diagnosis or disorder they are designed to address, or alternatively, by a range of problems experienced by particular clinical populations (i.e. children, adults families) upon which they focus (Anchin 2003; Schottenbauer, Glass & Arnkoff, 2005). The relevance of presenting these differing classifications is the demonstration that the Integrationist movement is a "live" field, still being shaped by the primary research voices. While researchers are categorizing what therapists may be doing in practice, it is unclear how individual practitioners label their approaches (when not choosing among pre-set alternatives) and whether they are drawing from the literature to do so.

Further, in considering the question of how therapists make decisions about which treatments from which theories using which techniques, it may be helpful to add yet another dimension of organization to this list. One primary question to ask regarding treatment selection in psychotherapy is, "who is doing the selecting?" Published models of Integrative therapy could be organized by placing them on a continuum representing the degree to which each model advises privileging the client's theory of change. On one end, the therapist acts as the expert to prescribe a treatment, and to provide a convincing rationale for why that it is the best approach. On the other end, the client is in the role of the expert (or, indeed, "hero" as described by Duncan, Miller and Sparks, 2004) while the therapist's role is to use his or her knowledge of theories and techniques to best accommodate the client's world-view. And, in the middle, there are models that advocate an explicit negotiation of treatment decisions between therapist and client (Van Audenhove & Vertommen, 2000).

Pros and cons of I/E psychotherapy: Critiques and controversies

Many I/E proponents assert that within the human condition, affective, behavioral, cognitive, and interpersonal aspects of an individual's life and problems are interrelated, but the

major single-schools of therapy tend to focus on one area while under-representing or ignoring

others. Those who are Eclectic have given the reason that they use whatever techniques are the

best for the individual they are working with, without regard for their theoretical origins, because

they then have tools to address many of the different domains that together affect their clients'

lives. They also see I/E approaches as allowing for flexibility, practicality depending upon the

treatment setting, and a focus on the therapeutic relationship (which, although also important in

single-schools, is less explicitly emphasized).

Stricker and Gold (2003) elaborate these reasons Integrative therapy approaches to

treatment might be preferable to single, traditional therapy systems. They state, "Integrative

psychotherapies seem, at least in theory, to be uniquely suited to the needs of patients with

diverse backgrounds and problems, whose lives, personalities and psychopathologies deviate

from the 'ideal types' that are most easily treated by one of the sectarian approaches" (p. 337).

These authors also highlight the focus on flexibility for the uniqueness of each client; the goal of

developing the most effective patient-technique match possible; the ability to allow the focus of

treatment to be broader and more individualized; and the main idea that one is using the best of

what works to try to "cover all the bases" (p. 337) of what impacts problems. Finally, Integrative

psychotherapy tends to be used more often with severe problems that traditional treatments have

not worked for.

However, Lampropoulos & Dixon (2007) acknowledge that Integration and Eclecticism

have often been accused of "idiosyncratic, unsystematic, and unscientific practice" (2007, p.

187). Yet at the same time, when these authors surveyed internship training directors, they found

that "90% agreed that knowing one therapeutic model well is not sufficient for the treatment of a

variety of problems and populations; instead, training in a variety of models is needed" (p. 197).

The reconciliation of these two positions has been stated as the "need for a clear, coherent, systematic and data-driven integrative practice" (p. 204). This goal remains an aspiration for those who publish, study, critique, teach, and apply models of psychotherapy integration (Norcross & Goldfried, 2005).

Alford and Beck (1997) described three primary areas of disagreement between psychotherapy integration and established systems of therapy--specifically CBT. One philosophical difference is seen in positions on the worth of debates and arguments between camps in journals (with CBT encouraging the exchange and I/E aiming to reduce arguments in favor of a more collaborative approach). A second disagreement concerned the way CBT has been inaccurately portrayed as overly committed to scientific theories, and narrowly focusing on the role of cognition. Alford and Beck note that Integrationists are themselves just as committed to their own theories and approaches, and that science has progressed due to the testing of theories. They also suggest that CBT is highly flexible, and has never single-mindedly valued the role of cognition. These authors frame the two approaches as "competing" with one another, but also as being much less polarized than is portrayed in the literature.

There are also controversies within the area of I/E practice, as compared to criticism leveled from "outsiders" who recommend the use of one single therapy. Regarding Assimilative Integration specifically: "to its proponents, assimilating is a realistic way-station to a sophisticated integration; to its detractors, it is more of a waste station of people unwilling to commit themselves to an evidence-based eclecticism" (Norcross, Kariak, & Lister, 2005, p. 1593). Likewise, Lampropoulos (2001) identified limitations of Theoretical Integration. Although TI ideally aims to integrate all or many existing theories into one universal approach, existing theories only integrate 2-3 single approaches at most, and only incorporate those aspects

of pure form treatments that are initially compatible with one another (rather than being successful at fusing disparate approaches). Second, new integrative psychotherapies may focus only on treatment of a specific disorder, and not be designed to work for all diagnoses. Finally, and importantly, TI lacks systematic empirical validation.

Further, Technical Eclecticism as a sub-form of integration has been criticized for being "haphazard, arbitrary and idiosyncratic" (Lampropoulos, 2001, p. 7). This is the case despite the fact that some forms are explicitly based upon systematic, empirically validated models of treatment selection which were developed based upon Aptitude-Treatment Interaction designs. But even with the possibility of such ATI designs furthering TE research, criticism remains. Lampropoulos (2001) points out that by definition, TE does not follow from one overarching theory. Thus, it is not possible to test only a limited number of logically derived hypotheses to advance the approach, but instead produces a need to test the over 1.5 million possible interactions among identified variables.

Overall, lack of empirical evidence for Eclectic and Integrative approaches, as opposed to single-school approaches (Stricker and Gold, 2003) has been a major critique. But in some ways, making progress on one front has led to problems on another. Eclecticism's criticism for being too random and ungrounded was partially addressed in the movement of psychotherapy integration, which tried to combine only 2-3 or a few specific single-theory-based treatments within its own new theoretical framework, thus making these treatments more amenable to systematic research. However, this approach has also garnered criticism because at this point, there continues to be the proliferation of integration methods, mirroring the proliferation of single-form treatments. And, as Wampold (2001) notes, echoing Arkowitz (1992), "The central issue for psychotherapy integration is to avoid having the integrated theory become a unitary

theory of its own, and to generate hypotheses that are distinct from the theories on which the integration is based" (p. 22). Thus, this issue of integrative psychotherapies 'taking on lives of their own' is a critique coming from both inside, and outside the I/E movement.

In actual practice, perhaps Integrative and single-school treatments do not differ as much as in theory. This line has blurred and changed over time. Therapies that were once considered "integrative" have since developed into their own coherent "pure form" treatments. Beck's Cognitive-Behavioral therapy in the 1970s is one example (Stricker & Gold, 2003). On the other hand, the widespread adoption of Integrative and Eclectic modes of practice was shown even when only members of a particular "pure form" orientation were surveyed. A study of Behavioral therapists indicated a large percentage identified themselves as "Eclectic behaviorists" (Garfield, 2000).

Research on Integrative and Eclectic (I/E) psychotherapists: What is known

Norcross, Karpiak and Lister (2005) surveyed Clinical Psychologists in APA's Division 12 with the goals of learning a) how many practitioners endorsed an I/E approach to therapy, b) what each called their specific approach to integration c) which "single form" therapies they most often drew upon in their Integrative/Eclectic practices, and d) how these psychologists "defined or explained" their theoretical orientation. A complementary aim of the study was to compare the results to earlier studies (Garfield & Kurtz, 1977; Norcross & Prochaska, 1988), which had asked these same questions, to examine trends over time. Because these authors addressed key issues related to the study of I/E psychotherapists' conceptualization of I/E practice, I focus more closely here on the details of this study. Of particular interest are the study's strengths and limitations pertaining to ways the study advances knowledge of I/E therapists' practices, and ways the study leaves gaps open for future investigation.

Provided that participants endorsed I/E as their overall orientation, the second issue (b) was addressed by presenting participants with Likert-scale items allowing them to indicate their preference for the terms "eclecticism" versus "integrationism". Thirty-nine percent preferred the term "integrative", 20% preferred "eclectic" and 21% reported no preference. Additionally, participants were asked which of four sub-types of I/E--"Assimilative Integration" (AI), "Theoretical Integration" (TI), "Common-factors Integration" (CFI) or "Technical Eclecticism" (TE)-- best described their practice. Results found that AI was endorsed by 26% of respondents, TI by 27.5%, CFI by another 27.5%, and TE by 18%.

Greater detail about reported in-session behavior was gathered by listing six major therapeutic approaches (Cognitive, Humanistic, Behavioral, Psychodynamic, Interpersonal, Systems/Family, as well as a seventh "Other" category), and asking participants to rate, on a 5-point Likert-type scale, how frequently they utilized each (from "no use" to "repeated use"). Results showed that for each of the 15 possible two-theory combinations (based upon each participant's two most frequently used theories), there were indeed therapists who used them. Interestingly, the most commonly endorsed combination was Behavioral and Cognitive. Yet, instead of identifying as a "pure form" cognitive-behavioral therapist, these participants had all reported identifying with an I/E orientation.

Next, because practitioners do not always limit themselves to only two sources of integration, the authors used a "K-means cluster analysis" to distill the results of the Likert-scale responses into a 9-cluster solution. They then created descriptive labels for each cluster according to the number and regularity of theories used. Specifically, those who reported using all six theories frequently (all rated with 3's and 4's on the Likert scale) or very frequently (all rated 4's and 5's) were represented by clusters labeled "Moderate Eclecticism" (7% of

respondents) and "Extreme Eclecticism" (9%) respectively. Similarly, the few who reported using each of the 6 therapies with low or no frequency were described as part of the "Uncommitted or Naysayers" cluster (3%). Three more clusters described different degrees of reliance upon cognitive and cognitive-behavioral-based therapies, and encompassed a total of 31% of the respondents ("Broad Cognitive-Behavioral", "Traditional Cognitive-Behavioral", and "Uber-cognitive"). The remaining three clusters were "Mulitmodal" (18%; all therapies were used, but like Lazarus's Multimodal Psychotherapy, cognitive and behavioral approaches were reportedly used the most); "Cognitive-Analytic" (20%; these two approaches were most frequently used); and "Interpersonal-Humanistic" (13%), which encompassed a situation in which there was very high reported use (ratings of 5) of Humanistic and Interpersonal approaches, along with high reported use (ratings of 4) of Psychoanalytic and Cognitive approaches (Norcross et al., 2005). While very informative about the range of approaches to selecting treatments for use in an Integrative or Eclectic practice, these data share the caveats of other self-report survey data. It is unknown how individual practitioners were interpreting the terms for the therapies "Humanistic", "Psychodynamic", "Cognitive", and so on, that they rated for frequency of use. Or, if in response to the Empirically Supported Treatment movement, they were perhaps showing a bias towards endorsing frequent use of, for example, Cognitive and Behavioral approaches, as these are among the most often studied and efficacious in RCTs.

A final survey item differed from other items in that it was framed as a "free-response" question. Thus, instead of quantitative ratings, participants were asked to write a qualitative "definition and explanation" of their I/E orientation. While a potentially rich opportunity to learn how therapists saw their theoretical orientations, analysis of these data were limited by methods used in prior studies. Data were coded into pre-identified categories (based upon findings in the

1977 & 1988 studies) rather than interpreted anew from the raw data in a grounded manner.

Thus, while successfully addressing one goal of the study (to compare results over time), it is

possible that this choice of data analysis did not fully address the goal of understanding I/E

practice from the perspective of therapists themselves. There appears to be an interesting

contradiction between the methods used in the K-cluster analysis to categorize I/E types based

upon the data and *then* to apply descriptive cluster names post-hoc, and the methods used in the

qualitative analysis which began with descriptive category names a-priori, and fitted the data into

them.

The above study added much important information about the reported combinations of

therapeutic approaches used in practice, and the ways psychologists described their orientations.

A main finding is summarized in the authors' conclusion: "It is clear from these results that

psychotherapists who describe themselves as I/E are a very heterogeneous group" (Norcross,

Karpiak, & Lister, p. 1591). This empirical work illuminated the diverse *content* of participants'

treatment selection decisions (which therapies were drawn from and how frequently), but did not

focus on the *processes* by which these decisions were made by the respondents, or the

information regularly used to influence those decisions. Thus, these results stimulate further

questions about treatment selection decisions among I/E psychotherapists.

Outcome research on models of treatment selection

Schottenbauer, Glass and Arnkoff (2005) reviewed the psychotherapy outcome literature

and categorized 29 different Integrative psychotherapies (published between 1981 and 2005)

according to the design and number of studies that support them. They listed 9 models with

"substantial" empirical support (4 or more RCTs), 13 with "some" support (1-4 RCTs), and 7

with "preliminary support" (studies with no control group or a nonrandomized control group). In

addition to these, the authors listed 25 more therapies, which they classified as "promising". This category included models that had one or more published, successful case studies but no group tests to support their effectiveness or efficacy. The nine most studied and most well-supported integrative psychotherapies were Acceptance and Commitment Therapy, Cognitive Analytic Therapy, DBT, Emotionally Focused Couples Therapy, EMDR, Mindfulness-Based CBT, Multisystemic Therapy, Systematic Treatment Selection, and Transtheoretical Psychotherapy.

Research-based prescriptions for treatment selection

In accordance with the ideals of Theoretical Eclecticism, much treatment selection research has focused on answering Paul's (1967) question about which client-therapist-situation-treatment matches lead to the best outcomes. Vervaeke and Emmelkamp (1998) reviewed the psychotherapy outcome literature and made inferences about what may be most important to consider when making treatment selection decisions. Specifically, their goals were to examine research on matches between a) patient characteristics and therapist characteristics, b) patient characteristics and type of therapy, and c) patient diagnosis and type of therapy. Advice to practitioners and predictions about future directions included placing more emphasis on assessment of clients' interpersonal patterns, expectations, preferences, and potential matching characteristics. This was advised so that therapists could focus more energy on the initial treatment decision, and avoid the wasted energy and poor outcomes involved in premature dropout or poor progress towards therapy goals. Comments also included advice to use more manualized, standardized, short-term treatments, create similar manualized treatment selection manuals, and to place less trust in the Dodo Bird's verdict. However, this was tempered by an acknowledgment that "even the most sophisticated treatment selection manual won't ever completely decrease the importance of a clinician flexibly responding to client needs in any

given moment" (p.57). Overall, these authors recommended that empirical evidence be the primary guide to treatment selection decisions.

Studies of Treatment Selection as Usual (TSAU): Research on practicing psychotherapists

Despite recommendations to use empirical data in treatment selection decisions (e.g. Vervaeke & Emmelkamp, 1998), the actual contribution of such evidence to practitioners' decisions has largely remained a mystery. However, two recent articles addressed this question. They concluded that while results of empirical studies are indeed one consideration contributing to treatment decisions, they were not the only ones. Nelson and Steele (2008) surveyed 206 practicing clinicians to determine the relative importance of different considerations in choosing a treatment and to determine, within the category of research as a determiner, which types of research (i.e. efficacy or effectiveness) were most persuasive. Participants worked in diverse settings, with diverse training backgrounds, degrees, and theoretical orientations. The most highly rated considerations were found to be the flexibility of a treatment, tied with a treatment's empirical evidence based on real-world conditions. Other main considerations were colleagues' endorsement of a treatment, and a treatment's appeal to clients. Although there were no self-identified I/E therapists among the respondents, it is interesting that along with efficacy-study evidence, flexibility was the number-one-rated characteristic that would recommend a treatment to them.

Stewart and Chambless (2007) found somewhat less encouraging results for practitioners' reliance upon empirical evidence to inform treatment selection decisions. Indeed, as opposed to Evidence Based Practice's emphasis on "using research to guide practice, albeit tempered by the therapists' clinical experience" (p. 276), therapists in this study reported doing the opposite: emphasizing their clinical experience and tempering this knowledge with considerations of EBP-

type research. A survey of 591 APA Division 29 members (based upon only a 25% response rate) asked two types of questions. One set addressed influences on daily clinical practice, attitudes towards psychotherapy outcome research, sources used to improve therapy skills, and sources consulted for their last difficult case. The second set pertained to a case study provided. It asked how the respondent would treat the hypothetical client with Panic Disorder, and why. Questions also asked the respondent's likelihood of attending a workshop on treatment of Panic Disorder using one of 4 different theoretical orientations. Results indicated that clinicians rated clinical experience as significantly more important to typical decision-making than research, advice from colleagues, and personal therapy experiences. Each difference represented a large effect size. Overall, the authors concluded that "there is an enduring research-practice gap" (p. 267), and that "further research is needed to elucidate in more detail how clinicians decide to approach cases in there practice" (p. 278). This interesting study also prompts the questions: *How* are therapists using their "past clinical experience" to make these decisions? And, *what aspects* of their clinical experience are particularly salient for them and why?

Also largely unknown are the cognitive processes (in addition to the primary considerations, as described above) used in clinicians' decision making. Consequently, one vein of treatment selection research has explored if therapists' decisional processes are consistent with formal psychological theories of decision-making, and if they utilize formal "rational" logic. One recent, and one early study showed mixed results.

Schottenbauer, Glass, and Arnkoff (2007) provided a demonstration of the ways that Bounded Rationality, a general theory of decision-making, could be used to interpret data from studies on treatment selection decisions. That is, it was a "demonstration" because instead of using the theory to make a priori predictions and then testing them, they used the theory in their

discussion section to understand their data post hoc, as an example of the potential usefulness of such theories. Their original empirical study had three goals: first, to describe what therapists report doing when they reach an impasse in therapy with a client who has experienced trauma; second, to explore differences in these second-round treatment selection decisions between "pure form" and Integrative therapists; and finally, to speculate about ways the most frequently reported strategies were, or were not consistent with what is predicted by the Theory of Bounded Rationality. One hundred seventy-one psychotherapists (both masters and doctoral level) completed an online survey that included open-ended questions asking how they might proceed with a hypothetical client diagnosed with PTSD if the client did not improve during the initial portion of therapy. Based upon the qualitative responses, the authors created a 16-category coding manual and asked two outside raters to assign responses to one or more categories. The 16 different categories of choice-content included switching from the initial treatment to one of 6 name-brand psychotherapies (one category for each); enlisting outside assistance (ranging among consultation with colleagues, increasing one's own education, suggesting medication referral, and initiating termination/referral to another psychotherapist); introducing a new strategy (but not a whole new therapy) such as exploring the therapy relationship; stepping back and reassessing aspects of the case (i.e. client motivation, therapist case conceptualization, or the client's wider environment); making an unspecified "change" in approach; and doing nothing/ continuing as usual. Results indicated that the most frequent treatment decisions made, regardless of respondents' theoretical orientations, were 1) reassessing the case 2) referral to another provider or treatment modality 3) consultation with colleagues or gaining more education 4) making unspecified changes in approach, and 5) considering medication consultation. Few said they would choose a specific new treatment, approach, or technique (such

as switching to an EST such as EMDR or CBT). Finally, while the authors concluded that these types of decisions very well could fit with tenets of the Theory of Bounded Rationality (e.g. Ecological Rationality, Psychological Plausibility, and use of an Adaptive Toolbox), it was impossible to say from their study if this was indeed the case, and advised further research.

O'Donohue, Fisher, Plaud, & Curtis (1990) conducted structured interviews with 25 practicing therapists to determine the degree to which treatment decisions about assessment techniques, goals, and methods were made using systematic, rational processes. These questions were addressed in reference to 3 recently closed cases for each therapist. For each aspect of therapy (assessment, goals and methods) participants were asked what choice they had made, the decisional processes leading them to that choice, and how they would justify the decision. Each response was then coded as either "rational" (showing evidence of inductive or deductive reasoning, such as in the form, "In all cases X, thus in this case X") or as "begging the question" (when the conclusion was considered "obvious" or if the processes leading to the decision were not known). These authors found that for each therapeutic activity (choosing assessment methods, goals and methods in treatment) over 90% of therapists described their decisional processes in ways that begged the question. In regards to justification of treatment method decisions, therapist preference and history of personal success with a method were the most frequently cited. Research evidence for the chosen method was a somewhat distant second. O'Donohue et al. (1990) expressed concern with the lack of formally inductive and deductive processes described, but noted that perhaps therapists did indeed use these processes, but simply did not describe them in ways that met the study's criteria. They suggest that in light of ethical mandates and requirements of managed care for accountability, closer exploration of therapists' treatment decision-making processes is needed.

The prior two lines of treatment selection research (on contributions of empirical evidence, and the role of formal logic and decision-making) explored general categories of considerations and thought processes used by practitioners. Other lines of inquiry on TSAU have focused more specifically on correlations between client or therapist factors and the treatment selection decisions that were subsequently made.

VanManen et al. (2008) examined treatment selection decisions in the context of treating clients diagnosed with personality disorders. The study specifically focused on "macro-level" initial treatment decisions made by intake clinicians: treatment setting (inpatient or outpatient), duration (long or short-term), intensity (supportive or confrontational), and recommended theoretical orientation (symptom focused or insight-focused). A list of 18 client characteristics thought to influence treatment assignment decisions were drawn from the literature, and then further winnowed to a list of 12 after consultation with 29 therapists and two of the authors. These were ego-strength, motivation, psychological mindedness, capacity for relationships outside/within the therapy relationship, defense style, symptom severity, type of personality disorder, treatment history, focal vs. general problems, employment status, and care responsibility. Twenty-seven intake clinicians responded to structured interviews asking how they would use either "high" or "low" levels of the patient characteristics listed above to assign clients to either "high" or "low" levels of the four dependent variables: treatment setting, duration, intensity, and type of theoretical orientation. Results showed that none of the 12 patient characteristics were deemed consistently relevant for deciding upon treatment setting. For duration, degree of problem focus and ego-strength were said to be important patient characteristics to consider. Clinicians overall reported that when making decisions about treatment intensity, they considered many characteristics, namely ego-strength, psychological

mindedness, capacity to relate in/out of therapy, defensive style and symptom severity. For

example, intake therapists indicated that a client with high ego-strength should be assigned to a

more confrontational/expressive therapy, whereas a client with lower ego-strength should be

assigned to a more supportive therapy. Decisions about theoretical orientation were also said to

be made with consideration of psychological mindedness and ego-strength. For both, high levels

indicated psychodynamic assignment and low levels indicated CBT assignment. While

interesting to discover which individual client characteristics would hypothetically influence

macro-level treatment decisions, the authors acknowledge that it is unlikely that clients'

characteristics are considered one at a time in actual decision-making. Or, that they are seen as

having bi-polar high/low values. Rather, the range of possible interactions quickly becomes

burdensome to measure or systematically consider.

Also exploring macro-level treatment decisions, Scheidt, Burger, Strukely, Hartmann,

Fritzsche & Wirsching (2003) found that while client characteristics seemed to influence whether

the client was accepted for treatment or not, it was the therapists' characteristics, and the

therapeutic relationship, which were often better indicators of later treatment decisions. Whereas

VanManen et al. asked clinicians hypothetical questions about decisions they would make,

Scheidt et al. (2003) examined the actual treatment selection decisions of 24 psychotherapists in

private practice over 12 months. They compared treatment selection criteria for clients who were

ultimately accepted for treatment and those who were not, and criteria for those assigned to

short-term therapy, long-term therapy, or very long-term psychoanalysis. Interestingly, the

authors found that it was the therapist's emotional response to the client that most influenced

assignment to short versus longer-term therapy. The more emotionally sympathetic, involved,

and interested the therapist was, the more likely the client would be assigned to longer-term

therapy. This is especially interesting when compared to VanManen et al.'s (2008) study that showed that when asked hypothetically, therapists were more likely to assign clients with better ego-strength and interpersonal relationships to short-term therapies. Yet overall, in both studies, diagnosis was not predicted to be, or shown to be a major contributor to initial treatment selection decisions. It is notable that although these therapists all identified their theoretical orientation as psychodynamic, knowing about these decisions could also be pertinent to I/E therapists who may make decisions about accepting patients for treatment and the necessary length of treatment to recommend to any given client. This study is one of the few that acknowledged the relationship between therapist and client as an influence to treatment selection.

Continuing with studies that examined therapists' perceptions of the client as contributions to macro-level treatment selection decisions, Murdock and Fremont (1989) predicted that therapists' attributions about what caused a client's presenting problems would influence their decisions about assigning the client to short term, long-term, individual, or group therapy. Fifteen therapists conducted 116 intake interviews. After each intake, the therapist rated the client's presenting problem along four attributional dimensions. On a 7-point scale, they noted the degree to which the main problem was caused by: 1) something in versus out of the client's control, 2) something internal versus external, 3) something stable or transient, and 4) something specific to one situation versus pervasive across situations. Therapists also rated the intake client's problems on severity, duration, and treatment urgency, and provided a recommendation to individual therapy that is very short, short, or long, to group therapy, or no treatment. It was found that ratings of problem duration and therapist attributions of cause to a stable versus transient reason best predicted the therapists macro-level treatment decisions. This

supported the hypothesis that therapist interpretations of clients' problems lead to differences in treatment selection.

If therapist conceptualizations affect treatment decisions, is it also the case that clients' formulations of their own problems impact these decisions? Zuber (2000) used a creative design to examine this question. As part of a larger psychotherapy study, clients participated in an extensive initial assessment, which resulted in a recommendation to either an insight-oriented (e.g. psychodynamic) or a symptom-focused (e.g. behavioral) treatment. For each of the 159 clients who participated, their own problem formulation was transcribed verbatim during the initial clinical interview. These were then coded into three categories: symptom-focused formulations (i.e. insomnia, lack of concentration, fatigue), relation-focused formulations (i.e. problems with loneliness, arguments, being too close or too distant from others) and combination-focused (expressed both symptom and relationship components). A second measurement taken was the length of the typed problem formulation transcription in millimeters. The diagnosis assigned by the intake clinician was also noted for each client.

Overall results indicated that therapists did indeed recommend treatments consistent with the client's own formulation (Zuber, 2000). Specifically, symptom-focused formulations more led to symptom focused, directive treatment recommendations, and relationally framed problems led to insight-oriented treatment recommendations. Interestingly, while formal diagnosis was not predictive of the treatment decision made (except for anxiety disorders), something as subtle as the *length of the patient's formulation, in millimeters*, was predictive. Clinicians tended to assign those with longer formulations (more "verbal" clients) to more verbally oriented therapies, such as psychodynamic. This is especially striking since clinicians were not aware that the verbatim reports they wrote would be used to predict their decisions in this way. The authors note that this

study highlights the subtle cues that therapists must pick up on while considering their treatment decisions.

The prior studies have examined treatment selection decisions made before therapy begins. But the need to consider such decisions does not end when therapy begins. Stewart and Chambliss (2008) surveyed 591 Division 12 therapists in private practice about what they have done when their initial treatment decisions result in a lack of client progress, and how they reached that decision. Specifically, this question was asked in the context of their "most recent difficult case of a client who did not improve, or with whom you did not know how to proceed." Decisions were most often informed by consultation with colleagues and reliance on the therapist's own clinical experience. The results were also analyzed according to theoretical orientation of the clinician. Psychodynamic therapists, compared with Eclectic and CBT therapists, reported giving a longer time before deciding whether the initial therapy was helping or not. They were also less likely than Eclectic and CBT therapists to refer to other clinicians and to use materials from psychotherapy outcome research to reassess their therapy in the event of no improvement.

In addition to use of survey data on different aspects of treatment selection as usual, researchers have begun to complement such investigations with qualitative methods geared to ask more open-ended, exploratory questions. In the search for understanding the processes, considerations, and nuances of TAU in the context of treating adult survivors of childhood sexual abuse, two recent articles represent this qualitative approach. Each focused on experts' experiences of making treatment decisions with this particular population. Kessler, Nelson, Jurich, & White (2004), and Kessler and Goff (2006) addressed treatment selection at the level of approaches and techniques used during individual psychotherapy (as opposed to the more macro-

level decisions about theoretical orientation and modality). Kessler et al. (2004) conducted a

Delphi study of American Association of Marriage and Family Therapists (AAMFT) who were

Approved Supervisors for the organization. Three rounds of data collection were used, each of

which informed the next. Round one focused on descriptive approaches to treating survivors of

CSA, round two focused on practice and application of those approaches to a hypothetical case,

and round three asked respondents to provide rationales for the applications used in round two,

and to explain how they would carry them out. As all of the data were qualitative, two coders

analyzed the data manually as well as with the help of the N.U.D.I.S.T. software program.

A second study also examined initial treatment decisions with adult survivors of CSA

through interviews with experts in the field. Employing qualitative, phenomenological methods,

Kesser and Goff (2006) used intensity sampling to recruit 11 practitioners who met their criteria

for "expertness" around the issue of CSA, and conducted telephone interviews. Interview

questions were semi-structured, non-binding, and based on a literature review with special focus

on gaps in the literature. Two categories of inquiry seemed especially relevant for the study of

treatment selection decisions more broadly. These were, how experts determined the treatment

focus (i.e. to focus on the details of the CSA, on historical coping and/or on current

concerns/coping) and how they determined the treatment modality (i.e. couples or individual

therapy). Throughout, it seemed that therapists based many of their decisions on the larger goal

of providing an empowering, safe, and warm relationship with appropriate boundaries. For

example, in order to keep clients at the helm in steering therapy, many decisions about treatment

focus were made based upon client's goals and preferences in order to promote autonomy and

respect in the relationship. There were, however some exceptions, such as a client's current

stability that might cause the therapists to present a rationale for waiting to focus on CSA until

later in therapy. Thus, this study showed that it was a combination of client preferences and goals, as well as therapist's concerns and goals that influenced these experts' treatment selection decisions.

A review of the above studies indicates some gaps and limitations to the current understanding of TSAU, especially in regards to decisions made by I/E therapists. The preceding studies were not focused on I/E therapists specifically, although several did include this group. The preceding studies also provided useful but circumscribed data. The focus has tended to be upon specific influences on the eventual decisions made, rather than on the process used by practitioners to choose, sort, rank, and otherwise digest the huge variety of therapist, client, relationship, and contextual issues which have the potential of affect treatment selection. Further, several studies focused on "macro-level" treatment selection decisions. Although a necessary step in any decision process, this level does not address more fine-grained decisions once individual talk-therapy is selected. On the other hand, when studies have looked more broadly at treatment selection issues at the macro, orientation, approach and technique levels, they have done so only in the context of examining single-approach practitioners who were treating specific issues (i.e. CSA).

Summary

Integration and Eclecticism are widely endorsed approaches to psychotherapy. I/E can be considered both a movement with broader goals for the future of the field and a theoretical orientation used by individual practitioners. Originally labeled "Eclectic", those using the approach have come to favor the term "Integrative" which encompasses Eclecticism as a method of bring together the "best" from different schools of psychotherapy. Over time, some approaches that began as "Integrative" are now considered to be new therapies (CBT; EMDR;

DBT) in their own right, with their own manuals for implementation. Although there are many

models of integration (with the number continuing to grow), it is not known how many therapists

adhere to one or more of these approaches in practice. It is known that therapists report not using

manualized treatments and not necessarily looking to published research as the primary guide to

their therapy practice. Nor do they appear to utilize formal, "rational" decision-making

processes. As the Integrative psychotherapy movement continues, the present study aimed to

provide a detailed description of practicing I/E psychotherapists' reported processes of treatment

selection.

CHAPTER THREE: METHODOLOGY

Since the early 1980's, qualitative research-based questions and methods have made an increasingly frequent appearance in professional psychology journals, especially within the field of counseling psychology (Berrios & Lucca, 2006; Hoyt & Bhati, 2007; Rennie, Watson, & Monteiro, 2002). But while counseling psychologists have been relatively late adopters of qualitative research designs, other disciplines (i.e. other social sciences; law; medicine; nursing) have long traditions of valuing their unique strengths and potential contributions (Yeh & Inman, 2007). Until recently, the reticence in adopting qualitative research methods and using them to their full potential has been in part because the philosophy of science underlying qualitative inquiry is out of step with the philosophy underlying quantitative research, the traditional "gold standard" of knowledge acquisition. Specifically, the two paradigms differ in their conceptualization of the nature of reality, the role of the researcher vis a vis participants, the role of values, style of reporting results, and the criteria by which they are judged (Ponterotto, 2002). Where qualitative traditions are relationship-focused, subjective, exploratory, descriptive, interpretive, naturalistic and conducted in participant-focused settings, quantitative traditions have advocated an approach that is interpersonally removed from one's participants, objective, confirmatory, explanatory, positivist and conducted in laboratory, or researcher-focused settings (Haverkamp & Young, 2007; Rennie, Watson, & Monteiro, 2002).

Yet while counseling psychology has historically focused on quantitative methods, the field has much in common with the values represented in qualitative methods, and there has been a call for a greater balance of methods from each tradition. For example, Berrios and Lucca (2006) note that there are vital compatibilities between counseling psychologists and qualitative researchers: their views of human nature, similar tolerance of ambiguity and non-linearity, focus

on process as well as content, and openness to hearing others' stories.

Collective, instrumental case study: Definition and rationale for selection of approach

The current study used qualitative methods to address questions about how practicing

psychologists make treatment selection decisions. And although there are several qualitative

methods with which to investigate such questions (i.e. biography, phenomenology, grounded

theory, and ethnography; Creswell, 1998) a collective, instrumental case study was chosen as the

specific approach here, because of its match with the particular goals of the present study. In this

section, I first define and provide a rationale for use of the case study method overall (explicating

the "match" between question with method). I then discuss how the further method-specifying

variations of a "collective" and "instrumental" case study were appropriate. Further, I define "a

case" in the current study.

First, to define case study approaches. Creswell, Hanson, Plano Clark and Morales (2007)

define case study research as:

> "A qualitative approach in which the investigator explores a bounded system (a case) or
> multiple bounded systems (cases) over time through detailed, in-depth data collection
> involving multiple sources of information (e.g., observations, interviews, audiovisual
> material, and documents and reports) and reports a case description and case-based
> themes" (p. 245).

Yin (2009) offered a complementary definition of case study research that focused on its

intended function, rather than its form (as Creswell et al. did above). That is, Yin described the

circumstances under which it was most appropriate (functional) to conduct a case study:

> "You would use the case study method because you wanted to understand a real-life
> phenomenon in-depth, but such understanding encompassed important contextual
> conditions-- because they were highly pertinent to your phenomenon of study…[and]
> because the boundaries between phenomenon and context are not clearly evident" (p. 18).

The present research question presents just such a circumstance. My aim was to understand the

phenomenon of I/E therapists' treatment selection decision-making processes. I began the study

with the assertion that such decisions cannot be understood outside such contextual conditions as the person of the therapist, that person's broader I/E orientation, and so forth. Because decisional processes are embedded in the context of the decision-maker, they cannot be deeply understood independently of that context. Case study methods provided a means to seeking this deeper understanding.

Case study methods are appropriate when a researcher's goal is to understand a given process, salient aspects of the context that impacts that process, and insights into idiographic wisdom that has been acquired about the process. In the present study, the given process was treatment selection decision-making. The context of interest to the process included the person of the therapist, their I/E theoretical orientation(s), their personal/professional background, and the physical, social, and cultural settings in which they worked. The idiographic wisdom sought was these practicing therapists' descriptions of their own personal experiences related to the process of treatment selection decisions.

In addition, a case study approach was chosen because the format in which its results are traditionally written can address calls for examples of Integrative practice that could "allow trainees to read about how seasoned therapists themselves struggled in their early attempts to develop an integrated approach to therapy" (Goldfried, 2001, p. 450). Case studies are often written in a rhetorical form similar to literature with descriptions that place the reader into the process of interest. Because of this, they are thought to be especially useful to practitioners and to students of the process being studied. This is not because of the generalizability of case studies in a quantitative sense. Rather, because the "thick description" called for by case studies allows readers an opportunity to empathize with, and to simulate the participants' actual actions, perceptions and cognitions. Such a "simulation" process on the part of the reader is made

possible when reading text that (like case studies) vividly captures the context and language of the participants (Havas, Glenberg & Rink, 2007). By doing so, consumers of research can get a sense of what the process entails for the individuals studied, and can make informal connections with their own personal experiences to aid and deepen understanding. In this way, the case study tradition can provide psychotherapy trainees a sense not so much of what treatment decisions *should* be made, but of *how* other practitioners have engaged this question in their own work.

Next, I address the specific choice of conducting a collective (versus single-case) and instrumental (versus intrinsic) case study. As I briefly discussed earlier in the Statement of the Problem, case studies may be comprised of either a single case, or of multiple cases. When more than one case is presented, the study is referred to as a collective case study.

Case study research is further classified by its aims (i.e. what question it is intended to address). A case may be focused on an individual/entity to be studied because of its uniqueness (as in an intrinsic case study), or on a process or activity engaged in by one or more individual(s)/entities (as in an instrumental case study, Cresswell, 1998). In the present study, "the focus is not primarily on the individual in the case, but on the *issue* the individual case was selected to help understand" (p. 13, Creswell et al., 2007), and is thus considered an instrumental case study.

Defining a "Case"

If the focus of the inquiry is not on the individual participant per se (as in an intrinsic case study) it may introduce confusion-- Is the "case" still the individual if the focus is on a *process* that the individual engages in? Yes. Stake (2006) further clarified this issue:

> "With these [instrumental] cases we find opportunities to examine functioning, but the functioning is not the case. Even when our main focus is on a phenomenon that is a function, such as 'training,' we choose cases that are entities. Functions and general

activities lack the specificity, the organic character, to be maximally useful for case study (Stake, 2005). We can use the case as an arena or host or fulcrum to bring many functions and relationships together for study" (p. 2).

Thus, in the present study, each individual therapist-participant comprised "a case," as he or she was the "arena or host" in which the function of interest (making treatment selection decisions) took place.

I offer one parenthetical note here as well: Stake's terms are very effective at conveying a process-in-context metaphor (and are very appropriate for instances where a case might be a program or organization). But, I recognize that they have rather unfortunate connotations when used to refer to an individual. I simply note here that of course I prefer not to speak about participants as "arenas" or "hosts," as this seems inappropriate and counter to the type of respectful, collaborative stance advocated by qualitative traditions. But I chose to quote Stake's metaphorical language here, with this caveat, for the sake of clarity.

Case study approach and data collection methods

Regarding data collection, Yin (1989, as cited by Creswell, 1998) stated, "One aspect that characterizes good case study research is the use of many different sources of information to provide 'depth' to the case" (p. 251). He goes on to recommend that researchers use as many as six different types of information in their case studies, including interviews, observations, documents, field notes, researcher and participant journals, and audio-visual materials. The present study used information from interviews, observations and documents. Each is discussed below.

Interviews. To allow for "depth" of exploration in the present study, I conducted a series of three interviews with each participant over the course of several weeks. This method is based upon the qualitative research approach proposed by Dolbeare and Schuman (Schuman, 1982; as

cited in Seidman, 1991), and is an especially suitable model for a case study of therapists' decision-making because it purposefully addressed both the decisions they have made, and the processes and contexts that contributed to those decisions:

> "A basic assumption in in-depth interviewing research is that the meaning people make of their experience affects the way they carry out that experience... interviewing allows us to put behavior in context and provides access to understanding [participants'] action" (Seidman, 1991, p. 4).

As detailed in the above section, the case study approach is appropriate when a process of interest and its context are closely intertwined (as is the state of affairs with treatment selection decision processes and the therapists who make them). In this same way, the specific data-collection method of in-depth interviewing (which also acknowledges and seeks to address process-in-context issues) is well matched to both the purpose/spirit of case study research and to the present research question.

The longitudinal three-interview format is also consistent with "validity" standards in qualitative research as defined by Lincoln & Guba (1985). Seidman (1991) cautions against having a "mechanistic response to validity" (p.17) but notes that within the philosophical framework of qualitative research designs the three-interview framework is useful because it:

1. Places participants' comments in context
2. Encourages interviewing over the course of a few weeks to account for idiosyncratic days, and allowing for checks of the internal consistency of what is said
3. Recruits more than one participant allowing for comparison across cases as well as within one case, and
4. To the degree that the experience meets the goal of allowing participants and interviewers to make sense of the topic of interest, of themselves, and of their actions, it is valid (p. 17).

Specifics of how the in-depth interviewing structure was implemented in the present study are described in detail in the research protocol section (below).

Observations. The three interviews took place with each participant (except one) in the

office where he or she practiced psychotherapy. (One participant, Therapist D, was interviewed

in the location he used for research activities). This allowed for observation of participants'

physical contexts, and allowed participants to speak with the researcher in their usual

professional setting-- generally the one in which they made the types of clinical decisions we

discussed. Consistent with the study's aim to understand an aspect of practice-as-usual, I was

allowed an approximation of the kinds of logistical interactions a client might usually experience

with each therapist. I spent time in their waiting rooms, returned to their offices to meet weekly,

every-other-week or intermittently, and experienced the atmosphere and social flow of each

setting. This social flow included, for example, being welcomed with an offer of tea, or a

question about my preference for having an office window open or closed--which one therapist

later confirmed was indeed "as usual" for her when seeing clients. Observations were integrated

into the Intra-case analyses.

Documents. In addition to interviews, the present study included data from between-

interview correspondence with participants. Email messages served to clarify and extend

interview conversations, and also demonstrated the development of researcher-participant

relationships over time. The research protocol also encouraged participants to privately (to

protect confidentiality) consult and make use of their own documents (i.e. progress notes from

past clients' cases) as a means of supporting retrospective recall of the clinical decisions made,

and the context in which they occurred.

Participant Selection Considerations

Few individuals are included in case-study designs, and thus selection of particular cases

requires a systematic rationale. Several approaches are possible, and Creswell (1998) highlighted

the flexibility that may be exercised in choosing among them: "I prefer to select cases that show

different perspectives on the problem, process, or event I want to portray, but I also may select ordinary ones, accessible cases, or unusual cases" (p. 62). To choose among these, Creswell (1998) advised looking to the Purposeful Sampling Strategies proposed by Miles and Huberman (1994). Here, it is also useful to note that the criterion of "expertness" has often been used when selecting participants for qualitative psychotherapy research (e.g. Jennings & Skovholt, 1999; Kessler & Goff, 2006; Williams & Levitt, 2007). This has allowed the field to benefit from the wisdom of the most effective therapists, and has efficiently used research to highlight those most likely to provide useful insights. However, the present study was most concerned with the way "usual", and "local" (although not randomly selected or necessarily representative) therapists make treatment selection decisions. That is, "expertness" per se was not used as a selection criterion in the present study. Complementing the valuable contributions made by research with experts, studies with therapists not explicitly identified as "stars" (Seidman, p. 44) can contribute to filling gaps in understanding psychotherapy processes as they occur in "treatment as usual" (Street, Niedereche, & Lebowitz, 2008).

To select participants in the present study, a combination of two strategies was used. First, "criterion sampling" narrowed the participant pool, and then "maximum variation sampling" within the group of potential participants meeting the initial criteria was considered. Criterion sampling was initially desirable to ensure that all individuals involved were engaged in the process of interest (making treatment selection decisions) and were members of the population of interest (Eclectic and Integrative psychotherapists). Maximum variation sampling is recommended when conducing collective case studies because it allows exploration of the process of interest from different perspectives, while also allowing for comparison of common themes despite those differences (Creswell, 1998). This strategy can apply to both sites and

people (Tagg, 1985, as cited by Seidman, 1991).

While it is not possible to obtain generalizable findings based upon case study research, the benefit of interviewing therapists who practice in a variety of settings is that it increases the chances the study will be of interest to a wider audience of practitioners and researchers (Seidman, 1991). Therapists tend to place the most emphasis on research carried out in "real life" settings (Nelson & Steele, 2008). Thus, offering viewpoints and voices from a variety of such settings may be most desirable.

Specifically, participants were selected based upon the following criteria: a) they identify their theoretical orientation as integrative, eclectic, or a variation which does not include adherence to a single, "pure" treatment approach b) are licensed psychologists c) currently conduct clinical work in outpatient settings, with at least 50% of their professional time spent on psychotherapy practice-related activities (i.e. direct client hours, supervision, paperwork, and other administrative or support activities) d) have at least five years of psychotherapy practice experience. This experience criterion was chosen based upon prior research on Integrative and Eclectic therapists. Therapists who have practiced for a longer period of time are more likely to have developed their own Integrative/Eclectic style as compared to therapists who are newer to psychotherapy practice because most doctoral programs focus on teaching one or more single-theory therapies rather then teaching integration per se, (Lampropoulos & Dixon, 2007). Thus, there is a pattern of initially adhering to a "pure form" therapy and then incorporating strategies and techniques as one becomes more experienced over time. Finally, criterion e) was chosen to ensure the possibility of conducting face-to-face interviews. Only clinicians practicing locally were contacted. All study participants met these criteria.

Regarding the number of cases to be studied, and thus the number of participants to be

recruited, maintaining the focus on depth (versus breadth) was a primary goal that necessitated working with fewer participants rather than more. While there is no specific required number cited in the literature, "typically, no more than four [cases] are chosen" (Creswell, 1998, p. 63). Remaining within this range, four cases were initially selected. However, here it is important to note that although four cases were initially selected, five psychotherapists were eventually interviewed as participants. One of the initially selected participants chose to end his participation following the first interview. He provided consent for the data from that meeting to be included in the final analysis, but declined to participate in the second and third interview stages. Because of this, I requested participation from a fifth therapist, who completed the full three-interview sequence. Thus, the Cross-case analysis is based upon data from all five therapists, whereas the Intra-case analyses were conducted only with data from the four participants who completed all three interviews.

Participants: Integrative-Eclectic Therapists

Five licensed, currently practicing I/E psychologists initially consented to participate in a series of three in-depth interviews. However, one male participant with 25 years of experience (Therapist B) withdrew after the first interview. He nonetheless still consented for his responses from that interview to be included in the study. Those responses were analyzed, but the Case Findings that emerged were included only as part the Cross-case analysis. That is, because his data were incomplete, there was no separate Intra-case analysis for this participant. Of note, Therapist B cited concerns about client confidentiality (due to being asked to discuss de-identified case material as part of the second interview) as his reason for stopping participation. These circumstances are discussed in depth within a separate, explanatory section regarding Therapist B in the Intra-case analysis chapter (included there in place of an Intra-case analysis).

Thus, five participants' data contributed to the Cross-case analysis (Therapists A-E), and only four participants (Therapists A, C, D, and E) had complete data for separate Intra-case analyses. These four were one man and three women, with 5-15 years of post-licensure experience. Participants worked in three different settings: private practice, a university-affiliated counseling center, and an outpatient clinic. This variety allowed examination of themes from therapists situated in a variety of contextual environments. Table 1 summarizes participant characteristics:

Table 1. Participant characteristics

Participant Code Letter and Degree	Gender	Self-Identified Theoretical Orientation	Years in Practice	Current Practice Setting
Therapist A, Ph.D. Counseling Psych	Female	"Integrative"	15	Private practice
Therapist B, Ph.D. Clinical Psych	Male	"Eclectic"	25	Private practice (Withdrew participation after first interview)
Therapist C, Psy.D. Clinical Psych	Female	"Integrative-Eclectic; I feel like they are similar labels"	5	University counseling center
Therapist D, Ph.D. Clinical Psych	Male	"Solidly Eclectic"	10	Outpatient clinic
Therapist E, Ph.D. Counseling Psych	Female	"Informed Eclectic"	10	Private practice

Recruitment Procedures

Criterion sampling was used to locate licensed psychologists who fit the criteria for

practice activities and theoretical orientation described above. Letters providing information

about the study, and an invitation to participate (see Appendix A) were sent to 40 individual

psychologists working at local and regional sites. These sites included settings such as private

practices, community mental health centers, managed care clinics, and university-affiliated

clinics and counseling centers. Potential participants' names and contact information were

obtained via agencies' web sites. When therapists' email addresses were publically available,

letters were sent electronically. When email addresses were not available, hard-copy letters were

sent to therapists' business addresses. This represented a practical strategy using publicly

available information. It mirrored the way in which therapists may be sought out or contacted by

clients in the course of naturalistic practice, thus coinciding with the present goal of studying

psychotherapists in community settings. This method was also chosen to increase the likelihood

of inviting psychologists who are primarily engaged in practice as opposed to research, teaching,

or other professional activities.

Recruitment letters resulted in replies from three potential participants (a 7.5% response

rate). Of these, one therapist did not meet study inclusion criteria (as he held a license in a mental

health profession other than psychology). The remaining two volunteers met study criteria, were

sent a consent form (see Appendix B) for review, and subsequently agreed to arrange a time for

the initial interview. They were included as participants. However, one of these individuals

(Therapist B) later elected to stop his participation after the first interview. After his withdrawal,

the initial recruitment strategy of sending invitation letters was supplemented with word-of-

mouth requests for participation. Three additional therapists agreed to participate through this

method of invitation. Of note, this writer knew one of the five participants in an acquaintance-

type capacity prior to that person's participation in this study. However, word-of-mouth

invitations were mostly facilitated by my contacts in the psychotherapy community, who in turn

referred their colleagues (with whom I had no prior contact) for possible participation. To offer a

further clarification, snowball sampling was not used. No participant referred, or was referred by

another participant.

In-Depth Interview Procedures

In conjunction with recruitment strategies, I provided detailed information about the study in order to obtain informed consent from participants. This process carries additional significance in the tradition and philosophy of qualitative research, because participants are considered co-researchers in the investigation. Interested individuals who met the five sampling criteria were sent a consent form. During the first face-to-face meeting, but before the first interview began, the consent form and study procedures were discussed. In particular, participants were reminded that each interview is audio-taped and transcribed, that the study consists of three 1-1.5 hour interviews, and that they are free to end their participation in the study at any time during interviews or data analysis, with no negative consequences. Preserving the confidentiality of each participant was also discussed. In addition to asking therapists not to provide any identifying information about a case or client they may reference during the interviews, they were reminded that after each interview, they would receive a copy of the transcript, and be invited to remove any comments they believed could identify themselves, or another person. While I used only code letters to refer to participants, this additional step of transcript review provided another means to safeguard confidentiality. Participants signed the consent form and at that time the first interview began.

Within the three-interview framework, "the goal is to have the participant reconstruct his or her experience within the topic of study" (Seidman, 1991, p. 7). Each interview was semi-structured, with pre-chosen questions and prompts augmented with follow-up questions based upon participants' responses throughout the interview. The first of the three interviews was designed to establish the context of the participant's experiences with the issue of interest. This included questions about the learning experiences that contributed to their current views and

actions, and addressed the focal issues and processes of treatment selection from a developmental perspective.

The first interview also explored the participants' Integrative, Eclectic, or other non-pure-form theoretical orientation, how they arrived at their current orientation, and in what ways it influences their understanding of the treatment selection process. This interview provided the groundwork for more clearly understanding how the therapist thought about treatment selection in general, and how they typically engaged in this process (see Appendix C for list of a priori question topics for each of the three interviews). While the prepared topic lists were used to keep the focus of the interviews broadly on issues related to "treatment selection," they were not strictly adhered to. Rather, conversations were also free to develop based upon participants' responses.

The purpose of the second interview was to "concentrate on concrete details of the participant's present experience in the topic area of study" (Seidman, 1991, p. 11). In contrast to the first interview's focus on theory and opinion realted to treatment selection, the second interview's focus helped participants reconstruct (rather than remember) " a day in the life" in relation to recent treatment selection decisions. Here, the therapist was asked to explore a single recent case from beginning to end in order to discuss how treatment selection decisions were made with that individual, at that point in time, in that setting. Specifically, participants were asked to choose one recently terminated psychotherapy case, and to engage in an interpersonal process recall (IPR: Kagan & Kagan, 1997)-inspired interview. Therapists were asked to bring any documents or notes which could aid in reconstructing their treatment selection decision process. During this meeting, the therapist "walked us through" the case in terms of treatment selection issues that were salient for him or her at different points in time. Although therapists

were encouraged to bring client material to the meeting for their own reference, they were asked to remove or hide all client-identifying information, and to refrain from providing any verbal information which could identify the client. As the interviewer, I did not have access to any client-related documents so that confidentiality was maintained. These documents were only vicariously known to me: therapists consulted them prior to or during the interview, and used them to inform their interview responses.

The third and final interivew aimed to integrate what was learned from the initial two interivews and to inquire about how the participant made sense and meaning out of them. The third interview was also used to solicit reactions about participation in the study, and to ask how the therapists understood their own processes in light of their responses to general and specific questions in the two prior interviews. In addition, after re-reading transcripts of the first and second interivews, I created memos that included follow-up questions to address any misunderstandings on my part. The last interview also provided an opportunity for a sense of closure in the research relationship.

After each of the three interviews for each participant, I transcribed the audio taped material, and made additional research notes about my own questions, and areas on which I wished to follow up. Participants were then sent a copy of the transcript and were encouraged to provide feedback, corrections, and changes to enhance accuracy and confidentiality. The sending of transcripts occurred between the first and second interviews, between the second that third interviews, and after the third interview. Interviews were scheduled far enough apart to allow time for transcription and participant review of transcripts between meetings. Each of the participants provided feedback on their transcripts.There were no major, substantive changes suggested. In most cases particpants' comments consisted of correcting words or phrases which I

had transcribed incorrectly, or providing additional notation to clarify comments they had made during the interviews. Two therapists responded to this request for feedback by spontaneously sending me their own detailed memos, which elaborated upon their interview remarks. Information about these documents (in context with other data) is discussed in depth in Chapters four and five.

Data Analysis and Verification Strategies

At its most basic level, qualitative data analysis across the qualitative traditions involves reading and re-reading collected materials, breaking down and rebuilding data in new structures, and doing so in a way that is loyal to participants meanings, cognizant of one's own biases, and rigorous in regards to depth and quality of interviews or observational data (Yeh & Inman, 2007). Robson (2002) further noted, "The fact that a study is a case study does not, in itself, call for a particular approach to the analysis of the qualitative data which it produces" (p. 473). In the present study, I completed data analysis and verification in two stages. Stage one was completed with another researcher, and stage two (which followed procedures described in Stake, 2006) was completed alone. These stages are described in detail below.

First however, because stage one involved a data "coding" process, I take time to clarify the meaning of this term for the current study, and to distinguish it from formal Open, Axial, and Selective Coding, which are part of the specific Grounded Theory tradition of qualitative research. The current study did not attempt to follow Grounded Theory analysis techniques, or to eventually develop a theory of the process of interest. Here, the term is instead meant as 'coding with a lower-case c,' similar to Miles and Huberman's (1994) usage. Robson (2002) cites these authors and explains:

"Qualitative data rapidly cumulate, and even with regular processing and summarizing, it

is easy to get overwhelmed. The material is unstructured and difficult to deal with. Coding provides a solution" (p. 477).

Here, a "code" is identified as merely: "A symbol applied to a section of text to classify or categorize it. Codes are typically related to research questions, concepts, and themes. They are retrieval and organizing devices that allow you to find and then collect together all instances of a particular kind" (p. 478). Robson further makes the important distinction that Grounded Theory analysis also refers to "coding" but uses "a somewhat different terminology" (i.e. Open, Axial, and Selective Coding), and has a different aim: not only to apply a symbol to a section of text, (as in Miles and Huberman's usage), but to eventually generate a theory (p. 478).

With that clarification, I offer one further note about the varied use of this term. In addition to defining a "code" in general, Miles and Huberman (1994) go on to create additional, proprietary meanings for Coding with a capital C: they discuss such processes as "First-level Coding" and "Second-level Coding." Again, the current study did not attempt to follow their formal analysis technique (because it instead followed Stake's) or to adopt their more specific usage of the term "code." Faced with the (wonderful and "overwhelming") qualitative research situation of having 13 transcripts with a modal length of 20 pages, a coding process did indeed provide a legitimate solution for systematically reading and beginning to make sense of the data.

Data Analysis Stage One. In the first stage, a team of two researchers (comprised of Doriane Besson and this writer, both Counseling Psychology doctoral students at the time of the study) analyzed interview transcripts via a coding process. Again, as described in detail above, the term "coding" here refers simply to a process of attaching a label to seemingly significant sections of text. Doriane graciously volunteered as a co-researcher for this stage of the project, and brought to bear strong experience working on her own, and others' qualitative research

teams. Our initial meeting involved a discussion of the purpose, background, and methods of this study, as well as a broader discussion of case study research. Researchers discussed our understanding of coding as a first round of data analysis. We agreed to keep track of the relevant line numbers of text that corresponded to each code (in part so that quotes exemplifying that idea could later be re-located). Doriane and I first completed coding procedures independently, then met in person to consult about similarities and differences in coding.

During the coding process, we approached the task with two goals in mind: first and most importantly, we aimed to remain loyal to participants' meanings, and to work at understanding their comments in the context from which they emerged. Context included both the surrounding text, and what we knew about the participant from any of their earlier transcripts. Secondly, we held the goal of reading transcripts with an eye towards their deeper meanings. This may be understood as reading with a "third ear" (eye) in a way that allowed for recognition of subtle themes. Freud's advice to analysts to listen to clients with "evenly hovering attention" may be an apt metaphor for how we worked to keep the two goals in balance. Evenly hovering attention referred to remaining open to seeing and hearing whatever was present, at any level of explicitness, but without imposing preconceived ideas and biases. (Or, more realistically, to own one's preconceived ideas and biases whenever possible). When in doubt, we followed the first tenet of sticking close to the data, and to participants' most likely, explicit meaning. But at times when we both independently noted a less-explicit theme, we made a note to tentatively consider such 'third ear' data.

Of note, to ensure confidentiality, no identifying information about participants or their clients was included in transcripts used by the coding team. Initial consent forms were stored separately from transcripts, and only a code letter identified transcripts.

Regarding the timing of research tasks discussed above, we conducted initial coding concurrently with further data collection. That is, as soon as an interview had been conducted, transcribed, and checked by the participant, it was made available to researchers for analysis. This was done in order to allow my future interviews to benefit from data gleaned from prior interviews. It allowed for follow-up questions to be formed not only from my own assessment, but also from discussion with another researcher. Whenever possible, researchers analyzed transcripts from only one participant at a time. (For example, we completed analysis of all three interviews from Therapist A before beginning work on interviews from Therapist B, and so forth). This allowed us to become immersed in understanding one therapist at a time. By doing this, we had the opportunity to be aware of each participant's communication style, and of subtle themes that continued across interviews.

Timing of researcher meetings varied, and depended in part upon this writer's schedule for completing interviews, transcriptions and participant checks, and ultimately occurred approximately once every one to two weeks. At each meeting, we shared codes and perspectives about the meaning of the data.

Data Analysis Stage Two: In a second stage of data analysis, this writer (working alone) used the initial codes derived from Doriane's and my coding process as a basis for identification of Case Findings (within cases). Later, Merged Findings and Assertions (which took into account Case Findings from across all participants) were identified to complete a Cross-case analysis. In case study research, a single researcher often completes these levels of analysis (Stake, 2006). There are many possible approaches to the logistics of managing data at this stage. To facilitate the iterative process of organizing the data to find higher-order connections, I worked with the initial codes in the form of three-dimensional objects (codes typed on small strips of paper) that

could be manually sorted and resorted (as advised by Stake, 2006). First, I printed and cut out a strip of paper for each of the approximately 900 initial codes. From here forward, I refer to these as "code strips". As recommended, I color-coded each of these to indicate the participant (A-E) and interview number (first, second or third) from which it came. Transcript line numbers from which a given code was originally derived were also typed on each code strip.

Then I separated code strips by participant (e.g., all code strips from Therapist A's data were placed together in one "deck", all code strips from Therapist B's data were placed together in another "deck" and so forth). I then worked within-participants to sort code strips with other code strips that expressed similar themes or ideas. After "like" was sorted with "like," a summary title was given to each newly formed group. A group of code strips sharing a theme formed a Case Finding (capitalized as in Stake, 2006). Since I was manipulating these concepts as concrete objects, I used a small rectangle of paper, folded in half length-wise into a "V" shape, as the Case Finding strip. The appropriate code strips were stored inside each folded Case Finding strip. At the end of this stage of analysis, I had a total of 113 Case Findings. (Each therapist's initial code strips yielded between 17-28 Case Findings.) These Case Findings formed the basis for both the Intra-case analyses (considering each participant's set of Case Findings separately) and the Cross-case analysis (considering all participants' Case Findings together). Please refer to Appendix D for a complete list of Case Findings (and the initial codes that combined to create them) for each participant.

In the Cross-case Analysis, themes were explored independently across all cases (Creswell, 1998; Yeh & Inman, 2007). All 113 Case Findings were included, representing data from all participants. Stake (2006) explained the physical process of a researcher "doing" the Cross-case analysis. Because this is something of a technical process with its own specific terms,

I include his exact words below. Of note, Stake wrote about a fictional researcher, "Anna Lee" as the subject completing these research activities. I substituted "the researcher" for references to "Anna Lee" in the following passage to avoid confusion. The first such substitution is bracketed:

> "[The researcher's] task is now to merge Findings across Cases. For merging Findings into clusters, she combines all the decks of Findings strips. She lays out the strips, one by one, placing each according to its similarity to those already on the table. The Case from which each Finding came gets little notice. Findings similar in topic get placed close together; those dissimilar are placed farther apart. Even if Findings are contradictory, any two strips that are on the same topic are placed in the same cluster.
> Next, the researcher studies the content of the clusters. Adding a strip nearby, or dropping a misfitting strip, she identifies the most important clusters. She gives each Merged Finding a name that identifies the trust of the cluster. She writes the name given each Merged Finding on its own title card" (p. 60).

After following the above procedure, I formed 18 Merged Findings from the original 113 Case Findings. To further sort Merged Findings into Assertions, I repeated the same process. I grouped the 18 Merged Findings such that they formed six clusters. These new clusters are titled "Assertions," and were similarly each given their own title card that named and "identified the trust of the cluster." Please refer to Appendix E for a complete list of all Cross-case Assertions, Merged Findings, Case Findings, and initial codes.

Data Verification. In addition to participants' input on the accuracy of transcripts, and their reflections between interviews, participants were also asked to review the Intra-case analyses and the Cross-case analysis after completion. They received an invitation to comment upon, and offer their views on the accuracy of the results derived by this researcher. This process is referred to as "member checks," and is considered an important component of rigor in case study research (Stake, 1995). Participants were asked to return their comments in the time space of one month to be incorporated into the final manuscript. Three of the five participants (Therapists A, B, and D) responded to this request for feedback with their comments. They each

offered remarks indicating they supported the results. No participant expressed disagreement

with findings, or suggested substantive revisions. Therapist A responded via email:

> "Hayley, I just want you to know that I am reading your pages with such pleasure. I am slow only because I have so little time. It is so interesting to read your integration of ideas as they emerged from your research. Your presentation, not surprisingly, is beautifully written, crystal clear, and lively. Thank you for sharing this, [Therapist A]."

Therapist B replied,

> "Hayley, I read it fast. It is clear, well written and thought provoking. [Personal/identifying details deleted…] I did enjoy meeting you and respect and support your efforts. Sincerely, [Therapist B]."

Therapist D provided this feedback:

> "Hayley, Great to see progress on your dissertation! I took time to read through all of the chapters you sent and I added a number of comments and edits (see attached document). First let me say that this is impressive work that you are doing and I feel privileged to have been asked to be one of your interviewees. I very much enjoyed reading the three chapters and I learned a lot both from your analyses and from what the other therapists shared with you. In fact, as I think about it, my overall experience as a research participant in your study (including reading the three chapters) has helped me to gain deeper understanding of what it means to be an integrative-eclectic therapist and I think that I will be a better therapist for it. Although there are clear differences among the therapists, I felt a great sense of validation about what I do as a therapist. I feel that others expressed certain core ideas quite well, and many of their insights and observations, especially about the therapy relationship, really resonated with me (and helped to clarify my own thinking about various issues). After reading [the Intra-case analysis], I realized that I, more than the others, self-disclosed certain personal and developmental experiences that shaped who I am as a therapist and as a person. I debated whether or not to ask you to scale back some of what I disclosed but I actually think that the details of my experiences are key to readers' understanding of how I evolved into an integrative-eclectic therapist. So, I'm comfortable leaving everything as written. Thanks again for inviting me to be part of your dissertation study. I hope your defense goes well! If you have time, I'd enjoy hearing about your defense and your plans for the future. Cordially," [Therapist D].

Of note, the "comments and edits" Therapist D noted were related to pointing out

sections he particularly agreed with, as well as kindly pointing out places where there

were typos and other minor errors.

CHAPTER FOUR: INTRA-CASE ANALYSES RESULTS

The "how" of treatment selection has much to do with the "who" of the therapist.

Decision processes were situated both within therapists' internal (or internalized) and external

contexts. And while the image of 'internal' versus 'external' contexts is almost certainly an

oversimplification, it is useful here to convey how the "contexts" of treatment selection decisions

were understood to be more than external aspects of place, time, and physical setting (although

these are certainly important). Analyses indicated that treatment selection decisions were also

internally situated in the contexts of therapists' basic assumptions and core values about therapy.

These assumptions and values, in turn, were further situated within the person of the therapist,

including his or her training, practice, and life experiences to date. Therapists explained how they

integrated their core approaches to therapy, views of the therapeutic relationship, and specific

intervention tools to address clients' concerns.

At the next level, the person of the therapist him- or herself was also situated in

"external" contexts of environment, profession, history, and culture (although these of course

interact with and shape the "internal" contexts discussed above). Each case begins with a

description of that participant's practice setting, and physical environment. Identifying details

have been omitted to protect confidentiality, but I have included other details that give a sense of

what it was like interpersonally to be in the room with each individual. These descriptions also

introduce the social context of the therapist in the role of participant in the present study. Further,

in many cases there were enlightening parallels between the interpersonal processes occurring in

the research interviews, and therapists' descriptions of their approaches to treatment. This

experiential context provided another layer of information to aid in understanding participants'

meanings.

Here, below, I include a table to display the timing (dates) of interviews with each participant. In this timeline table, I also highlight the occurrence of substantive (other than scheduling or routine exchange of transcripts for member-checking) extra-interview contact with participants (labeled "Contact"). Whenever important, such timing issues are elaborated in detail within each case.

Table 2. Timeline of interviews and other substantive contacts with participants

Therapist	Contact	Interview 1	Contact	Interview 2	Contact	Interview 3	Contact
A	Email: 5/23/10	5/28/10	Email: 5/29/10	6/16/10		1/27/11	Email: 11/7/12
B	Email: 5/25/10	6/9/10	Email: 8/24/10	(Withdrew)		(Withdrew)	Email: 10/27/12; 11/4/12
C		10/8/10		12/15/10		12/21/10	
D		12/14/10		12/21/10		2/7/11	Email: 7/26/11; 11/4/12
E		6/24/11		7/13/11		7/27/11	

As shown in Table 2, (and discussed earlier in Chapter 3) Therapist B consented to participate, and completed one of the three interviews before he withdrew from the remainder of the study. He did, however, give permission for me to include his responses from that first interview in my analysis. Because I was unable to complete the full in-depth interview series with Therapist B, I made the decision to analyze his responses (in the same manner as other participants') but not to present these in a separate written case analysis. Rather, with the goal of

nonetheless still including Therapist B's voice, I combined the Case Findings from his one

interview with all other participants' Case Findings, so that they contributed to the Merged

Findings and Assertions in the Cross Case Analysis. In place of a full case analysis in this

chapter, I include a more circumscribed introduction to Therapist B and his practice context. I

also discuss the circumstances around his withdrawal from the study. It is hoped that such

information will provide a basis for better understanding his contributions as they appear in the

Cross-case analysis (in the following chapter).

The purpose of each Intra-case analysis was to provide a description of that therapist's

unique approach to treatment selection. In doing this, and in light of the discussion of contextual

situated-ness above, particular attention was given to how therapists discussed the connections

among various influences and contexts on their decision processes. Because of the fluid ways

therapists described these connections, their decision contexts and decision processes were, at

times, both figure and ground. This state of the data did not lend itself to splitting analysis

discussion into sections of "pure" context or "pure" process. Further, different aspects of self,

history, environment, and intellectual processes were more or less salient in each case. Thus, to

best preserve and present the individuality and spirit of each case, analyses interweave these

elements in ways that were meant to best match and express therapists' meanings (as opposed to,

for example, creating and adhering to a single results presentation structure to be used for each

case.)

Therapist A

To introduce Therapist A's approach to treatment selection, I begin by describing my

introduction to Therapist A. This therapist (a woman, working in private practice) was the first

person to respond to my study recruitment letter. In hindsight, my early interaction with her

proved to be uniquely prescient. The concerns raised by Therapist A would later be echoed and

elaborated by other participants. Moreover, beginning the interviews in this way affected me as

the researcher. It quickly sensitized me to key issues for this practitioner (and later others) and

(graciously) provided me with the opportunity to articulate my in-coming research stance and

commitment to open-minded inquiry. It is one thing (albeit important) to explicate these

intentions in one's opening chapter, or in formal academic discussion. It was quite another to

share these ideas with participants themselves, and to feel the interpersonal reality of making

such statements directly to those whose experiences I wished to understand. Therapist A invited,

allowed, and challenged me to "go there" as a researcher:

> "Hayley, I have an interest in supporting therapy research, and would like to be able to help
> you in your study. I have a couple of concerns. Firstly, you are asking for a considerable
> time investment. Do you plan to conduct interviews in person or by phone? What is your
> time frame? Freeing up three clinical hours would be a challenge for me. Secondly -- I at
> least, and I believe many more seasoned practitioners no longer think in terms of
> "treatment selections." We do what we deem to be most effective for each individual
> without cognitively sorting through the possible theoretical frameworks or intervention
> options. Any analysis is ex post facto, and more a matter of deconstructing what has
> become a fluid, integrated process. Does this concern you?
> Let me know what you think, [Therapist A]" (Personal email communication, May 2010).

In response to Therapist A's email, I asked myself, *does* this concern me? Below I provide my

response. I include this in its entirety, with the goal of providing a sense of the interpersonal

context in which Therapist A and I began a researcher/participant relationship. This exchange

further highlights the practical and financial context in which interviews [and by extension, the

work and decision-making therapists described during those interviews] occurred. (E.g., It is

indeed asking a lot for a clinician in private practice to offer three hours of uncompensated time.)

> "[Therapist A], Thanks so much for your message, and your interest in the study. I was
> excited to read your email because the issues you raise about the fluid process used by
> seasoned practitioners (versus what the literature calls "treatment selection") are just what
> I'm interested in exploring in this study. I've come across several "theories of treatment
> selection" in the psychotherapy integration literature that talk about therapy as a kind of a
> priori decision-making process. But, no one knows if this is the way therapists do things in

actual practice. More recently, it seems there's been a call for research that goes beyond questionnaires testing *researchers'* hypotheses about how things might work, and instead focusing on qualitative studies of therapist's first-hand reflections. So, my goal is to ask therapists about this topic in as open-ended a way as possible. I think this would definitely include getting feedback about different therapists' views on the accuracy of the concept of "treatment selection" itself.

       To respond to the second part of your concern, it definitely makes sense to me that such moment-to-moment means of intervening are more intuitive and complex than can be easily articulated post-hoc. The questions I'm asking would require participants' after-the-fact recall to try to re-construct what they do naturally. Given that, what I'm hoping for is to somehow make the implicit therapy processes more explicit (in hindsight). This would be very valuable not only for measuring the gap between theory and practice, but also I think for considering ways to train beginning therapists. Although I would be asking therapists to explain intervention strategies that were likely not "selected" in advance, I'm not concerned that this will be prohibitive to the study. Even if it is not exact, my assumption is that therapists' reflectivity would be valuable in the same way clients' reflectivity is: To kind of look at one's intervention patterns in therapy, and re-construct why they might have made those choices that way, even if the choices were not explicitly premeditated. I also hope that the time between interviews, and the opportunity to re-read one's own transcript could lead to additional reflections and clarifications.

       My plan is to conduct the interviews in person, and I realize that this is asking for a significant investment in time and logistics. I hope to reduce the burden on participants at least somewhat by having a flexible timeframe, and being available to meet when it is most convenient for them (including early mornings, during the work-day, evenings, weekdays or weekends). For the location, I can meet anywhere that is quiet and private, including a participant's home, office, or a room on campus that I arrange. My timeframe is to conduct the interviews this summer, roughly between June 1- Oct. 1. They can be spaced as frequently as one per week, or as far apart as one per month. (And the time intervals between each interview don't need to be equal). Of course, participants are also free to end their participation at any time during the interviewing or data analysis process, without penalty.

       Again, I appreciate your interest, and I'd be happy to provide any other information I can. I've also attached a copy of the study consent form for some additional detail. If you are willing, and it's possible given the time commitment, I would be very excited to be able to talk with you about your experiences as a practitioner in the study.
Thank you, Hayley" (Personal email communication, May 2010).

I admit I was somewhat surprised, but quite grateful and excited for her response:

"Hayley, Well put! I'm in. I love process research (big surprise :)). I'll consult my schedule and offer you a few options. I think it would be best to meet in my office, to give you the real life setting. I am right by [identifying details omitted] hopefully not too out of the way for you. Do you need your consent form signed in advance, or can we do that when we meet? [Therapist A]" (Personal email communication, May 2010).

   At the time of the interviews, Therapist A was working full-time in private practice (with

one other therapist) and had been a licensed Psychologist for approximately 15 years. We met to conduct the interviews at her office. Due to her busy practice, interviews with Therapist A were scheduled when a client cancellation coincided with my availability. Therapist A would email me as soon as she was aware of an open hour, and I accepted the time when my schedule allowed. As with all participants, the second factor that determined our meeting times was my ability to complete the transcription of the prior interview, and send it to the participant for review before meeting for the next interview. Scheduling in this manner, the first two interviews took place 3 weeks apart. The third interview, however, was not completed until seven months later due to repeated scheduling incompatibilities (see Table 2).

Of note, prior to my interviews with Therapist A, I was made aware (by Therapist B, who had been independently recruited) that B and A had spoken with each other about participating in this study. (To clarify, one therapist was not "referred" by the other to participate--I had separately mailed each a recruitment letter.) However, I also learned from Therapist B that he would not have considered volunteering for this study if Therapist A had not shared the above email exchange with him (as he had initially shared similar concerns). This is further discussed in the section on Therapist B in this chapter. During my interviews with both therapists, they were aware that I "knew" they knew each other. Therapist A spontaneously stated that she planned to make a point of not continuing to speak with Therapist B about her or his participation so that she did not "influence" either of their responses.

The fact of these participants having discussed this study together speaks to the professional context in which the interviewees lived and worked. Participants were recruited from a relatively small city. Moreover, it is interesting that these colleagues consulted one another around the decision to volunteer for this study. Therapist A shared additional information

(not present in my initial mailings) that influenced Therapist B's decision to volunteer. Similarly, in the course of the interviews, Therapist A reported that she also uses consultation with colleagues as a way to assess and tune her treatment decisions.

While the researcher/participant relationship is of course quite different from a therapeutic relationship, I nonetheless had an opportunity to experience her style in this different "helping" context: her assisting me by sharing her knowledge via participating in the present research. This in-person interaction allowed for another source of contextual information, especially as this clinician defined her approach to treatment selection primarily in relational terms. I experienced Therapist A as warm and enthusiastic, with a very present, closely engaged energy. She was quick to use humor, and to communicate her ideas with verbal fluency and animated, expressive gestures. The notation "[*laughed/both laughing*]" occurred frequently throughout our transcripts. Her attentiveness and precision with words gave a sense that she did not miss much-- leaving me, as the researcher, with the impression of being both taken seriously and also slightly scrutinized (for example, when Therapist A made a humorous comment after I inadvertently misused a term). Comfortable and informal, Therapist A slipped off her shoes at one point during the second interview (and then, noticing me notice this, promptly clarified this was not something she would do in session with a client). Therapist A's approach to the research interview process was supportive, engaged and generous. In addition to completing the interviews, she invested additional time to review our transcripts, consult prior case notes, and even initiate email communication to clarify or expand upon points made in the interviews. She was further one of the three participants who provided feedback after reading the results chapters (see Data Verification section in Chapter 2).

Therapist A described a somewhat non-traditional and eclectic educational background.

She had earned a BA in the humanities, and a graduate degree related to the arts before she

pursued a Ph.D. in Counseling Psychology. She noted that her early training still impacts her

approach to treatment, but there was also a gradual evolution over time. She described having

broad training in multiple theoretical orientations in an academic environment that did not favor

any one approach, and she learned about different theories from different faculty in her program.

Therapist A noted that during coursework and training, she was not taught about approaches to

integration in any formal way. Instead she learned about combining approaches in practica from

supervisors, and found that linking theory to practice really only began coming together for her

on internship. She explained that early in her practice, she was somewhat concerned about not

following a single approach, but over time and experience saw drawing from different theories

"as a sign of integration versus ignorance" (A/1/429-435).

Therapist A was unique among participants in her focus on longer-term therapy. She

reported that many of her clients' goals were around personality change, or "reaching a new base

line" of functioning, in addition to symptom reduction. Thus, she estimated that 18-24 months of

weekly therapy was not an unusual time course for pursuing this type of goal. Further, she

observed, "I never terminate." Rather, she described viewing the therapy relationship as on

going, such that clients often returned to therapy at various stages in their lives to address

problems at new levels. Her approach to treatment, including the importance of "knowing the

client well" over time, can be understood in light of this long-term therapy context.

Participant A was remarkable for another reason, in that throughout the course of the

interviews, she re-interpreted her view of her approach to clinical decision-making. Or, perhaps

more accurately, while discussing and reflecting on her approach, Therapist A 'uncovered' or

'rediscovered' additional nuances and basic tenets of her practice that had become automatic

over time. Below I provide a four-part description of Therapist A's unique approach to treatment selection, based upon all information gathered (from the interviews, as well as from between-interview communications). Again, this therapist did not present these details all at once. Instead, they gradually emerged from the collaborative interview process. The specific processes of 'uncovering' will be discussed in more detail below, but it is roughly the case that points one and two were the most readily available to be described by Therapist A, and points three and four were articulated later in the course of the three-interview process.

Point one: Generally, clinical decisions are experienced as a non-conscious process. Early in the interview process, Therapist A expressed concerns that my research question itself--how therapists make treatment selection decisions--contained an inaccurate assumption: namely, that therapists engage in explicit, conscious, a priori, structured decision-making. She expressed skepticism that she practiced anything that could be called "treatment selection." In hindsight, this early exchange seems to have gotten to the "heart of the matter" (to borrow a phrase from another participant, Therapist D, whom I would meet later). Namely, the purpose of my study: to understand how therapists select treatments, and whether this corresponds with the assumptions contained in the literature. Other participants expressed similar concerns, and provided corrective feedback when terminology from the literature did not match with their own experiences, but none as immediately as Therapist A. Later, she further explained, "It really does feel like trying to put a taxonomy on something that is--that is so fluid" (A/3/74-75).

Point two. "Treatment selection" is more accurately understood at "relationship selection." The therapeutic relationship is the most important element of change. Therapist A described how this might look in practice for her:

"Subjectively, the way I experience treatment selection has much more to do with, where

do I position myself, in relation to my patient. It doesn't have to do so much with, should I offer them some cognitive strategies to, you know, deal with anxiety, do we need to learn some relaxation techniques, do we need to refer back you know, to the corrective emotional experience. You know, it's not like that. It's more--am I supporting and going with, am I challenging and being a force to push against, am I, you know, what am I--what am I trying to accomplish in that moment of the interaction. Is it to try to have someone feel they are being understood? Is it to bring into their awareness something that I'm seeing that they're not seeing? Is it to…illuminate historical factors that are currently at play, but again not acknowledged? …And I guess I think of it being very much in the moment. I mean, ideally, when we talk about treatment selection, it would be--seems to be more like, you have a vitamin C deficiency, ergo you should be taking vitamin C every 4 hours for the next 10 days. Right, but I think that the fluidity--the end--the goal is much less concrete in therapy. It is to diminish distress and to enhance functioning and life satisfaction, but there's not a chemical profile we can offer that gives us that. So it's the ever-ongoing effort to figure out what works for each person" (A/3/92-116).

This focus on the relationship is very consistent with Therapist A's core theoretical approaches, as her "thinking was definitely formed around psychodynamic ideas" (A/1/102). She conveyed facets of a relational focus through her direct statements and more inferentially via her case example. However, she stated, "I don't identify anymore with a [one] school of theoretical thinking" (A/1/116), and is thus I/E instead of Psychodynamic in orientation.

"I've always been more dynamically oriented, and had my love affair with self-psychology and Kohut…went through that whole thing…my internship was very strongly around the self-psychology, object relations and dynamic background. So that's always been a better fit for me than the other, really clearly cognitive behavioral, or solution focused, or systems --those other schools of thought" (A/1/48-58).

"In very broad strokes…we are profoundly influenced by our original relationships in family of origin, and they often create unconscious patterns of relating to ourselves and others which tend to be reconstructed and repeated through life unless you figure out what you're doing and do something to change it. I believe in the unconscious…a defining element" (A/1/102-107).

She described a focus on both past and present when choosing interventions, as both historical perspectives and a client's current functioning are important. "It's like these parallel tracks that you refer back to all the time in therapy. So it's not like a sequence-- you start with the family of origin, and then you move into the present-- it doesn't work like that. You've got to do both at

the same time" (A/1/ 153-155). She also notes that currently her approach includes existential

and developmental lenses, which she began using later in her practice. In combining these

elements, her relational focus seems to operate in the context and awareness of time: she

considers clients' pasts, their developmental path and stage, ways their conscious and

unconscious thoughts/feelings impact present functioning, and their fears/hopes about the future:

> "I'm much, much more heavily influenced by existential thinking now then I ever was as a
> student. Probably because I'm growing up and moving along in my lifespan, but I think
> that the influence that mortality has on each of us is immediate and profound, and runs
> through everything that we struggle with. And that very much informs the way I approach
> and understand the challenges that people walk in with" (A/1/111-116).

> "Let's just talk about Erickson. I have a very strong developmental perspective that runs
> through the life span. And I have very clear ideas about how that may influence the way
> that people relate to whatever it is that brings them here, because it's going to be different
> for you, than it would be for a 60 year-old man who might be experiencing very similar
> symptoms…so that is one thing that comes into my thinking" (A/1/126-131).

Point 3. In addition to the truth of relationship selection, there is a bit of treatment selection

as technique selection. But, these techniques flow freely from a storehouse built on knowledge of

techniques, and theoretical orientations, and are applied based on "feeling it's right to do so".

There is conflict between I/E and the medical model.

Point 4. As opposed to the above, intervention selection gets 'more clunky,' or more

explicit when there are impasses in therapy. Therapist A noted that in general, impasses are most

likely linked to problems in the therapeutic relationship. These problems may at times be caused

by problems with therapist discomfort (i.e. not trusting self, not connecting to the client, not

'trusting the process'.) At times of impasse, Therapist A explained that she may find herself

going back to a "formal assessment process" for clues about how to proceed: "And certainly I'm

aware that my sense of confidence in the process-- when I have a dip in confidence in my own

process is when I'm more likely to refer back to diagnosis, symptom checking, a more technical

treatment selection thought process" (A/3/56-59). In addition to being a sign that there is an

impasse in therapy, for Therapist A, looking explicitly toward theory or techniques was also

diagnostic of the state of the relationship. That is, if the relationship were doing the work of

therapy as usual, there would be no need to step out of that stream of more intuitive, relational

intervening in order to reassess:

> "The more comfortable I am with a particular client, the less likely it is that any sort of
> formal theoretical thought will cross my mind. When I'm scrambling--and it still happens
> [*laughs*] you know, 20 years later! That's when I'll sort of revert, I would almost say
> regress back to, like, OK, let's think about this in terms of, what would Kohut say? Or what
> would Kernberg say? Or what would--what's the behavioral guy's name…what would Ellis
> say? It's almost a way that I monitor my own comfort level or my own level of confidence
> or certainty with an individual (A/1/162-173)…[several lines, discusses another issue]…If
> I'm less comfortable and I'm thinking theory, what it means to me is that I haven't
> connected deeply enough with the person to have an intuitive understanding of where we
> are" (A/1/213-215).

As mentioned above, Therapist A revised her narrative around treatment selection over

the course of the three research interviews--a shift consistent with epistemologies that say

knowledge (even about oneself) is socially constructed. I explain this with the help of a narrative

or story metaphor: Whereas initially the main "plot" of therapist A's narrative was one of "non-

conscious relationship selection," through the experience of talking about her decision-making

processes she identified an additional counter-plot: that technique and theory played a larger

more explicit role than first thought. Specifically, Therapist A found herself "surprised" by the

degree of "technical" processes and formal assessment that her work includes. Ultimately, there

were two points in her process where she identified a more technical and explicit treatment

selection process: at the initial intake and assessment, and at times of impasse when the

relationship seemed to falter.

In the course of the interviews, and particularly when she reviewed progress notes in

preparation for the second interview, Therapist A "realized" that she draws significantly from her

training in order to do a clinical diagnostic interview as part of getting to know the client prior to

deciding how to intervene. To illustrate, this segment of transcript is from early in the second

interview. I ("H" below) had asked Therapist A to describe a case in which she used her "usual"

approach to treatment selection, and she had prepared for the interview by reviewing case notes:

> A: "Then I started thinking about--I was reading notes of the person I'm going to talk about. I was quite struck by how technical they were.

> H: The notes were technical?

> A: Um hmm, yeah. And I was realizing that my internship was an inpatient psychiatric hospital and we got very rigorous training in doing psychiatric diagnostic interviews. Which I was really good at--I loved doing them, they were so much fun. We had an hour and you had to suss-out the whole story and then come up with a diagnosis. It wasn't a structured interview in the sense that you ask this question, then that question, then that question, but it was very sharply laid-out areas of inquiry that you have to cover in that time period. And I remember using the word 'quadrants' with you?

> H: Quadrants, yeah, um hmm.

> A: And I wasn't thinking in those terms. But as I thought about it I realized that in my first interview with most people---hell if I don't do a psychiatric interview! [*laughs*]

> H: [*Laughs*] Yeah?

> A: Diagnostic interview. And I don't structure it, but I get there. You know, it's everything, from presenting problem, history of current illness, previous treatment, medical issues, financial issues, criminal issues, substance abuse issues, family condition, umm…what am I missing…depression--I mean, mood, cognition, affect, physical illness--it's the whole--you have to do this whole kind of global assessment right at the very beginning so you kind of know…something about what to focus on.

> H: Um hmm.

> A: So I find that very interesting because I've been talking to you so much about 'intuition' and 'relationship.'

> H: Yes!

> A: And sort of, non-technical approaches and yet-- my very non-technical approach is--

has this under-girding of very technical, clinically focused, diagnostic thinking. Which surprised me. I never would have said that" (A/2/64-94).

Therapist A went on to discuss how the technical elements integrate with, and lay the groundwork for other elements of therapy.

"I think what that [technical under-girding] does is it gives me a sense of orientation. About--in global terms, where to focus my attention…But I do take that opportunity to put it into this--very formalized, well-honed, kind of framework that I was given by training. And I think that that structure gives me the sense of freedom and confidence to abandon it, as I get deeper into the relationship. Because I do believe, with both my emotional--my intuitive--and my intelligence, that it is the relationship that is the active ingredient in psychotherapy. And you have to get to a place here you can trust the relationship." (A/2/99-121).

Explicit consideration of theoretical conceptualization was also identified as integral during moments of impasse, as Therapist A clarified to me in a follow-up email after the second interview:

"Just a couple of follow up thoughts I wanted to share, before I lose them. When I was talking about [the client in the case example I discussed in the second interview] I distracted myself, and am not sure I ever articulated the point, which was that in the face of uncertainty about progress, I find myself more prone to retreating into "theoretical thinking" both in terms of a theoretical framework that I can organize the clinical material around and in terms of treatment selection, i.e. "OMG, maybe he needs cognitive behavioral therapy to rid himself of those pesky irrational thoughts." What seems important to me is that this is in fact a distancing from what I know to be the most powerful therapeutic intervention, i.e. staying engaged in the relationship and working with what that is like. I do believe that in the interaction there is a counter pull between intellectual conceptualization and engagement. Of necessity, the former includes a measure of objectification and movement toward a more medical style of thinking.
        That being said, I also need to mention that I have worked with many individuals with severe psychiatric illnesses – not in private practice –and that when you enter the realm of psychosis, severe personality disorders, or organic material everything I have said to you is moot. Likely, [my client who wore aluminum foil to a session] was psychotic. Sullivan, of course, would say that we are just afraid of craziness, and I'm not certain whether the issue is that the approach I take would be ineffective (I believe this) or that I just don't want to enter that world sufficiently to be of use (I know this.)" (Email communication, Therapist A, May 2010).

During the final interview, Therapist A initiated a discussion of an interesting parallel

between our research interactions and "what happens in therapy" related to why it was at times

difficult to articulate her processes around intervening. We agreed there was a sense that we were

jointly immersed in the interaction, even--or perhaps especially--at times when disconnections in

explicit, verbal meaning occurred:

> A: "It was interesting to see--there were times in our conversations when I thought we both knew exactly what we were talking about, and really understood each other, and on paper, it was completely incomprehensible?! Did you have that experience?
>
> H: Yes, I totally did! [*laughs]*
> A: [*laughing]*
>
> H: I was looking at [some sections] thinking, ok, let me try to re-create this-- [but] at the time it did seem to make perfect sense.
>
> A: It made perfect sense! And I looked at some of those things and it's like [*makes confused facial expression*].
>
> H: Yeah, like, what the hell is that?
>
> A: So that was interesting… it makes me think about that--words and sound are such a limited information source? Because there's a lot of visual stuff that goes on, and there's a lot of common thinking that you can't hear. And so it's sort of like, that's exactly what happens in therapy. To some extent, there are probably those moments where there is an experience of understanding, but it doesn't come out in--in words that would be recorded." (A/3/465-484).

Earlier in this interview, Therapist A had elaborated on this challenge of putting the therapy

process into words:

> "That's why it's hard to talk about. Because hopefully we're using so many more of our capacities than just cognition, and those are very hard to articulate, as in any relationship. And the challenge is to take that, and not have it undermine the verity of this--it is, it is a--it is not a mushy process. I mean, it is and it isn't. The components of it are ambiguous, they bleed into each other, they're hard to define, they're hard to name exactly when they're happening, but the overall construct is quite well defined, and you can measurably see movement from it" (A/3/219-228).

Therapist B

While he chose to withdraw from study participation after the first interview, Therapist B

nonetheless provided important insights about I/E decision-making that I included (and gave equal weight in relation to insights from other participants) when analyzing data for the Cross-case analysis. In this section, I provide an introduction to Therapist B and his philosophy related to psychotherapy. Next, digressing slightly from the focus on this case alone, I examine how my timeline of interviews impacted my approach to them. Specifically, I discuss factors that influenced my thinking and interview style as a researcher between meetings with Therapists A and B. Finally, I relate the circumstances under which Therapist B withdrew from the study, and his reasons for doing so.

Therapist B was a colleague of Therapist A (as discussed above, in the Intra-case analysis for Therapist A). When responding to my recruitment letter via email, he disclosed their connection, and explained that he had spoken with her about our (A's and my) initial email exchange. Therapist B indicated he had had similar concerns about participating in a study on "treatment selection" and was not planning to participate until he happened talk with Therapist A about it:

> "I received your request to participate in your research and initially chose not to respond because my approach to doing therapy is predicated on a deeply held belief that how we help (when we do) requires responsiveness to each individual's unique story. I regard the "science" of psychotherapy as a useful but not primary guide to how I practice. [Therapist A, identifying details omitted] mentioned that having exchanged ideas with you, she believes you are open-minded to this "alternative" approach. I write as one who values the education I received; what I have learned from my patients and my supervisees in [academic department] before that discipline was relegated to biochemical manipulation almost to the exclusion of therapy and the therapeutic relationship. FYI, I have been influenced by books like Yalom's "Gift of Therapy" and James Gustafson's "Self-Delight in a Harsh World." All of which is to say that I would be delighted to participate in your research if it can usefully include someone with my briefly sketched approach. Best regards, [Therapist B]" (Personal email communication, May 2010).

We agreed to meet at his office for the first (and eventually only) interview in early June 2010 (see Table 2).

Here, before further introducing Therapist B's context and approach, I digress to describe how my thinking as a researcher shifted at this point in time: between completing two meetings with Therapist A, and planning to begin meeting with Therapist B. In planning for study interviews, I had decided to allow for a combination of bringing topic areas to ask about, and an intention to follow participants' lead. This occurred both within participants (i.e. asking follow-up questions to explore areas therapists introduced) and between participants (adding new questions or topic areas to my original list to potentially--but not necessarily--ask other participants). Because of this approach, time (and order of participant meetings relative to one another) became an important part of the landscape of interviews.

Specifically, I added a new, unusually pointed question to my interview with Therapist B that I had not originally planned to ask in this way, and had not explicitly asked Therapist A. But based upon my conversations with her, I believed it may be useful to more closely pin-point this area with other participants: Therapist A was clear that the term "treatment selection" was not a good fit for her experience intervening in therapy, as it implied a rather explicit, didactic process. But after meetings with her, I was not, at that time, sure that I had been able to 'nail down' what she *was* doing. Where were the tidy variables and if-then contingencies? I found I couldn't see the trees for the forest. Later looking back from the perspective of completing the study, I realized that this was because for Therapist A, her decisions were tightly intertwined with her context (e.g. the therapeutic relationship, her beliefs about what is helpful, her use of self and all the experiences that have shaped her). But of course, what she "was doing" was there. It would just take time during the analysis process (which was not complete at this point) to identify what the influences were, and how these did form a coherent pattern (as described above in Therapist A's analysis).

Again with the benefit of time, I can further identify a (perhaps ironic) parallel process between the decision-process Therapist A described to me, and my own decision-process at that time about how best to proceed with the interviews. Therapist A had described that when she begins to 'doubt the process' of therapy, or feel more anxious about progress, she might "retreat" into more formal, explicit conceptualization and assessment. Similarly, I as the researcher began, at this early point, to 'doubt the process' of using open-ended, participant-guided discussion to answer my research question. Thus, I "retreated" into feeling a need to be more explicit, more concrete with some questions. It seemed that perhaps Therapist A's initial comment: "I at least, and I believe many more seasoned practitioners no longer think in terms of 'treatment selections,'" might, in fact "concern" me.

Therapist B's initial email to me (above), which expressed a similar theme about having an "alternative approach" to therapy, led me to wonder if I may face a similar challenge to exploring and understanding his work. Because of this "concern," I chose to explicitly ask him about his approach in contrast to a definition of "treatment selection" from the literature. My goal was to explore and better understand where he might place his own experience with 'knowing how to intervene' in relation to this construct. Did any aspects overlap? What term(s) or process description might he use instead? And if I were to take this more structured approach to a question, I wanted to transparently present the source of my starting-point toward understanding "treatment selection" (a review of the literature). To do this, I brought a definition to our meeting, read it out loud, and explicitly asked Therapist B for feedback and any reactions to this material:

> "Treatment selection, I would go back to the notion again, of, it starts for me with the person--the interpersonal selection process. Which again--I'm being redundant here--has to do with the foundation. And the foundation as I see it is whether there are enough

grounds for common understanding between me and the person with whom I'm working" (B/1/303-307).

Of course, this question change still occurred as part of a predominantly 'free-flowing' interview conversation. And Therapist B's comment that, "I'm being redundant here" led me to realize that we had already been addressing these issues throughout the interview, so perhaps I could 'trust the process' and still reach the important points. This increased my assurance in "the process" and allowed me to better focus on listening, recording, and understanding whatever it was that participants expressed about treatment selection. This helped me to have greater confidence in my approach when working with future participants as well, and feeling less internal pressure to somehow find simple (or easily described) answers to research questions. The important task was again to elucidate these practicing I/E therapists' views and approaches to decision-making processes, however complex, context-embedded, or therapists-specific these might be.

Returning to an introduction of Therapist B, he was working full time (30-35 direct psychotherapy hours per week) in a private practice with one other therapist, and was 25 years post-licensure at the time of the interview. He was the participant with the most years of psychotherapy experience, and, as such, was the farthest from his Ph.D. training. I experienced Therapist B as sincere and welcoming, but without him making attempts to control our interaction. Thus, while I was the one visiting his practice space, he fully allowed me to structure and lead the "frame" of our interview. At the same time, he appeared comfortable with freely articulating the "content" of the interview (as the interviewee) and leading us into different or new areas he believed were relevant to the topic. On one hand, feeling the responsibility to lead the interaction in another professional's space felt a bit uncomfortable at first, as if I might have

'enough rope to hang myself with' in terms of potentially being awkward with timing or space (e.g. my coordinating where to have each of us sit, moving furniture to place the recorder in the best spot in relation our seating arrangement, etc.). But soon into the interaction, I realized that I did not feel any judgment from Therapist B, whether this (any awkwardness on my part) had been the case or not. I imagined that his clients might experience an interaction with him similarly-- that is, with Therapist B initially providing a great deal of autonomy and freedom in the structuring of sessions, a client feeling some anxiety about "doing therapy right" with so much freedom, but then having the realization that there was, in fact, not any one "right" way. Instead, Therapist B's style would be to meet the client in whatever way he or she began.

After this interview, and especially while transcribing it, I thought that the way Therapist B referred to his clients--consistently not as "clients" or "patients" but as [various grammatical constructions of] "the person with whom I'm working"--was unusual. Transcribing this phrase from the interview again and again made it quite salient to me, in a way I had not fully noticed during the interview itself. The close interaction with it (typing word by word) allowed me to note its consistency, and to consider the meanings and implications of this deliberate linguistic choice for Therapist B. It seemed to be quite respectful, collaborative, and very much in line with his philosophy of not pathologizing individuals or medicalizing therapy. Therapist B had not sacrificed accurate connotation for quick reference.

He explained that prior to earning his degree in Clinical Psychology, he "took a rather circuitous path" (B/1/17) to the field. This path led him through 5 universities in two countries, and nearly led him to earn a Ph.D. in a different field (humanities) before, "I was working on [that humanities] Ph.D. and feeling lost, and actually someone with whom I was connected suggested to me that I would be good as a psychologist" (B/1/32-34).

Therapist B described the population he currently worked with as "Very diverse. Diverse in terms of socioeconomic class, diverse to a degree that [current city] allows in terms of race, diverse in terms of age. I don't work much with children. I like children, but [mainly I work with] adolescents to the elderly" (B/1/66-69). He currently provided both individual and couples therapy. Prior to his current setting, he had worked in an inpatient facility, an outpatient clinic, and a nursing home. He further described his scope of practice:

> "I'm largely a generalist in the sense that--it gets to something we may get to in a more-- you may get to in a more focused way, and that is that I really am interested in meeting people on an individual basis, rather than trying to look at them in terms of diagnostic categories" (B/1/84-87)… "To the extent that I can say that I have any kind of particular area of work, it would be, I suppose, with people who have experienced trauma. But, I wouldn't want to emphasize that to the exclusion of meeting people wherever they are" (B/1/92-95).

After the first interview (and having time to transcribe it to send to him for correction/addendums) I contacted him again by email on July 15. He replied and let me know that he would be away on vacation for approximately 3 weeks, and would be in touch again after that to schedule the second interview. After he returned, he emailed me to explain that he had chosen to withdraw from the study based upon his convictions that even with the alteration of identifying details, he did not feel comfortable discussing a case without that client's permission to do so. (As a reminder to readers, the structure of the second in-depth interview was for participants to 'walk me through' their treatment selection processes in a recently terminated, de-identified case.) He wrote:

> "Hayley, I apologize for not being in touch sooner. I have struggled with my feelings about participating in the second part of your research. I do not feel I can "disguise" a case without altering the whole. I also have reservations about confidentiality. Whether disguised or not, I personally would want a release of information from my client letting him/her know what I was doing and getting written permission. This reflects my personal feeling, not some moral judgment about how others (obviously including you) regard this matter…[potentially identifying details omitted]. I choose not to go against my

sentiments in this instance and regret that I did not think and "feel" it through at the outset. I wish you and your research well. With best regards, [Therapist B]" (Personal email communication, August 2010).

In addition to the above, Therapist B also offered a personal perspective on his decision. He indicated that in his own life experience, he had once been in therapy with a therapist who wished to reference material from Therapist B's treatment in a book. While this therapist indicated the material would certainly be altered to protect confidentiality, Therapist B was still informed in advance, asked for his written consent, and directly given the option to decline permission for his material to be included. Thus, especially having been on 'the other side' of this situation, (and presumably, feeling what that had meant to him in the context of that therapeutic relationship), he had a strong commitment to provide the same option for his own client(s).

Therapist B did not happen to ask me about the possibility of taking additional time to seek such consent and permission from a current client, and I did not suggest that possibility. In my reply to his email, I instead offered further clarification regarding my expectations for the purpose of the second interview (i.e. to focus on the therapists' processes and not on the client's specific details), and highlighted that I would not be including the full transcripts in the final manuscript, but rather would seek to identify important themes about the therapist's work from our conversation about the specific case. I also wrote that I wished to ensure/ask if I still had his permission to include the data from our first interview. He replied, and confirmed that permission. He further noted that he felt the protections and second interview goals I had reiterated were indeed clear, but did not alter his decision to withdraw. He again wished me the best with the research, and expressed his lack of any negative judgment about the process or ethicality of the research study as a whole.

His decision to withdraw due to the concerns he mentioned does appear to be consistent with his emphasis on the importance of trust in the therapy relationship, and creating a therapeutic atmosphere in which transparency can be bi-directional--the client can feel free to discuss issues within the relationship as they arise, and the therapist can earn this trust with his openness towards hearing and understanding the client, and explaining what it is he's "doing". It would appear to follow that transparency in other aspects (such as how the therapist may be "using" the client's material) would also contribute to that prerequisite trust. Of course, all participants noted trust as a crucial aspect of therapy as well, but knowing this focus may help to make sense of Therapist B's particular concern around this aspect of confidentiality:

> "When I meet a person for the first time, I don't assume they are going to trust me, in fact I will say, often explicitly to people with whom I'm working, that I think trust is a gift. It isn't something that comes about because I happen to have degrees on the wall, because I'm a human being before I'm a therapist. And I acknowledge that with them. So I keep coming back to the relationship. If there isn't that kind of fundamental sense that there is a sufficient understanding on my part, and a sufficient trustworthiness, that the person with whom I'm working feels, then it's not going to go anywhere regardless of what technique I use" (B/1/242-249)… "So, it's important that there be, I think, an atmosphere created with respect not only to a person telling a story about their lives or what their concerns are, their immediate concerns, outside of what is going on between me and the person with whom I'm working--but also to create an atmosphere (without emphasizing it or allowing it to dominate) but to at least make it clear in one way or the other, that included in the work should be the freedom to be able to share in what's going on between me and the person with whom I'm working" (B/1/316-322).

Certainly, reasons for any action can also be multiply determined, and it is possible that factors in addition to those Therapist B disclosed may have influenced his decision to withdraw from the study. To understand if he might have differed from other therapists who remained in the study in significant ways (which may have contributed to his decision) comparisons among participants could be explored. In terms of demographic/situational characteristics and therapeutic orientation issues in comparison to other participants, Therapist B had much in

common with them: he shared a non-direct route to studying psychology, worked full-time as a

clinician, had a generalist practice and worked with a wide range of clients, and wished to

emphasize connecting with clients as unique individuals. Also like other participants, he

expressed disagreement with a strict approach to psychotherapy research's application to

practice, and use of manualized Empirically Supported Treatments. Also like (nearly all) other

participants (as discussed in the Cross-case analysis) he noted the feeling that practicing from an

Eclectic orientation was looked down upon by the profession more generally. He noted that

Eclecticism might be seen in such ways as, "not knowing what one is doing…being haphazard in

conceptualization…being sloppy" (B/1/156-157). He further noted, in another context within the

interview, that

> "[Eclectic orientations] can sound thoughtless…I don't like to think of myself as
> thoughtless [*laughs*]. I have a vested interest in [*Hayley laughs*] not thinking of myself as
> thoughtless. But I don't want to think that to be thoughtful, even in a conceptual sense,
> necessarily requires thinking in terms of diagnostic categories of approach to treatment,
> any more than I would think in terms of needing to put a diagnostic label on someone in
> order to understand them" (B/1/370-380).

In a similar vein, near the end of the first interview, he stated,

> "So, it isn't like outcome is disregarded, or it's irrelevant, but how we arrive at--I think
> this whole notion of evidence-based therapy, or evidence-based therapy outcome, is really
> an effort to out-strip ourselves with respect to what we are capable of measuring. Now
> that, again, can lapse into--the counter to that is, well, that's irresponsible, you know.
> You're not being aware of what's going on--and I don't agree with that. I mean, I think
> there are ways--first and foremost with the person with whom we're working, again, gets
> priority in terms of whether they feel that what is going on is meaningful to them. That's
> the first priority. But beyond that, I think that for the therapist, that doesn't mean to be
> thoughtless about what's going on. But it does mean the importance of recognizing our
> limitations. And I think it's dangerous to presume, you know, that we have the tools to
> measure outcomes with the precision that sometimes…You know, when we attempt to
> measure it precisely--you know and of course this brings in political aspects too--and
> economic aspects in terms of insurance companies and so forth and so on, I think we're
> creating a pseudo-science in terms of what we have available to us…So I think there is
> pressure being put on therapists from outside sources to be more precise than we can be.
> And that becomes--it takes on a life of its own, and there are rewards for doing it…but if

its carried beyond what is possible, I think then it has negative returns" (B/1/635-665).

Given this stance, it may be quite understandable that being asked by a researcher (me) to then explicitly/precisely describe one's decisions, and the logic behind them for a given case in Interview two, one may see this as an impossible (and potentially dangerous--embarrassing; harming one's professional reputation if "expected" answers were not given) task. If this were the case (and I highlight here that I am speculating about motives about which I did not directly ask) perhaps it would be another reason for this therapist to have declined further participation in the study.

On one hand, this appears plausible. On the other hand, first, almost all other therapists expressed very similar stances and thoughts, including fears of being "outed" or misrepresented as an I/E therapist, and yet continued to participate. While it may be that because other therapists were closer to their initial graduate training--and they may have felt that I/E was becoming more accepted than when Therapist B was trained, and thus considered this "outing" concern to be less of an issue--this still does not explain why Therapist B would have continued to give permission for his Interview one responses to be analyzed (versus removing all participation). Second, given Therapist B's stated values around transparency, this hypothesized reason may also be less plausible. I would assume Therapist B would have simply directly offered this (equally valid) reason for withdrawing from the study. But, it is also possible that that may have been viewed as an inappropriately personal disclosure given the nature of our relationship as researcher/participant and current level of rapport. Thus, while such speculation provides an additional "outside" perspective on Therapist B's withdrawal, it needs to be considered in light of the other factors presented above.

Therapist B did later resume his participation in the final portion of the study, in terms of

generously accepting my request (sent to all participants) to engage in member-checking of the

results. He read and provided feedback on both the Intra-case and Cross-case analyses, and noted

that he supported, and did not disagree with the findings (see Methodology chapter, Data

Verification section). And as noted, his insights from Interview one (along with other

participants') are further discussed in the Cross-case analysis to illustrate the Assertions.

Therapist C

Therapist C was working full time in a university counseling center, and at the time of the

interviews she had been a licensed psychologist for 5 years. She was the participant who was

earliest in her career, and (relatively) most recently in training (having earned a Psy.D. degree in

Clinical Psychology). In her current job, she noted that agency factors, including a brief therapy

model and session limits were part of her decision-making context.

She described having trained and worked in a variety of settings prior to beginning her

current position, and how these experiences shaped her professional choices:

> "I started my practicum at elementary schools and high schools, so working primarily
> with kids with learning disabilities and behavioral problems. And then I realized I did not
> want to work with kids [*laughs*] because really you have to work a lot with parents and it
> was very challenging to get them on the same page" (C/1/13-15).

She also described having experience working with refugees and torture survivors, adults and

children with severe mental illness in an outpatient mental health center, in an emergency room,

an adolescent substance abuse program, and an inpatient setting before training at a college

counseling center. She described how those experiences led to her current setting:

> "So, during my internship I chose a college counseling center because I felt a little
> drained from--all those intense experiences, and I wanted to work with young adults. I
> realized that I'd enjoyed the outpatient setting--I'd worked with a lot of students who
> were kind of in their 20s, and I enjoyed that the most. And I wanted to work with a
> population that's more highly functioning, so chance can be easily, maybe, you know,
> seen, or we can work on a lot of things so they can enjoy their life in this important stage

of their development. So I did that and I loved that, and I really enjoyed the variety of hats that I was able to wear outside being a therapist. Also a supervisor, interacting with community, and just kind of doing outreach work, so I really, really enjoyed that part of my experience. So for post doc I decided to continue that experience" (C/1/40-53).

Therapist C had been at her current position for 2 years at the time of the interviews.

Throughout my interactions with Therapist C, I found her to be warm, and easy to feel connected with due, in part, to her quality of disarming transparency. Although professional, respectful communication about clients was certainly present among all participants in this study, I was particularly struck by the quality of respect that Therapist C conveyed for her clients in the ways she chose to speak about them.

Therapist C's underlying philosophy of change, her role and stance as a helper, and worldview of therapy undergirds her approach to treatment selection. Her philosophy forms the basis of her approach. It directly influences the way she intervenes, and mediates the theories she most adheres to, which in turn influence her moment-to-moment interventions. The first principle of her approach is a focus on context. To support her awareness of context, Therapist C discussed the importance of "curiosity", and wondering how the pieces of a client's experience relate to their social position, culture, and family.

A second principle relates to the way she sees herself as a helper in relationship to clients. Therapist C views her role as supporting clients' autonomy.

> "I'm really big in saying, you know, you're an expert in your life, and I know a little about mental health, but I'm really just a guide on your journey to where you want to be, and not a person who's going to make those changes for you, or tell you what changes to make. So, I think that the more agency they have in their treatment, the better their outcome is" (C/1/212-216).

She enacts this value in several ways: providing education to clients about the process of change and about their particular concern, providing a rationale for interventions so that clients can

judge them for themselves, and being careful not to impose her own values on clients. Therapist C also believes in, and relies upon clients' own resources, noting her view that therapy happens most significantly between sessions, outside the office. Another way she is true to this principle of supporting autonomy is a focus on collaboration with clients around session focus, types of interventions used, and other treatment planning decisions. She openly communicates this stance to clients from the beginning of therapy.

> "I always say to people, you know, this may not work for you, this may not be the perfect solution, but let's try it and see how it works, and if it doesn't work we'll try something else. So, people will have the freedom to, to not--to say this is not what I am about, and [I] let people pick something that works for them" (C/1/361-365).

For Therapist C it seemed that the more general/broad levels of treatment selection were the most stable and consistent from client to client, and then as you move more into moment-to-moment interactions and specific interventions, the creativity, diversity, flexibility, and range of what may be integrated widens. However, at the same time, these local treatment selection choices are embedded in larger, global ones. They are philosophically consistent (increasing agency, relationship-building, narrative, feminist, client-centered). But in their client-centeredness they differ, of course depending upon the unique client.

The 'person of the therapist' and the way she talked about herself and presented her work is also consistent with her core theoretical orientation. After describing her training background and diverse settings she had worked in, she summarized by saying, "So, that's kind of my story. [*laughs*] My journey, being here" (C/2/61). This reference to stories and journeys was just one small example of her not separating her conceptualization of clients from her method of conceptualization of herself. Thus, the language of Narrative approaches seemed to be implicitly "good enough" for both self and others, reinforcing the focus on facilitation of equality in her

approach. Here, she describes this story/journey:

> "So, my theoretical orientation kind of evolved throughout my years of training. And now I view it--there are a few components of that. Like Interpersonal is a big one for me, and I can talk more in detail about that. I also like the constructivist narrative approach, which use a lot. And I'm grounded in humanistic. And lately I've been incorporating a lot of acceptance and commitment therapy techniques…kind of mindfulness ways of approaching different concerns that people bring. Especially anxiety and depression, I find that it works really well with that. But overall, the--kind of the big arc of all my theoretical orientation is more multicultural, kind of feminist-grounded theory. So, I look at people's concerns more in a systematic and social view, so you know, the culture, the context that they grew up in, the family, kind of the political and social climate, also contributes to who they are and how they view themselves, so that's kind of the pieces that I incorporate in the treatment. And I feel that it's very fluid. And there isn't any--I don't feel like I'm thinking, 'oh, right now I'm going to utilize this approach.' It just comes, kind of naturally. Given what people are bringing to the session, I use a lot of process-oriented comments in the here and now from the interpersonal perspective" (C/1/63-81).

Interestingly, Therapist C described the way her orientation "has evolved" and then also indicates that it continues to evolve today as she notes, "And lately I've been incorporating a lot of acceptance and commitment therapy techniques." Both the use of the word "lately" and statement of using ACT "techniques" (as opposed to ACT as a whole-sale theoretical orientation) seem to indicate that her continually-evolving approach is not developing by substituting one primary theory for another, but rather by bringing in useful ideas or techniques that would complement her already-present core approach.

Therapist C viewed theories as having significant commonalities with one another, (and not thus not as being mutually exclusive). Therapist C explained that for her, a common thread among the theories that make up her orientation is the focus on the therapeutic relationship:

> "It's just kind of pillars to the treatment. That are--that I pull from based on who the person in, what their relationship is, the concerns that they bring. So there isn't any one in particular that I use more than others. Um, I think there are commonalities to all of them. So, for example, I view relationship, therapeutic relationship as a very important part of treatment. So, having a safe environment where people can be themselves and explore very difficult parts of themselves is important to me, having trust, having equality, as

much as we can between me and the client--so the genuine, kind of unconditional positive regard is important to me. And I think without that, I cannot help a person…That the relationship is really something that is important for change, and change happens within the relationship. So I think that's kind of what grounds me. And then, within that, there's the narrative perspective, you know, people construct stories about themselves, and they have views of reality that--it's not necessarily *the* reality, but kind of the interpretation of their reality, so there's no right or wrong way of being or viewing the world, but it's based really on their experiences and their development of constructs about themselves and the world and the relationship, which then the interpersonal piece comes in. Which, I feel that it starts really early in life. And the family, the important relationships with parents, where they first kind of establish the relational patterns, the relational schemes, and the coping strategies also, to avoid the anxiety and maintain their self esteem. Which may be--at first may be adaptive, but then becomes maladaptive, and they kind of translate to other relationships in life. So it all kind of fits together for me… [*laughs*] I don't know if I make sense, but I'm explaining to you…So, yeah, so people kind of develop their ideas about themselves and the world in relationships based on interactions with others. So, the change then happens within the relationship as well, and providing corrective emotional experiences with people, and also kind of examining those constructs or schemas--however you want to call them--about themselves, and maybe empowering them to make different choices based on a new story that can develop. Um, within--and then, kind of understanding that some of those stories you know, who they are, the family they come from." (C/1/88-123)

Also, in the above quote, Therapist C again highlights that the important part of theories for her isn't the specific terms by which constructs are defined in any given theory. Instead, it is the commonalities that speak to ways individual might develop problematic stories about themselves or the world. In the above passage, she is initially talking about early relationships and corrective emotional experiences, and then switches fluidly into the language of cognitive-behavior therapy, and mentions "schemas" about oneself which one develops. She then signals that she has recognized herself switching languages, and at the same time, feels that this switch is unimportant in communicating the important parts, because she adds the parenthetical comment, "however you want to call them."

Therapist C provided another description of how different aspects of the treatment selection process work together to create her approach. Here, she discusses the role of 'stages of

change' in choosing interventions:

> "You know, I'm really interested in where people are in terms of their change. Maybe they really want to change, but they're not ready for that yet. Stages of change, like contemplation, pre-contemplation, you know, and it could be really anything…because we are very much attached to our problems, even though we don't want them anymore. Because giving them up is really scary. So kind of getting a feel of ok, where shall we start working? Getting you committed to change, or are you committed, and we can go into our work, and making those changes. Because if you do it too early, people get scared and they don't want to come back, you know, [laughs]…I think I would start with asking them why they want to change. Like, what is it that's not happening in their life that they would like to see happen. So I really like, I like to go to this question, of if we had a magical wand, you know, and if your problems disappeared, and you wake up in the morning--and but you didn't know that these problems disappeared, and you wake up in the morning--what would be different in your life? You know, how would you be different, what would you be doing differently, who would you be with, what are the things that you want to see in your life that--that because of the concern that you have, you cannot have right now…. So, I really want people to get, maybe, excited about change, and acknowledging that it can be scary, and also acknowledge that it happens slowly. And sometimes they take a few steps backwards and--so really--I guess I also want to know, hey, what do you like about having this concern? You know, because it really serves them well. For example, eating disorders, perfect one to talk about. Because it does help them to deal with problems. So people don't want to give it up, even though it's healthy to. Because, if everything was logical-- [*laughs*]. So there's a way that it's helpful for them. And it's important to acknowledge that, and recognize it, and then of changing their relationship to their problem. So dealing with their fear of change is important first." (C/1/259-301)

Interestingly, even in describing ways that a client's stages of change may impact her

treatment selection, she speaks about it in the language of her core Narrative approach. That is,

she speaks about "the problem" as being separate from "the person". She further, implicitly

reinforces this philosophy by speaking about problems in externalized language-- because they

are seen as separate 'entities' from the client, it is possible to 'deal with' them, 'change your

relationship with them' and even to incorporate the simple (but powerful) use of the pronouns 'it'

and 'them' to refer to problems.

Therapist C goes on to describe her approach with clients in later stages of change, (i.e.

Action) which include elements of CBT. She further notes how even this use of behavioral

techniques interacts with her core theories of Narrative and ACT.

"Well, I think that--then I would maybe start to make active--actively make those changes early, and see what happens. For example, someone that has social anxiety and they're like, 'I'm ready, I want to deal with this' then we might come up with a small goal for the week. Let's say, I don't know, going to a party even though they don't want to do it. And they're like, 'I'm going to do it.' They really want to do it, and then the week passes by, and they're like, 'I didn't do it.' And it's not because they didn't want to and they weren't ready to do it, but it was really scary. Or there was something else that was happening. So we talk about that, and kind of--understanding what's got them--or, what are the things they can be doing next time. Kind of treating it as an experiment. Let's say, and see how they would act if there as just like, you know, if they weren't committed to it for life, but just for a moment. What would be different about that? And I think I really try hard to work on acceptance with people. You know, where they are, not judging themselves for having those concerns, and really being relaxed about that. Like it's more a--being willing to experience all those feelings and all those things that are happening, instead of avoiding it and not looking at it. So if they're willing to kind of see it, Ok, this is my concern, and I may not like it, but I'm willing to look at it, or I'm willing to have it for now, with the understanding that I am working towards the life that I want to have. So, sometimes before the active behaviors can be implemented…the groundwork needs to get done, but even if people are ready to make these behaviors, they may realize there's some other obstacles that come in the way. So we kind of come back to talking about what it is that would help them either understand their concern, appreciate what the concern does for them, and also making the choices and experimenting with the-- knowing that maybe the first time it isn't going to be ideal." (C/1/304-336).

In this example, Therapist C described first working on behavioral change strategies, and

even sticking with behavioral approaches in perhaps trouble-shooting what made it difficult for a

client to complete therapy homework assignments. But she leaves the CBT model to also

approach the lack of change (what may be considered by still other therapists or still other

therapeutic orientations as 'resistance') via concepts of Acceptance, and mindful non-judging.

This is interesting because she is using a formal model from the literature as a template

for assessing where a client is, and then using the outcome of that evaluation (i.e. the stage of

change the person is in) to select her approach to treatment. The Trans-Theoretical Model (stages

of change model) provides a general goal for therapy in itself-- to help a client move from one

stage to another, such that they ultimately are able to change behaviors that create problems for

them. This model prescribes some techniques that may be used to help clients move from one

stage to another, such as making a decisional balance of the pros and cons of changing, and of

examining the client's sense of self-efficacy for making that change (Prochaska & DiClemente,

2005). But here, Therapist C uses her core theories, and ideas about the basic nature of change

and problems to fill in/add to the means proposed by this model. She does not speak about

decisional balances per se, but does seems to allude to this idea when talking about what a person

may appreciate about having a certain concern. However, she also adds to this. She notes the role

of Acceptance, as well as in identifying the problem as separate from the person (as in narrative

therapy). In this way, the stage of change a client presents in serves as a cue: it helps her to

choose from among her approaches which one is most appropriate. In her description, this does

not, however, appear to be experienced as two separate processes. Instead, they appear to flow

together-- with the therapist's core theories 'filling in the cracks' of the stages of change model to

make it practically applicable to clients. Further, in the specific language she uses to speak with

clients about problems, she infuses her core philosophy of therapy.

The treatment selection process itself is tied to assessment, and is ongoing. This idea is

also tied to Therapist C's view that clients may not always bring their "real" concern to the first

session, and thus she holds a somewhat tentative view of clients' first-stated presenting

problems:

> "And I think the assessment is ongoing, too. So maybe something that you-- I really also
> try to think about my own assumptions, or my own kinds of counter-transference issues
> that are happening in the session. So maybe what I thought about at the very beginning
> changes at Session 4, when we get to know each other a little bit, there may be some
> other things that come up that we haven't talked about, and that's also important. So, this
> assessment piece is on-going." (C/1/221-228)

Whatever the problem, Therapist C expressed that the more tools you have, the more

flexible you can be with your treatment, and thus match it to your client's [perhaps changing]

needs. In the second interview, Therapist C talked about a case that "illustrates how I work in

general" (C/2/19). She provided an overview of the range of approaches she utilized in working

with a student who was the survivor of another student's suicide. In this passage, she notes ways

she draws on her core theories to conceptualize client's needs, and then incorporates other

techniques to achieve treatment goals based upon the initial conceptualization.

> "As I mentioned last time, it's very important for me to develop a relationship and to build an alliance. It's really hard to have change or to see change or just create--just conduct therapy [without that]. So I felt first and fore most I wanted to make sure that my client and I connected, that she felt understood, we collaborate on choosing what she needs to work on, and also choosing how we're going to work on what she wants to work on, and so that's a conversation, and not just me saying, ok, this is what you need. And I think--I'll tell you the details of the case. Initially she came in in crisis and we needed to attend to what was the immediate crisis. And after that, I think I used a lot of, mindfulness approaches, from Acceptance and Commitment, to develop and build compassion for herself and acceptance of where she's at with her feelings and how she's reacting to whatever the circumstances were in her life. Also, being able to create some techniques from-- to diffuse those thoughts, so she doesn't feel like she's getting stuck in them. I used Narrative kind of approaches, of learning her story and recreating and rewriting her story and see what stuck points are throughout the story she was telling me. And we did use some techniques--the empty chair technique, to facilitate certain dialogues that she needed to have. And also a lot of [psycho-] education…interpersonal process, because we talked a lot about the relationship that was happening in the room, but also interpersonally how she relates to people outside of here, and how she relates to herself. So, you know, we talk a lot about just existential stuff, meaning making, and creating meaning with the experience that was happening for her, and the experiences that she had in the past related to grief. And I think there was a lot of--like the overall umbrella--for that was just multicultural understanding. She was a student from [country] and you know, I haven't worked with a student from [country] before, so it was understanding her culture, her worldview within that culture, and me learning the best kind of approaches that would honor her perspective. So, I think that's kind of the overview of that." (C/2/26-63).

Therapist D

At the time of the interviews, Therapist D practiced psychotherapy in an outpatient

primary care setting, and received many of his referrals from medical providers. More so than

other participants, Therapist D's professional activities straddled the worlds of research and practice. He had originally studied to be an academic and researcher, before re-specializing in clinical psychology to enable him to do clinical research as well as to practice. He was splitting his professional time between this community-based practice and a position at a university-affiliated research center as a principle investigator. He had practiced as a licensed psychologist for 10 years. Therapist D explained that this "indirect" and "unconventional" path to becoming a therapist ultimately contributed to his "open-minded approach" to therapy.

The story of Therapist D's approach to treatment selection is developmental. And often with developmental processes, the metaphor of a journey is useful. Here, I give an overview of the themes in this case analysis, stressing that all roads lead to 'the relationship'. Therapist D makes treatment selection decisions by first establishing a basic trusting relationship with clients-- which is a prerequisite for them providing self-disclosures on which he can then base subsequent interventions. The subsequent interventions are themselves based on theories with relational basis. Mechanisms of change are defined in relational terms, and include risk taking to try different interpersonal patterns in and out of session. At the beginning of the journey, Therapist D noted that his own relational history allowed him to gain skills (such as empathic attunement) that support his therapeutic work. In 'mapping' Therapist D's clinical decision-making history, there is one 'detour' (due to the road block of clinical anxiety as a new practitioner) that led him to over-emphasize formal adherence to one treatment. But this eventually led him back to a focus on the relationship via I/E practice.

Therapist D noted that his unique training and background also contributed to his experience of "conflict" between psychotherapy research literature and psychotherapy practice, which was a main theme in his views about treatment selection. He referenced a concern about

I/E orientations being seen as undesirable by the larger professional community (and proponents of Empirically Supported Treatments, in particular). For Therapist D, these issues were particularly salient: he introduced the term "maverick" to describe I/E therapists who openly "admit" to using this approach. Often, he described his current I/E approach in opposition to (and as an evolution away from) single-theory, formal, structured, or manualized Empirically Supported Treatments. By distinguishing his treatment selection process in this way, there was a somewhat ironic juxtaposition of his development as a psychologist (becoming more I/E as he moved from trainee, to early career practitioner, to more seasoned therapist) and his perceptions of developments in field of professional psychology moving in the other direction (becoming more focused on ESTs that were not I/E).

Perhaps fittingly to this conflict, I met with Therapist D in the physical setting of his research realm, amid shelves and piles of books, papers, and articles related to Evidence-based intervention, to talk about his approach in the practice realm. Interpersonally, I experienced Therapist D as engaging and warm, with a knack for sharing his experiences with enthusiasm and humor. He gave the impression of taking his work as a psychotherapist, and his commitment to the profession very seriously (while having the perspective of valuing humility, and not taking himself overly seriously). As a researcher, I was appreciative of his directness and open disclosure.

In this context, Therapist D spoke freely about what his approach to treatment selection *is not*: "Clients won't get a standard medical model with me" (D/1/287-289). He explained that working with more complex cases later in his career spurred his I/E approach, as he moved away from using a single theory:

"I have some patients who are referred to me who have rather narrowly defined

problems. And I'll give you an example. I had a patient referred to me with gambling addiction, and experienced depression and anxiety secondary to the gambling addiction. And so this required much more of a behavioral intervention. We didn't go very deep, as far as, you know, psychodynamic kind of exploration. Not necessary in that particular situation. And there are lots of cases I've had over the years where the problem area was fairly narrow. Marital conflict is another good example, or specific phobia. But those cases are far less common than the ones I normally see, which are the more complex cases. Where there's a mix of anxiety, and depression, and tremendous ambivalence, and conflict, and torment, and misery…when I encounter those cases where nature presents us with a complex mix of symptoms and history and goals, eclectic/Integrative gives me the greatest flexibility in order to martial my knowledge and experience to help this person. If I try to remain too faithful to a narrow therapeutic model, it just is not flexible enough. And that's why I eventually--after a couple of years of practicing at [clinic]-- really became solidly eclectic/integrative" (D1/145-171).

Throughout the interviews, Therapist D also spoke descriptively about what his approach

is: how it evolved; what basic philosophies underlie it; and how his life-experiences and personal

style interact in complex ways with training in theory and technique to guide interventions. At a

broad level, Therapist D defined treatment selection as a process in which he brings together

assessment and the foundations of the therapeutic relationship.

"Treatment selection involves a process. So you can define treatment selection as a process so that--that process involves kind of an interplay of careful assessment, as well as the beginnings of that relationship with a patient. And treatment selection is not something that I think is something like a recipe [*laughs*]. Just because your assessment might yield a particular diagnosis that would argue for a particular treatment selection, um, again, there's a highly subjective part of this, that involves kind of a comfort level as the therapist in terms of getting to know someone well enough to know if a particular treatment that you select is a good fit. And the fit has to do with a person's psychological mindedness, their emotional resiliency, you know, how much they can tolerate distress actually in the treatment process itself, readiness for change, you know. So there're a lot of these factors that go into this, which is why, in my view, it's extraordinarily difficult to do psychotherapy research. It's absolutely true. Because to somehow try to exercise rigorous control over such subjective kinds of things that go on, um, I think is an exercise in futility [*laughs*] (D/3/14-33).

He also noted how the inclusions and exclusions in his approach relate to the above "conflict":

"So what this amounts to is a very complicated information processing task. That's cognitive and emotional, all at the same time. And the subjective part of this is that I bring my life experience to the process. I bring my intellect; I bring my training, and all

these kinds of things. And I have to say that if [name of a psychologist who advocates for evidence-based, versus eclectic practice] were to-- know a lot of what we're talking about, he might be a little horrified. Because I think that he honestly believes that a stricter evidence-based approach is what's going to take our field forward. And that, to some degree, in my estimation, means that therapists don't really have that license to engage in this more subjective part of what I'm describing here, because they can't study it, they can't verify that it-- it-- that there's evidence that it's better than doing something else" (D/3/259-269).

In an email, Therapist D followed up on our interviews by responding to a clarification

question about which theories make up his core approach. Of note, regarding the meta-process of

his correspondence, Therapist D's use of empathy and humor (i.e. acknowledging the scope and

complexity of influences on his approach, and how I as the researcher might struggle in parsing

this information) as well as giving time and thoughtfulness to clarify a question for me as the

researcher in the first place, also seemed consistent with those very core therapeutic stances

which he lists:

"I will try to list the main theories, models, and writers that have shaped my approach as a therapist. First and foremost, I consider exploration and deeper understanding of the nature and quality of interpersonal relationships (with key people such as parents, family, spouse/partner, friends, supervisors/bosses, subordinates, etc., AND self!) within the broader nexus of the patient's human experience to be foundational in my approach. As you can imagine, the writings of interpersonal theorists such as Harry Stack Sullivan, Gerald Klerman and colleagues (IPT), and Jeremy Safran and Zindel Segal have influenced my thinking. Of course, years ago my reading of Zindel Segal's work led me to reading and learning about mindfulness which expanded to reading many others including Jon Kabat-Zinn and other mindfulness writers/theorists (including Thich Nhat Hanh). I have also been influenced by a number of therapists/theorists over the years including Irvin Yalom, N. Gregory Hamilton (object relations; also Winnicott), Michael Mahoney, Aaron Beck (and other cognitive theorists/practitioners; I incorporate selected ideas/techniques from CBT in my therapeutic approach), Michael Hoyt, Lorna Benjamin, Stephen Hayes (acceptance and commitment therapy), Miller & Rollnick - motivational interviewing (for smoking cessation and addressing other modifiable health risk factors), Michael White (elements of narrative therapy), Viktor Frankl (meaning-making, finding meaning in life), Leston Havens, Joseph Wolpe (and others for behavior therapy techniques with elements primarily used with anxiety disorders, appetitive disorders such as pathological gambling, etc.), and a smattering of others such as Jay Haley, Albert Ellis, Leslie Greenberg, and the list goes on. I suspect that this may not make your task easy in trying to characterize the theoretical underpinnings of my approach!! However, suffice it to say that fundamentally

my approach is interpersonal (primary focus on relationship with self and others) examining traumas, fears, regrets, betrayals, etc., with any eye towards finding meaning and purpose in life, developing plans and courage to undertake needed changes in one's life, and ultimately achieving a secure, autonomous, hopeful, realistic, and satisfying life (with resilience) going forward to be able to effectively navigate the ups, downs, and vicissitudes of life. I should also note that much of the time I focus more on emotions/feelings than on cognitions but I also am mindful of the interplay of thoughts and feelings in how life is experienced and interpreted. I also pay close attention to anxiety in its many manifestations (all the way from specific phobias/fears to existential anxieties) as well as internal conflict (consciously experienced or below awareness but clues abound). Anxiety is signaling something that needs attention or needs to be resolved - - a call to action as it were. So, as an eclectic/Integrative therapist, my task is to marshal all my knowledge and experience in service of the general goals listed here as well as the specific goals articulated by the patient. Goals evolve as you know, so I try to be flexible, creative, responsive, and empathic as I work with each patient. So, I guess, that is it in a nutshell!! (Therapist D, personal email correspondence, July 26, 2011, emphases in the original).

As Therapist D himself noted, each of the theories and approaches is relationship-based. This is

reflected in what he tells his patients, (below) both in content and process. In terms of content, he

explains that the first step in therapy is the therapist getting to know the patient, and the patient

better knowing him or herself. In terms of process, the fact that he is transparent and direct about

his approach conveys respect for the patient, and invites collaboration toward shared goals.

"At our very first session, I tell people that we're going to make some effort to understand how they got to that point in their life that they needed to come talk to a psychologist. I say, 'So, this is kind of understanding what's going on as best we can, and we're going to continue to do that as we work together,' I say to them. And then I look them in the eye, and say, 'But if that's all that we accomplished in this therapy, our work would be incomplete, because'--and I say this to them-- 'because I want you to have a better life. I want you to have a happier life. And what that means is that there's going to have to be some changes. Not just in how you think about things but in terms of how you live your life. And so our work together, I hope, will result in you getting brave enough to try certain things. To take some risks, to make some changes, and see what happens, see if your life is better. So we want to work towards positive change. And we want to make sure that those are durable, so that they last. That it's not just some temporary thing, and then you relapse, and fall back into past patterns of behavior.' People really connect with this. They go, 'Oh, so he wants to understand why I'm so miserable, and try to figure out what to do about it, and then he wants me to try to carry it out, to do something.' And so, I'm not all about, touchy-feely-let's-just-get-some-kind-of-clear-insight-and-understanding-- I do, I use quite a number of, you know, therapeutic maneuvers or approaches all in service of understanding the person that's sitting in the room with me,

and secondly, working with them collaboratively--which I am a very non-directive--but I can be directive if the situation calls for it--um, I'm mostly very collaborative. And I make it clear to people that, yes, you're in a real pickle right now…but at the same time, you bring strengths to this, lived experience that we can draw on, and there are new things that you may learn along the way, but for a lot of people what it's going to be is a willingness to take certain risks…So I make I clear to them from the very beginning that we're going to try to accomplish certain things in the process of this therapy, and so, when you talk about treatment selection, well…[*laughs*]. People are complex, and there're different things that people want to work on, or need to work on that may require different kinds of approaches (D/1/456-496).

In explaining the process of therapy, Therapist D highlights the need for clients to "be willing to take certain risks." In the service of this mechanism of change, and consistent with his relational approach, he emphasized the need for conveying accurate empathy, as a way to provide safety and earn trust. This is the basis of his current approach. Next, I turn to how he arrived at this destination-- how "an unconventional path" and the "conflict" around using research in a technique-limiting vs. -expanding way, merged with his existing personal values and strengths to get here.

Therapist D explained his view that there is a maturation process for therapists over time, and a parallel maturation of therapists' treatment selection processes. In his graduate program, Therapist D was exposed to many different models and theories of psychotherapy and psychopathology, and was trained in "all the usual suspects": CBT, psychodynamic, interpersonal, motivational interviewing, and object relations. His training included varied practicum and internship settings, from forensic inpatient to a university counseling center. Developmentally, Therapist D admitted he felt like he was "flying by the seat of my pants" the first year of practice, and noted it took time for professional comfort to develop. During this early career period, he did not identify as I/E, but "experimented with being faithful to my training" and described his approach to treatment planning as "more pragmatic, formal, and

structured, with a very structured initial clinical assessment." Therapist D observed that he

initially used CBT "too rigidly" due to his own anxiety as a beginning therapist. This shifted over

time, as he experienced "difficult cases" as "a trial by fire," in which he learned techniques in

therapy from experience, "and making mistakes."

> "And it really took quite a number of years for me to feel a level of comfort in listening
> to someone and you know, putting all the information together, that I felt that I--in an
> efficient way-- would be able to draw on that experience, intuition, what I know about
> diagnoses, what I know about treatment models, and so forth. So it is a fairly complex
> interplay of all those things" (D/1/360-365).

Interestingly, Therapist D conceptualized his transition from a single approach to an I/E approach

in research-oriented terms:

> "It's an on-going experiment where you gather data. And I discovered along the way, that
> if you are too rigid in the way that you apply CBT, IPT, and all these other major
> therapies, well, it really does not do justice to the complexity of people. And so it was not
> very long, you know when I was in independent practice that I began to figure out, ok,
> I've really got to be a lot more flexible here. And I had read a number of things about
> eclectic/Integrative type approaches, Saul, Garfield, and a number of other authors, and
> it--and again I'll use the 'r' word--it 'resonated' with me [*laughs at use of the word
> resonated*]" (D/3/374-382).

Around this period of time, Therapist D also became very interested in the mechanisms of

change in psychotherapy, and "immersed myself in the literature." From this process, he re-

confirmed for himself that trust in the therapeutic relationship, empathy, and a process of "asking

the right questions to help someone evaluate their lives in a therapeutic way" were fundamental

for effective change. 'Re-confirmed', because it seems that this process of reviewing the

literature allowed him to trust what he had experientially learned about the helping process

through more informal means, and to focus on using himself, and his strengths more in the

therapy.

One strength Therapist D said he brings to psychotherapy is his capacity for empathy.

Below, Therapist D described how his life experiences contributed to how he developed this ability. Following those passages, I further discuss the role of empathy in Therapist D's treatment selection process. In this way, the case analysis demonstrates: (from above) how this therapist came to re-value empathy in his process; (from below) how this realization interacted with the 'person of the therapist' and his strengths; how he developed these strengths; and finally, the larger facilitative role that empathy plays in his treatment selection process.

> "One of the strengths I bring to therapy--I think, and this is what I've been told--I'm relaying this to you based on thinking about this and also responding to what people have told me--is empathy. This is, for me, the foundation. Because if I--if I cannot experience to some degree what that other person is experiencing and feeling, I'm not gonna get it. Having a capacity for empathy is really critical. And one of the things I didn't share with you about my history is that my father is….a very empathic person. He just naturally has a great capacity in terms of empathy. And in his professional life, and in his personal life, you know, our friends and family members were always struck by his ability to understand, he showed tremendous support…and I think he passed some of that on to me. At least, I think that's what happened. The other part of this is that, I had my own personal therapy experiences pretty early on in life. When I was in college, because I had some difficulties in college. And I've had some therapy experiences since then. And, I highly recommend therapy for therapists…I've learned a lot from some of the therapists I've worked with over the years" (D/1/380-439).

Empathy appeared to be a necessary factor in his assessment process, from which he then based his treatment selection decisions (drawing from the range of approaches discussed above). Therapist D identified empathy as a key building block for trust in the therapeutic relationship, which in turn allows for accurate assessment, as the client feels comfortable enough to explore even difficult self-disclosures. Therapist D's emphasis on trust as a pre-requisite for disclosure and accurate assessment related to his important underlying assumption that the 'presenting problem' a client brings in is many times not the 'real' problem (or the 'whole' problem) with which they are struggling. Thus, it can take time and trust to create the conditions in which the 'real' problem can be revealed or discovered by both therapist and client.

"Some people are really anxious when they come in, and you know, they're sitting there with this psychologist and they're all respectful and everything--I make a real effort to connect with somebody as early and as quickly as I can, to put them at ease. Because I need to know really what's troubling them. That's going to guide the treatment selection…as I'm listening in that first session, I'm already of course beginning to formulate what I think is going on. And thinking about, what are the particular kinds of treatment that I can bring to bear, so that we can begin to understand and move forward" (D/1/253-275).

From this point, he noted that during history gathering, he begins to determine the complexity of the case for treatment selection purposes, but that this might change as he learns more. Therapist D explained that there are "no limits on types of interventions when the relationship alliance is strong."

Later, in our third interview (perhaps consistent with his observation that more extensive self-disclosure comes from having more time for a relationship to develop) Therapist D described additional roots that support his views of therapy, and his development of empathy:

"But the other thing that I'll say that's an important part of my education was my own struggles with depression. And going through a fair amount of therapy in my lifetime. There's nothing like walking that path. And I'm not saying that that's a necessity for someone to be a very competent therapist, but I've rarely met anyone who's a therapist who's not had a pretty significant life struggle with something--and it could be depression, substance abuse, sexual abuse histories, etcetera, you name it. And it--it gives you a perspective that, I think, having a less complicated life doesn't really give you. And so, I think one of the reasons that I understand it when someone is telling me about their pain and despair, and struggles and conflicts and everything else, is that it resonates. It absolutely resonates for me. And so, there again is that conflict: that part of it is not very scientific" (D/3/225-239).

Therapist E

The circumstances of interviewing Therapist E were related to my goal of working with an additional participant after Therapist B withdrew participation from the study. Further, our meeting, and her agreement to participate, originated under serendipitous circumstances. To provide full disclosure, I note here that I had been in acquaintance with Therapist E several years

prior to her participation, as we knew (of) each other from a past professional setting. However, we had not had an ongoing professional relationship (we were not, for example, supervisor/supervisee, etc.) at that time. I invited Therapist E to participate, and she accepted, after we happened to unexpectedly re-meet while at a local restaurant. Through casual conversation updating one another about our lives since we were last in contact, I disclosed my study topic, and Therapist E noted she was currently in private practice. After learning I was hoping to meet with one additional participant, she surprised me by stating her I/E orientation, and generously volunteering to participate on the spot. She confirmed this interest, as well as her status of meeting all criteria for participation, after I sent her the recruitment letter and a consent form to review. Compared to the time-lines for interviews with other therapists, the meetings with Therapist E occurred with the most regularity and the least time between them. We completed the in-depth three interview series in just over one month in the summer of 2011. This was partly by necessity, as I was leaving the area to attend Internship that fall, and mainly because Therapist E was very helpful and flexible with her scheduling.

Therapist E was working in a solo private practice (13-15 direct psychotherapy hours per week), and had been a licensed psychologist for 10 years at the time of the interviews. She also had provided supervision for psychologists in training. She described herself as a generalist who sees a wide range of client issues and presenting concerns, and noted that due to her broad range of training, "I feel that anybody could walk in the door and I'd have an idea of how to work with them" (E/1/34-36). In addition, Therapist E noted having a "niche" in, and enjoying work with clients presenting with anxiety disorders, eating disorders, and concerns related to pregnancy and roles as new parents.

In my interactions with Therapist E, I experienced her as thoughtful, professional, and

direct, and I enjoyed her sharp (at times a bit irreverent) sense of humor. I was grateful for her

openness, frankness, and clarity, as well as for her generosity in the time committed to interview

participation and transcript review. As further introduction, and as a way of providing an over-

view of Therapist E's approach, I include the following quote from our first interview. It also

seemed that this passage gives an example of the clarity with which Therapist E describes her

approach to treatment selection throughout the interviews:

> "I describe my theoretical orientation as--a psychodynamically and developmentally
> informed approach. That's how I conceptualize clients, typically. I often use cognitive
> and behavioral interventions. What I tell clients is that I offer a lot of cognitive and
> behavioral strategies in order to decrease their distress, their acute distress as quickly as
> possible. But if they're willing to stay and do more work, then we can go deeper and
> figure out what their long-standing patterns are, of behavior, of affect, of interpersonal
> relationships, self-concept--things that--patterns that they'd like to change. Also
> identifying things that are good, that they want to keep, that are strengths and help them
> be resilient. But I do think that--*And* I do think that the therapeutic relationship is
> important for change. And so, you know, that definitely comes from a more humanistic
> and psychodynamic perspective. That the therapeutic relationship helps to provide a
> mirror for the client, positive regard, and that transference and countertransference are
> important and can be useful in helping the client bring about the change they want in their
> life" (E/1/47-64).

Therapist E discussed ways that her training background and early career experiences had

influenced her current approach to treatment selection. Her graduate program training was

primarily CBT, but in practicum training, she had more exposure to humanistic and

psychodynamic approaches. Further, through supervision, she learned about treating personality

disorders with psychodynamic theory and underlying constructs of attachment, loss, and shame.

She explained, "I got training in a lot of different areas, but no one said, 'here's how you should

choose which one to use'" (E/1/430-431). Instead, "Everyone just teaches you their approach to

therapy [versus how to integrate]" (E/1/405-411). Related to her identity as an I/E practitioner,

she felt that having such an approach is not necessarily possible early in one's training or career,

because it takes time to develop the ability to attend to the multiple levels of therapy, and the on-going 'meta-level' of hypothesis testing and differential diagnosis necessary for I/E conceptualization. Instead, she said therapists need grounding in something to understand the process of therapy, and then as they become more knowledgeable, they can be more Integrative/Eclectic. Therapist E's training provided varied experiences that influenced the range of interventions she considers, but she found she learned more about treatment selection through her own clinical experience and from mentorship early in her career from I/E colleagues in private practice (versus from training supervisors). Consistent with her view that I/E orientations are developmentally dependent, when Therapist E serves as a supervisor to therapists in training, she does not explicitly supervise in terms of how to "do" treatment selection.

Just as a therapist learning several theories does not imply that he or she knows when to use each one, knowing the range of theories and techniques used by a particular therapist does not yet explain how the therapist decides to use them, under which conditions, and in which combinations in I/E practice. Above, Therapist E described her core approach to therapy as including developmental, psychodynamic, interpersonal, cognitive-behavioral, humanistic, and strengths-based elements. She later added that she often uses additional techniques from mindfulness, gestalt theory, DBT, and feminist or multicultural theories. Here, I describe how Therapist E 'knows when to use them.' Therapist E summarized one of the most variable components in her approach: "I think I always use a combination of, you could call it psychodynamic or interpersonal I guess, and CBT, but it's a question of when I introduce the CBT techniques that's the biggest part of my, quote, 'selection'" (C/1/560-562).

In further overview, it appears that Therapist E flexibly assesses and uses diagnostic variables, the client's personality, and the client's preferences as indicators of potentially helpful

moment-to-moment interventions. Client receptivity to a particular intervention is assessed

based, again, on personality, as well as symptom severity, and the state of the therapeutic

alliance:

> "Well, it's based on diagnosis and…umm…and personality probably. A combination of those two. Um…I see a lot of anxiety disorders, and cognitive behavioral therapy is really clearly effective for anxiety disorders, so that's what I use" (C/1/244-247).

It's important to note that temporally and experientially this assessment process takes place as

the therapist is "sorting through it in the moment with the client" (E/3/76).

> "I'm not spending time reviewing charts between sessions, thinking about when--I mean, not at all. And so I think it's a good example of how you're working on so many levels in the therapy hour, all simultaneously. And I think that skill develops over time. And you can't do it while you're in training, or in the first couple years out. It takes a while" (E/3/78-82).

In the next passage, Therapist E explains that the "it" she sorts through includes several "levels"

of thought and affective reactions:

> "Content, process, right. And then I think there's another meta-level with the whole differential diagnosis and hypothesis testing that you're constantly doing. And then there's the meta-level of the choices you make throughout the hour. Am I going to go in this direction or that direction? …. I think there is an underlying philosophy of, what do I think is best for this client in this moment. What do I think will be the most helpful? So I think that's the underlying philosophy. *laughs*]. Um…but in terms of decision-making, it is happening in the moment, on the fly. And I think it's based on--it's all very subjective. It's based on my feeling in the moment of what's best for the client. And yet I think…you know, I think there isn't-- you know, I can't articulate for you a heuristic or a--an algorithm for my decision-making. And yet, I suspect that if we recorded my sessions, we could probably sketch one out. You know, I think that, early on in the therapy, I'm doing what we were just talking about. And then, as the therapeutic alliance becomes more solid, I'm going more with what my instinct is, based on my connection with the client. I mean, I can really feel what they're feeling in the moment. And if I want to bring that out more, I'll ask certain questions, or if I think that they need help containing emotion, then I'll help them contain. And I think it--the connection is so important, once the alliance is established, that I'm really responding to the emotion in the room, and making those decisions accordingly" (C/3/83-109).

> The process aspect of Therapist E's approach (i.e. having a goal of collaboration, and

honoring a client's right to informed consent around treatment options) is one piece of her

treatment process that appears to remain constant across clients. While she stated she always

suggests what she believes professionally would be helpful, she focuses on implementing

interventions at client's pace. If they appear unreceptive to a suggestion in either the CBT or

dynamic realms (e.g. to keep a thought record, or to explore family patterns) she tends to educate

them about possible advantages of doing so, explores the client's concerns, and may then be

"prepared to back-pedal if they just aren't into it at all. And just express my respect for that and

to--state that I'm confident that kind of intervention does have a place, but maybe not right now"

(E/324-26).

One particularly fascinating aspect of Therapist E's I/E approach is the range of ways she

uses her core theories--Cognitive-Behavioral and Psychodynamic--together. It is important to

note that her *patterns* of theory and technique integration *themselves* vary flexibly depending

upon client variables. That is, Therapist E has not developed, and is not using any pre-developed

psychotherapy 'package' that combines CBT and Psychodynamic approaches in a set, formal

way: "I mean, it's not like I have my own theoretical orientation with which I make those kinds

of decisions. I don't have, like, a schema. It's not that formal" (C/1/328-333). On the other hand,

neither does she use CBT or Psychodynamic concepts alone in isolation of, or to the exclusion of

one another. In the following passage, Therapist E clarifies the interplay between her approaches,

with Psychodynamic approaches serving as the basis for conceptualization:

> "C: Yeah, I guess it is more integrated that way. No, I definitely don't see myself like,
> 'oh, I'll do psychodynamic with this person and not CBT at all.' No, they're definitely a
> blend. There's no way I could not think about somebody in terms of their relationships. I
> couldn't just turn that off and just--I can't just theorize CBT. Like, I'm never thinking,
> 'oh, they're behaving this way because it was reinforced' and--I'm never thinking just in
> simple behavioral terms. It's broader than that. I mean, I might think like, it was
> reinforced, but, I'm thinking it was reinforced by their father, because that's such an

important attachment--*that's* why it-- they're hung up on this particular issues, or they're recapitulating it in their current relationship. So, it goes to psychodynamic pretty fast.

H: And then, the way you might work with that with somebody is…'ok, instead of reinforcing that, here's a different strategy you could do now,' or…?

C: No. That sounds way too behavioral to me.

H: No?

C: No. What I'll usually do is if someone has the capacity to use this kind of intervention--like if they're sophisticated enough? [*laughs*] And non-defensive enough--and this'll be further along in the treatment for sure. But I'll point out--help them with some insight like that. Like, 'have you noticed the similarities between you know, you were just saying this about your dad, and you've kind of said that about your husband to…' and they'll go, 'ah ha'. And then I'll say, 'The way that insight can be helpful is that you now have an awareness of that, so you can actually tell yourself, in the moment, when you're having this reaction to your husband, this is not my father, he doesn't have the same expectation of me, and I don't have to act in the same way, and if you keep reminding yourself over and over about that, eventually you can break the cycle, and interact with your husband in a different way, in a more conscious way.' And so, that's the intervention. It doesn't go back to behavioral. It's very much dynamic. So you're making the unconscious conscious, and the insight is helping bring about the change.

H: Well that helps, I appreciate that clarification" (C/1/587-620).

In the course of data analysis, I noted several additional variations of ways CBT and Psychodynamic approaches become connected and synergistic in her work. It is however, an important caveat that Therapist E herself did not organize her description of her work in this way--rather, it flowed more organically via her providing multiple examples of integration. But I include it here, with intentional tentativeness; in the interest of offering an organizational framework that captures different ways this therapist discussed the connections between theories and between theories and interventions. These "variations" are also noted because they demonstrate Therapist E's view that theories have permeable boundaries-- that is, one theory can be interpreted in light of another such that it makes sense to combine them.

First, as noted in the opening quote above, Therapist E explains to clients that the two

approaches can be used somewhat sequentially, to reach different goals. CBT can be used to

work towards early symptom relief, and then the client may choose whether or not to "go

deeper" towards the further goal of insight into interpersonal patterns that may support their

symptoms. Therapist E described how this fits into her initial contact with a client:

> "I'll have somebody come in, I'll do a thorough intake, I give them my impressions and make recommendations about what would be, what I think would be useful for them. And then when they come back we develop a treatment plan. So I help them articulate what they're goals are for change or improvement in their life, and then that guides our work together. And typically those goals will be a combination of clear-cut behavioral goals that can be treated with cognitive and behavioral strategies, and longer-term goals that really need more interpersonal work. [Examples of longer-term interpersonal goals are]: 'to process grief related to loss,' or 'to understand how early family dynamics are impacting friendships now' "(C/1/337-350).

She provided another example of how she uses CBT strategies as an initial means to stabilize

distress, and then will go deeper into understanding triggers for both anxiety and depression:

> "And like I said earlier, I use it--initially I teach a lot of strategies to people for managing and reducing their anxiety, and I reinforce those throughout our work together. But once people are utilizing those strategies effectively, then I really try to, sort of…pull back a bit and get a wider picture of what's going on for that specific person in their life. And help them figure out what are triggers for anxiety, what maintains the anxiety, what are some important things that happened in your life that may have initiated or maintained the anxiety, so that they can have long-lasting benefit from the treatment, and anticipate when another really anxious time might come. And actually, I would say the exact same thing about depression: all of those things are true about how I treat depression as well. Some people are skeptical of cognitive-behavioral strategies, and so I won't--I don't belabor them if they're not interested. And I'll say things--actually here's some use of self-disclosure--I'll say like, 'yeah, I know, I used to think that this wouldn't work either, but it really does. And I've seen it work for a lot of people.' So, instillation of hope, and instillation of confidence in my experience and expertise. And it's true, I used to think, 'Really, deep breathing helps? Give me a break!' [*laughs/H laughs*]" (C/1/249-257).

However, in the next variation, Therapist E expressed that psychodynamic interventions

do not have a monopoly on promotion of insight. Cognitive behavioral interventions can

contribute in important ways to client insight about unrecognized emotions as triggers for

behavior:

"So, we started working on the eating disorder behavior in a very clear-cut, cognitive behavioral manner, so that I can link those thoughts and feelings to the behavior and--I think that was really news to her. She'd been so disconnected from her feelings that she really wasn't aware of these big feelings that were triggering this behavior" (E/2/157-161).

Third, Therapist E's training in personality informs how interventions are utilized within a session, particularly in timing what should be held off for future sessions (which could be related to her core question of 'when to introduce CBT'):

"I'm always paying attention to personality in the treatment. Even if the personality of the client isn't really along the pathological scale, just kind of paying attention to personality style. That really informs how I use interventions within the therapy hour, paying a lot of attention to, what can this person hear at this moment? What would be helpful to them right now? Versus, I'll hold onto it and wait until they're ready, sessions later perhaps. Um, also every--I mean we all have different aspects of different, um, personality disorders that are more along the normal continuum. And my knowledge of narcissism, and borderline, and passive-aggressive, can be really useful even when people aren't on the pathological part of that. But you know, for example, people who are having some problems with attachment, or fear of abandonment, like people with borderline personality disorder do, even if they have it on a smaller scale, empathy and validation is so key for those people. Versus, people who are more along the passive aggressive continuum, they interpret empathy and validation as disingenuous, until you have a really solid relationship and they know that you really mean it. And so you can't do a lot of empathy and validation with those people early on in the therapy--they'll think you're full of--full of it" (C/1/91-108).

The early introduction and use of CBT strategies (with the generally non-controversial goals of symptom reduction) secondarily gives Therapist E time and opportunity to learn about a client's personality style (perhaps 'CBT as grist for the mill') which in turn helps the therapist better tailor both future CBT interventions, and any other future interventions.

"While in those early sessions, while I'm teaching them cognitive and behavioral strategies for managing depression and anxiety, I'm paying a lot of attention to their personality, and to the dynamic between the two of us, so that I can utilize that in--well, first of all, even in how I'm introducing the techniques, or when I might teach them, or how I might teach them, and follow up on them. But also, for that longer-term work that I mentioned, I'm--again, I'm conceptualizing more psychodynamically, I'm listening for important information about relationships in their lives…so, I'll find out about things like, who's important in their life right now, and encourage them to get support from that

person in terms of utilizing the techniques I'm teaching them. But I'm also paying attention to, how is this relationship working for this person? How is it impacting their depression and anxiety? So that we can take a look at that more if they're interested" (C/1/275-287).

Finally, therapist use of 'third party' techniques (meaning basic techniques which are neither inherently CBT- nor psychodynamically-oriented) does 'double duty' towards informing treatment selection from both theories. For example, Therapist E explained that listening for important relationship information helps facilitate shorter-term CBT goals (by suggesting ways to solicit support for the client as he she tries CBT techniques). Listening for relational information at the same time facilitates longer-term dynamic goals or conceptualizations for a later focus (e.g. how relationships are working/impacting the presenting concerns).

Shifting to a broader scale, but still related to variables that impact clinical decision-making, Therapist E noted that earlier in her career, non-clinical factors had much more of an impact on how she approached treatment selection than they do currently. That is, rather than having treatment selection or intervention choice flow primarily from clinical observations in the consulting room (as now), they were previously much more informed by larger socio-cultural variables. These included cohort effects related to professional practice trends, "having 'grown up' professionally in the 90s when utilizing empirically supported treatments was so important, I think I became too--overly concerned about that" (E/1/474-477), or even the level of paternalistic dynamics and values in the institutions where she worked:

> "And then, constantly dealing with the politics of the place. And again, managing my own counter-transference. And also feelings that weren't stemming from my interaction with a particular patient, but from my position in [a highly patriarchal system]. So I was being asked to--what I thought was to empower these, mostly women [patients], who'd been so disempowered their entire lives, and yet I felt so disempowered as a new clinician, as someone who didn't get a lot of respect where I first arrived, because I had to prove myself, which is understandable, but also somebody who walked into a really bad political situation that I had no control over, and just on and on. And so I was really

disempowered. And how do I empower others when I'm so disempowered. And the answer is, you can't really. Or, if you try really hard you lose a lot of yourself. So the first few years of my career were--were mostly like that! Self-preservation mostly. But then, going into a big group private practice, it was like I'd shored up all these skills for managing Axis II stuff, and now I could just use my Axis I intervention skills, and they worked! That was delightful. Then it was about, using the CBT and also the relationship, and my well-honed ability to assess personality. And putting all that together, and creating the system I've described for you" (E/3/195-215).

Therapist E explained that experiences in different work settings and contexts over time helped give her permission to be more flexible with choice of interventions, while also holding on to her core value of research-informed practice: "I think for the first few years I practiced, I was always worried [*lowers voice to depict tone of concern*] 'is there enough empirical support for what I'm utilizing right now?' (E/1/470-472). She noted that later on, she was more able to find a balance between rigorous understanding of the psychotherapy literature, consultation, and a form of doing-what-works:

> "And once I got out of an academic setting, I was less paranoid about that. Because I-- being in a --I was in a big practice with lots of experienced clinicians who were smart and stayed up on the literature and training, and so, although it wasn't an academic setting it was still a very intellectually rigorous one-- which was a great fit for me, I didn't want to lose sight of the latest--the sort of state-of-the-art practice in psychology, and I didn't. But I also felt less pressure to sort of prove myself all the time in terms of making sure I'm utilizing the right techniques. And now I don't worry about that at all. I know I am. People get better" (E/1/492-500).

> To end, I include Therapist E's reactions to participation in the research interviews.

Somewhat similarly to Therapist A, who noted that the process of participating in the interviews allowed her to 'rediscover' aspects of her approach, Therapist E found the research process to be surprising in how clearly it represented what she feels she actually does in therapy:

> "Because reading the transcript from our first discussion, I was struck by--what a consistent thread there was throughout the discussion, and I felt that it so clearly reflected how I do therapy. And so I feel like, if I can explain it that clearly--at least I thought it was clear, maybe it was clear as mud! [*laughs, both laughing*]…Then it must be true! [*laughs*] It must be true. And, what was really striking to me was, I didn't know I could

be that clear, so that has been a great exercise for me" (E/3/137-151).

CHAPTER FIVE: CROSS CASE ANALYSIS RESULTS

Six Assertions, themselves made up of 18 Merged Findings, emerged from the data across all participants. In this chapter, I first give a brief overview of each Assertion and then describe each one in detail. As a reminder to readers, Therapist B completed the first interview prior to withdrawing from the study due to concerns about confidentiality (as described in Chapter Four). He nonetheless gave permission for his data to be included in the final analysis, and thus this Cross-case analysis was based upon five participants' views of treatment selection (even though only the four participants with complete data also had full Intra-case analyses).

Overview of the six Assertions

1) Treatment selection decisions emerged from the context of therapists' I/E orientations: What this orientation meant to the therapist, why it was chosen, and how it developed. They discussed how, why, and by what names they are Integrative/Eclectic, and how their approaches to treatment developed from 'eclectic' origins.

2) Therapists' treatment selection processes were informed by a stable theoretical or philosophical core, plus ample flexibility. Participants each reported a "core" of humanistic, relational, dynamic, or interpersonal approaches. They named flexibility as a fundamental distinguishing aspect of their approach to treatment selection, and stressed it over stability.

3) The therapeutic relationship was inextricably linked to the treatment selection process, and impacted it in complex and subtle ways. Therapists attributed their "intuitive" or "instinctive" decision-making to an implicit awareness of relational dynamics.

4) Therapists' conflicted disavowal of Empirically Supported Treatments (ESTs) led them to feel like a silent majority. This "outsider" status affected their treatment selection processes more earlier in their careers, and less later on, when their experience level or treatment setting

allowed more permission to deviate from prescribed approaches.

5) Therapists did base treatment selection on certain concrete, specific variables: timing, diagnosis, formal assessment, treatment goals, and larger sociopolitical contexts. But, these 'matching' type variables were relatively unimportant compared to other influences.

6) Reflecting on their study participation, therapists noted feeling "surprised" at their abilities to clearly describe their approach to treatment, and/or at their difficulties with this task. This underscored the implicit nature of their decision-making processes.

Below, the six Assertions, with the Merged Findings they are based on, are described.

ASSERTION I: Treatment selection decisions emerged from the context of therapists' I/E orientations: What this orientation meant to the therapists, why it was chosen, and how it developed

<u>I.1. I/E Orientations- Meanings and Motivations</u>

Therapists described their Integrative/Eclectic orientations both in strikingly similar ways and by creating customized labels for their own I/E approaches. For these five participants, these labels ranged from "integrative," "eclectic," and "integrative/eclectic--I feel like they are similar labels," to "informed eclectic" and "solidly eclectic." The most frequent language used to describe their I/E theoretical orientation invoked metaphors of flowing, spontaneous movement; malleability; and artistic construction or creation. Over the course of the interviews, therapists spoke of an I/E orientation as being related to: "flexibility," "flow," "adaptation," "complexity," "potential to be self-correcting," "freedom," feeling "liberated," "having license to," being "tailored," creating a "synthesis," "weaving together different threads," and "rolling with [the client]". Therapist B said,

"I like to think of it [his Eclectic orientation] more as a synthesis. You know, drawing

from different threads that I have thought about and weaving them together and using, or accentuating certain of those threads depending on what speaks to the person with whom I'm working" (B/1/160-162).

Thus, for this therapist, an Eclectic approach is a synthesis of different approaches that is tailored for a particular client and his or her concerns. For therapist D, an I/E orientation also represented flexibility: "With eclectic/integrative, the bottom line is it allows me to be fairly flexible and to roll with what someone is bringing in each session" (D/1/336-338). Further, part of his identity as an I/E therapist, as opposed to a therapist working within a single paradigm, was about tolerating anxiety in the face of ambiguity: "Because you have to be comfortable with a lot of the uncertainties that go along with being an integrative, Eclectic therapist. There's comfort in a more well-defined system" (D/3/745-746).

Participants described several reasons they had chosen an I/E orientation, and what they saw as the advantages of working this way. Therapist C said that an I/E approach felt "natural," and she appreciated "the freedom to do whatever feels appropriate" (C/1/235-236). Moreover, therapists believed that an I/E approach is the best way to treat a range of clients with a range of differing concerns. Therapist D expressed people are "too complex" to be using only one model or theory. He felt that while less complex cases might be amenable to "a more prescribed" approach (i.e. CBT), that more complex problems required an Integrative approach, and in fact it does clients "a disservice" if the approach to therapy does not match the complexity of their concerns. Therapist C similarly indicated that clients are not only complex, but also unique, and thus require approaches that are specifically tailored to them.

An important part of I/E orientation for these therapists was the ways in which they conceptualized how theories related to one another, and to interventions. I/E therapists also showed marked similarities in the ways they discussed the role of "theory" in their theoretical

orientation. They tended to see different theories as having much in common with one another, and saw many theories as being only artificially differentiated by the "definitions," terms, or jargon used by each theoretical school. That is, while they acknowledged that different theories explained behavior in different ways, they seemed to believe that if one theory were re-framed in terms of another one, both may likely point to similar interventions (albeit interventions that would be explained in divergent ways by proponents of the respective theories). This view is in contrast to focusing on epistemological differences between theoretical schools, or believing that there are important differences that keep theories separate and unique from each other. One hypothesis is that because of this view of theories, I/E therapists are more apt to draw from more than one theory in the treatment planning process. That is, if different theories are seen as not having rigid epistemological boundaries, (which would necessarily make them mutually exclusive from each other) then it would make it easier/more sensible to "integrate" them with one another. This would happen by therapists focusing on what is similar between theories, rather than what distinguishes one from another. Therapist C noted that she believes that the true degree of overlap/similarity between theories is obscured because of using different definitions/terminology for similar processes. She further believes that all theories have some aspects in common with others. Therapist D underlined this point. He suggested that 'much of theory and intervention overlaps, and it depends on how the therapist, or an observer labels it.' Therapist E expressed this idea in a vignette, which demonstrated one example of how this view of theories influenced the range of interventions she might choose among:

> "I think for the first few years that I practiced, I was always worried [lowers voice to depict tone of concern], 'is there enough empirical support for what I'm utilizing right now?' And I feel like having grown up professionally in the '90s when utilizing empirically supported techniques was so important, that I think I became too--overly concerned about that. When my training was solid and my intuition was good, I could've

just--and I did, pretty much go with what I thought was the right intervention in the therapy, but--I can remember having a conversation with a friend of mine who I respected a lot. I said [to her], 'I really felt like using the empty chair technique with this particular client was going to be useful, but I was worried that there wasn't enough empirical support for [*laughs*] gestalt techniques!' …And she said, 'Just think of it as exposure therapy, like you're exposing him to his thoughts and feelings related to the person he's going to be talking to in that empty chair, if that makes you feel better. But it's fine.' And this was somebody who was really steeped in the research, and did research on clinical outcomes…And that really helped me think about, right, just like anything else, when you think about or talk about theory and intervention, so much of it overlaps and it just depends on what lens *you* wear (E/1/47-492).

Therapist A compared her view on theories to being a "polytheist"-- having belief in more than one higher being, where each god has a particular specialty, perspective, or role to play in the affairs of humans.

 "I am not an anti-theorist by any means. I think we have to go through that kind of training to learn to think rigorously, to try to learn how to subject our assessments to some kind of test of, does it make sense, does it hold true. We do have to model, in our heads, what we think is going on. But I think that it's all going on. It's like all the ideas that have been offered to us by these brilliant theorists-- they're all true [*laughs*]. So, it's like I'm a polytheist. I just don't think it makes sense to belong to one religion. Thinking matters! Behavior matters! Choices matter, your dreams matter! You know, your relationships matter, your family matters, it all matters! [*Laughs*]. So, I think feeling more comfortable with that as an Integrative principle, and not so caught up on, you know, 'what would Kohut say?' is very liberating" (A/1/383-396).

Later in that interview, Therapist A and I co-constructed the idea of her being, perhaps, a "poly-theorist." This new term came about as a play-on-words in line with her poly-theist-like belief that all ideas offered by theories have some aspects of truth, and potentially some role to play in therapy:

H: In pulling from that…kind of cannon of--
A: Um hmm.
H: Gods…poly--
A: Yes--
H: --theorists [*laughs*]
A: [*both laughing, cross-talk*] Poly-theorists!
H: Yeah, poly-theorists [*laughing*] (A/1/431-442).

Therapist B similarly stated that theoretical orientations complement each other and are not mutually exclusive.

I.2. Development from Eclectic Origins

Regarding development of their I/E orientations, therapists described three primary themes. 1) They reported diverse training backgrounds, both in terms of the range of theories they were exposed to in their doctoral programs, and in several cases, the diverse range of educational experiences they had even prior to choosing psychology as a career. 2) Therapists were not explicitly taught about how to do treatment selection; it was instead something they developed and figured out with experience over time. 3) Their treatment selection processes developed in parallel to their personal development as therapists, including their increasing confidence and ambiguity tolerances, and clearer sense of the therapy process overall.

1) Diverse training backgrounds: In their graduate programs, each of the 5 therapists studied a wide range of theories in academic departments that did not adhere to any one single theoretical orientation. Rather, they took courses, and frequently talked with faculty members, supervisors and mentors who each provided consultation from various theoretical perspectives. For example, Therapist D spoke of being "trained in all the usual suspects," including CBT, psychodynamic theories, interpersonal approaches, motivational interviewing, and object relations. Therapist C credits her supervisors for encouraging her to think flexibly, and thoughtfully about treatment while feeling free to "think outside of the box." Therapists also had training experiences in a broad range of practicum and internship sites, which were often very different from the settings in which they were currently working.

Adding another layer of Eclectic experience, therapists A, B and D traveled "unconventional paths" to becoming therapists, which they believed contributed to their open-

minded approaches to doing therapy. Therapist B described his "path" to psychology as "circuitous," and Therapist D used the term "indirect." B's path led him through a graduate-level education in the humanities before he "found" psychology, and D's passed through a degree in a field of experimental psychology prior to his decision to re-specialize in Clinical psychology.

2) Lack of explicit training in treatment selection:

"I got training in a lot of different areas, but no one said, 'here's how you should choose which one to use'" (E/1/430-431).

Participant A acknowledged that learning about treatment selection is difficult in the abstract, and for her, this learning came more from practicum and internship experiences with clients. In particular, her internship setting was primarily where "connecting theory to practice really happened." Likewise, Therapist E did not get much treatment selection training in graduate school. Instead, "everyone just teaches you their approach to therapy."

Within this general theme, Therapist D was somewhat of a contrasting example. He described a more explicit, direct route to learning about treatment selection in an Integrative/Eclectic context. He noted that his mentor influenced the development of his Eclectic approach. Further, he sought out books and articles about Integrative/Eclectic approaches to psychotherapy, because he was actively searching for greater flexibility:

> "What I tried to do early on was to be pretty faithful to what I was being trained to do. That in itself is an experiment. It's an on-going experiment where you gather data. And I discovered along the way, that if you are too rigid in the way that you apply CBT, IPT, and all these other major therapies, well, it really does not do justice to the complexity of people. And so it was not very long when I was in independent practice that I began to figure out, ok, I've got to be a lot more flexible here. And I had read a number of things about Integrative/Eclectic type approaches, Saul, Garfield, and a number of other authors, and it--and again I'll use the 'r' word-- it 'resonated' with me" (D/3/371-382).

3) Development of treatment selection process paralleled personal/professional development: Therapist C said that trusting yourself comes from experience. She became more

comfortable with ambiguity over time, and now in practice, finds that she thinks about how she approaches treatment in less detail than she did in training. She developed what works for her based on experience with clients. Therapist D explained that early in his career, he tended to have a more pragmatic, formal, structured approach to treatment planning. Developmentally, he felt at times like he was "flying by the seat of my pants," the first year he practiced, but he learned from experience. Themes in his development included "trial and error" and "making mistakes." He specifically noted that over time, he got better at noticing clients' moment-to-moment reactions to his interventions, which enabled him to more closely tailor what he was doing to clients' needs. Therapist A originally began as a psychodynamically oriented therapist then added self-psychology. She still draws from theories she learned about in training, but does not adhere to them to the same degree. She speculated that "early career psychologists might still have [one] theoretical orientation," but more seasoned therapists may not. Over time, she increased her confidence in not following exact theories, and saw this as a sign of "integration versus ignorance." This last point also highlights a hypothesis for further checking in future research: perhaps Integrative/Eclectic approaches are for therapists who are more advanced, and that therapists first need a grounding in one approach to understand the process of therapy, before they can become more knowledgeable about other approaches and then attempt to integrate them.

ASSERTION II: Treatment Selection comes from a Core of Stability, Plus Flexibility

Interplay between stability and flexibility characterized treatment selection processes of these I/E therapists. While flexibility may be more what is thought of when one thinks about Integrative/Eclectic practice, aspects of stability and consistency were just as important to participants' approaches. A dance metaphor may be apt here. Dancers must develop their core

muscles for stability and power. At the same time, they must be flexible, fluid, and adaptable in their range of movements, to be able to express all elements in a piece of choreography.

II.1. I/E Therapists have a stable theoretical/philosophical core that forms the basis for treatment selection:

Every participant conceptualized and intervened from a 'core' of primary worldviews and theoretical orientations. The state of having a 'core' approach was important, as this formed the basis of their Integrative/Eclectic treatment selection. Interestingly, participants spoke more *explicitly* about the flexible, changeable aspects of their treatment selection process, and more *implicitly* about the stable, consistent aspects in their work. However, during coding, these stable themes stood out for us in the narratives. For example, Therapist C referred to her core approaches as "pillars to the treatment" (C/1/88), upon which other additional approaches are built. She also used the idea of being "grounded" in her core orientations (C/1/66). Stability themes were also detectable as therapists described the evolution of their orientations. Here, therapist B describes how his early preference for humanistic approaches continues to infuse his practice, even while it has been augmented by other approaches:

> "…But it's been kind of an evolution. You know, I think when I started out I thought of myself very much--and I was drawn to--Rogerian therapy. Client-centered therapy. And then, uh, I mentioned [name] who was a mentor and has become a very deep friend. That opened my mind and heart to a psychoanalytic perspective. And then, you know, the existential over-lay, which I don't think really is a therapeutic model in a self-enclosed sense, but Yalom's work. And Yalom after all was trained as an analyst-- has influenced me. The issues about--facing the basics of the human condition. So, yeah, I'm eclectic. I mean, I try to meet people where they are." (B/1/135-142).

Therapist B's words (above) also illustrate another observation about therapists' stable cores. There was marked similarity between therapists in what made up this core: Every participant spoke of having an Interpersonal, Relational, and/or Client-centered core, which

emphasized the importance of the therapeutic relationship in the change process. Therapist C

described her stable interpersonal/humanistic core, which also contained supporting Narrative

and Multicultural elements:

> "So, my theoretical orientation kind of evolved throughout my years of training. And
> now, I view it--there are a few components of that. Like, Interpersonal is a big one for
> me, and I can talk in more detail about that. I also like the Constructivist Narrative
> approach, which I use a lot and I'm grounded in Humanistic. And lately I've been
> incorporating a lot of Acceptance and Commitment Therapy techniques. Kind of
> mindfulness ways of approaching different concerns that people bring. Especially anxiety
> and depression, I find that it works really well with that. But overall, the--kind of the big
> arc of all of my theoretical orientation is more multicultural, kind of feminist-grounded
> theory. So, I kind of look at people's concerns more in a systemic and social view, so the
> culture, the context that they grew up in, the family, kind of the political and social
> climate, also contributes to who they are and how they view themselves, so that's kind of
> the pieces that I incorporate in my treatment" (C/1/63-77).

> "Probably my conceptualization would vary the least, and my interventions would vary
> the most. So, my understanding of a client and their concerns, probably, I probably see it
> as an ongoing, I mean, as a--something that is stable for me because that's kind of how I
> think about the concerns. As I mentioned at the beginning, [see quote above, C/1/63-77],
> what [it is that] informs my thinking. And then, the interventions I would pick probably
> would be based on different factors…I think the relationship, and the basic kind of
> relational structure of therapy, like trust and safety and the positive regard, and
> genuineness, and kind of process comments are definitely something that do not change
> for me. Like, that's always with me. Because that's what builds the treatment I believe"
> (C/1/418-433).

In addition to specific theories, participants' cores consisted of their larger worldviews

and philosophies of doing therapy, which transcend theory. Namely, across participants, these

worldviews emphasized three therapeutic stances: collaboration; recognizing and downplaying

power differentials; and striving to understand clients' worlds from their perspectives.

Participant A described a core of relational/interpersonal process, psychodynamic, and

developmental theories. She noted that existential theories have become more a part of her core

work over time. She spoke about "trusting the process" and putting in the time and effort to

develop the therapeutic relationship.

Participant B's core theoretical orientations included client-centered, psychoanalytic, and existential approaches. An important commonality in this foundation is a relational focus. Therapist B explained that his role as a therapist is to identify themes the client refers to over and over, and identify themes in the "stuck points" which may be either cognitive or emotional. In addition to this core, B incorporates some cognitive interventions as well. However, these seemed to be less rooted in modern Cognitive Behavioral theories, and more in what he described as "Jung's dialectic." In particular, he has found that "dichotomous thinking" is a frequent problematic cognitive theme across clients.

Participant C reported that there is little variation in her core approach from client to client. Yet, the fact that the core approach itself values client-centeredness and flexibility, allows her to integrate techniques from outside her core that are consistent with its aims. She described a foundation including Interpersonal, Relational, Multicultural, Feminist, and Narrative elements. These theories lead her to be highly attuned to affect, idiosyncratic and culturally contextual meanings of events for clients, and the power dynamics in therapy and society. In discussing her approach to treatment, she noted another constant is not imposing her own values on clients. This is consistent with many approaches, but in particular with the views of feminist, multicultural, and narrative therapies that highlight client agency and knowledge.

Participant D's core was primarily Interpersonal and relational, but also included significant elements of Psychodynamic, Mindfulness, and Strength-based approaches such as Narrative. In an email, he followed up on our interview by responding to a clarification question about which theories make up his core approach. Of note, regarding the process of his correspondence, Therapist D's use of empathy and humor (i.e. acknowledging the scope and complexity of influences on his approach, and how I as the researcher might struggle in parsing

this information) as well as giving time and thoughtfulness to clarify a question for me as the

researcher in the first place, also seemed consistent with his core therapeutic stances.

"I will try to list the main theories, models, and writers that have shaped my approach as a therapist. First and foremost, I consider exploration and deeper understanding of the nature and quality of interpersonal relationships (with key people such as parents, family, spouse/partner, friends, supervisors/bosses, subordinates, etc., AND self!) within the broader nexus of the patient's human experience to be foundational in my approach. As you can imagine, the writings of interpersonal theorists such as Harry Stack Sullivan, Gerald Klerman and colleagues (IPT), and Jeremy Safran and Zindel Segal have influenced my thinking. Of course, years ago my reading of Zindel Segal's work led me to reading and learning about mindfulness which expanded to reading many others including Jon Kabat-Zinn and other mindfulness writers/theorists (including Thich Nhat Hanh). I have also been influenced by a number of therapists/theorists over the years including Irvin Yalom, N. Gregory Hamilton (object relations; also Winnicott), Michael Mahoney, Aaron Beck (and other cognitive theorists/practitioners; I incorporate selected ideas/techniques from CBT in my therapeutic approach), Michael Hoyt, Lorna Benjamin, Stephen Hayes (acceptance and commitment therapy), Miller & Rollnick - motivational interviewing (for smoking cessation and addressing other modifiable health risk factors), Michael White (elements of narrative therapy), Viktor Frankl (meaning-making, finding meaning in life), Leston Havens, Joseph Wolpe (and others for behavior therapy techniques with elements primarily used with anxiety disorders, appetitive disorders such as pathological gambling, etc.), and a smattering of others such as Jay Haley, Albert Ellis, Leslie Greenberg, and the list goes on. I suspect that this may not make your task easy in trying to characterize the theoretical underpinnings of my approach!! However, suffice it to say that fundamentally my approach is interpersonal (primary focus on relationship with self and others) examining traumas, fears, regrets, betrayals, etc., with any eye towards finding meaning and purpose in life, developing plans and courage to undertake needed changes in one's life, and ultimately achieving a secure, autonomous, hopeful, realistic, and satisfying life (with resilience) going forward to be able to effectively navigate the ups, downs, and vicissitudes of life. I should also note that much of the time I focus more on emotions/feelings than on cognitions but I also am mindful of the interplay of thoughts and feelings in how life is experienced and interpreted. I also pay close attention to anxiety in its many manifestations (all the way from specific phobias/fears to existential anxieties) as well as internal conflict (consciously experienced or below awareness but clues abound). Anxiety is signaling something that needs attention or needs to be resolved - - a call to action as it were. So, as an eclectic/Integrative therapist, my task is to marshal all my knowledge and experience in service of the general goals listed here as well as the specific goals articulated by the patient. Goals evolve as you know, so I try to be flexible, creative, responsive, and empathic as I work with each patient. So, I guess, that is it in a nutshell!! (Therapist D, personal email correspondence, July 26, 2011, emphases in the original).

Although he did not describe it explicitly as Feminist, Therapist D's focus on

collaboration, acknowledging and reducing the power differential, and transparency would also

be quite consistent with that approach. Therapist D highlighted that one intervention he sees as

most consistent for him is "Asking the right questions." Although we did not explicitly discuss it

this way during the interview, one hypothesis is that this right-question-asking represents a

technique that is pan-theoretical, and functions for Therapist D as something like a "technical

core" (as opposed to being a theoretical core). Of note, when this therapist read these results

during final member checking, he confirmed that my hypothesis about a "technical core" was

indeed consistent with his experience.

Therapist E expressed a style that is humanistic, with the intention of "Doing what is best

for the client in the moment." She shared the view of other participants about the importance of

collaboration, client empowerment, sharing rationales for interventions, and encouraging a more

egalitarian relationship in therapy. Therapist E explained that she primarily integrates from three

foundational theoretical orientations: Psychodynamic, Developmental, and CBT, and influences

from each of these approaches tend to occur at different points in the therapy:

> "I describe my theoretical orientation as a psychodynamically and developmentally-
> informed approach. That's how I conceptualize clients, typically. I often use cognitive-
> behavioral interventions. What I tell clients is that I offer a lot of cognitive and behavioral
> strategies in order to decrease their distress, their acute distress as quickly as possible.
> But if they're willing to stay and do more work, then we can do deeper and figure out
> what their long-standing patterns are, of behavior, of affect, of interpersonal relationships,
> self-concept--things that, patterns they'd like to change. And also identifying things that
> are good, that they want to keep, that are strengths and help them be resilient. And I do
> think that the therapeutic relationship is important for change. And, you know, that
> definitely comes from a more humanistic and psychodynamic perspective."

Interestingly, a final aspect of participants' stable cores was their consistent valuing of

flexibility, and the importance of being adaptable as a therapist. This is discussed in the

following category, as the other side of the Stability/Flexibility coin.

II.2. Flexibility

The hallmark of I/E treatment selection for these therapists was flexibility in the service of tailoring treatments to each particular client's needs. Therapists talked about being flexible in their interpersonal stance, interventions, timing, beginning and endings in therapy. Therapists spoke about four different forms of, or arenas for, the use of flexibility. Each of these is elaborated below. These were: flexibility was a means of overcoming therapy impasses; flexibility in the form of 'balancing' between different intervention stances; flexibility in being client-driven and collaborative when choosing treatment approaches; and finally, defining the range of what "flexibility" would contain for these therapists. For some therapist(s), choosing treatments is not only flexible, but also fluid. "Trying to define treatment selection feels like trying to put a taxonomy on something that's fluid." The structure of therapy is not created by the theoretical orientation, or by treatment selection guidelines, or by a manual. Instead, therapists explained that for them, it is created by the conventions of therapy/therapeutic frame/boundaries created by the special healing relationship, (and by, as one therapist described, the client's themes). The flexibility of intervention occurs within the boundaries of therapy. Therapist A stated that the overall structure of therapy is well defined (with boundaries) but the individual components within that structure are ambiguous, hard to differentiate, or label. Another source of structure, within with flexibility occurs, is the therapist's training (Therapist A said, "Structure comes from training so you can then abandon structure").

II.3. Flexibility: Treatment Selection at Therapy Impasses

One therapist expressed that her Eclectic orientation gave her permission, or license to be flexible. In particular, she indicated that the Eclectic approach "allows" her to use a back-up plan *if the first approach isn't working* for the client. As discussed above, therapists at times reported

that the term "treatment selection" did not accurately coincide with what they felt they were doing in therapy. But perhaps the clearest case of when therapists *felt* themselves to be engaging in treatment selection per se was when they were in the process of treatment *re*-selection. That is, when they were noting a problem within the therapy, and considering what to do about it. This was a main situation in which their value of 'flexibility' was called upon. The most concrete and specific response to questions such as, 'When do you flex?' 'How do you know when to 'flex'? etc., were along the lines of, 'I flex when what I'm currently doing isn't working.'

Specifically, therapists spoke about two phases of this [my term] 'treatment re-selection' process: first, knowing when you are at an impasse, and second, knowing what to do about it. Therapists identified several indicators of an impasse. These included: slow, no, or regressed client "improvement;" the response of client dissatisfaction with the progress of therapy when asked directly; the client's more subtle resistance or skepticism towards current interventions; consistent mismatches over time between client's affect and events they are discussing; increase in clinician's anxiety about not "doing" something; and getting new information from the client that contradicts the premises on which the prior treatment strategy was based.

When in a position of impasse, therapists did a number of things to improve the progress of therapy. It is interesting to note that some of the therapists' strategies for addressing impasses (by employing flexibility) would be externally visible to an observer, and some would not. Most impasse-correction strategies were based on some version of the assumption that the impasse was caused, at least in part, by the therapist having based the initial treatment selection decision on insufficient or inaccurate information, and thus needing to flesh-out or correct their conceptualization before going with another intervention strategy. Some specific examples of what this 'what to do' phase looked like included: first, and most importantly, stopping doing

'more of the same' and not belaboring the same interventions; being more curious about the client's unknowns; working on improving accurate emotional attunement; returning more explicitly to the assessment phase; reconsidering the therapeutic relationship, and in particular, the level of trust present, such that the client can feel more comfortable disclosing important information; talking directly and openly with the client about "not clicking" or about the impasse; referring again to the initial treatment goals; and finally, in the most extreme case, considering referral of the client to another therapist if the impasse cannot be overcome.

II.4. Flexibility: Treatment selection as 'balance'

One important way therapists talked about flexibility in their treatment selection process involved the concept/metaphor of "balance". This is notable because it resonates with the way that all therapists described their lived experience of [what I'm calling] treatment selection. That is, that it they saw the process as being embodied, fluid, on going, and adjustable on a moment-by-moment basis. 'Balance' has connotations of subtlety, nuance, small corrections in one direction or the other. Balance also calls to mind a sensory system, or at least refers to non-verbal processes. This fits with the way therapists talked about, in particular, treatment-selection-as-balance in the context of "relationship selection," (as discussed below in the section on the importance of the therapeutic relationship).

Often, balance was invoked related to "walking a line" between poles of interpersonal reaction alternatives. The following is a listing of what therapists balanced. I have organized them into different realms/levels/focuses of balance.

One level involves what the therapist might be balancing between at any given moment in the therapy with a client. These included affective vs. cognitive focus; supportive vs. change-focused interventions; helping client become more flexible without breaking/invalidating her

cultural/religious values; closeness/empathy vs. maintaining objective distance; monitoring

client's thoughts vs. feelings; therapist getting 'over-involved' versus being 'under-involved'

with client; and focus on understanding/emphasis on relationship vs. being "too touchy feely";

and balancing "touchy feely" with "problem/solution focus".

Another level involves larger questions of what therapists are adjusting between:

technical vs. relational aspects of intervention; intuitive vs. scientific aspects of doing therapy;

out-of-the-box-approaches that may be more multiculturally appropriate vs. keeping appropriate

boundaries; and being ok with trusting clinical intuition vs. noting explicit

intentionality/motivations behind interventions.

At the broadest level, therapists noted that they are balancing between seeing therapy as

"an art" and "a science". Almost all therapists spoke about this largest polarity. But among the

five therapists interviewed, there were, likewise, five spots along the continuum of art--science.

Some thought it was more science, some thought it was equal parts art and science, and one

thought it was "all art". One therapist moved from this "all art" end of the continuum farther

towards it being some mixture during the course of the interview, as she became more aware of

her technical underpinnings. This is discussed more fully in the section on "meta-level reactions

to participation" and in the Intra-case analysis of Therapist A's treatment selection process.

It is important to note that therapists did not discuss any of these "poles" as mutually

exclusive, or irreconcilable, but just as different ways they might 'lean' to best meet the needs of

the client, or to best understand their own overall approach to working with clients. In other

sections, I discuss the 'variables' therapists might come into contact with that 'sway' them in one

direction or the other in each unique therapeutic encounter.

II.5. Flexibility: Being collaborative/client-centered/client-directed/client's role

Balance was one form of flexibility, and another important form/implementation of flexibility was approaching treatment selection and moment-to-moment interventions by being collaborative, and being client-driven. Therapists' behaviors could be characterized as either collaborative or client-driven. In looking more closely at the dynamics of each, there did seem to be a difference in the way therapists talked about these two tightly related concepts.

Being "collaborative" seemed to indicate a way of explicitly, overtly working with the client to discuss, and make choices about the course of treatment. Collaboration was one main way in which clients directly influenced the treatment selection process. This included actions such as working together to make meaning; "checking in" with the client about how therapy was progressing; educating the client about "how to be a client" so that they would have the tools needed to function with more equality in the therapy relationship; and negotiating the focus of sessions with clients when there was disagreement (i.e. if the therapist thought it would be important to discuss a topic, but a client was reluctant to 'go there').

Being "client-driven" seemed to refer to a more implicit stance from the therapist. Here, the therapist aimed to move flexibly, and change their approach to "meet" the client "where they are at" in any given moment. Therapists expressed that it was through this means of following the client that they were able to understand and respond to the uniqueness of each client's personality and needs. Here, the "where" of "where the client is at" was determined more through the *therapist's perceptions* of the client's "location" than from the client explicitly giving 'directions' to their current location. This approach to flexibility involved more of the conceptualization level of treatment selection. For example, one therapist discussed this concept being present when she works to understand the client's concerns through the lens of the client's culture/worldview instead of through those of the therapist. It is also about "following the

client's lead" and "starting where the client starts." One therapist discussed this ability to follow

as being, indeed, "where the structure of therapy comes from". That is, he described that instead

of approaching therapy from his own structure, he first focused on hearing and identifying

clients' themes, and then having those themes create the structure/organization for sessions. This

seemed to be one 'pure form' of client-driven treatment selection.

II.6. Flexibility: What is integrated? What 'content' is selected for?

Therapists talked about the "tools" in their "tool bag/tool belt" or alternately, "groceries"

in their "cart" of therapeutic techniques they draw upon. Honoring the contextual and co-

constructed nature of the interviews, (as well as appreciating the humor expressed by Therapist C

in the interview) it may be useful to note that the 'grocery' metaphor was created in an interview

occurring after working hours in the early evening, near dinner time.

> "It's kind of like….hmm…let me think of an analogy…like, I don't know. Like if you go to the grocery store, and you have a list of groceries, what are you going to pick because you're making dinner [*laughs, both laugh*]. So, I definitely have an idea and a plan, and think about what I want to do. But then I'm going through the groceries, and then, like, 'oh, this looks good, and that would be helpful to flavor this thing, and maybe I'll pick this for dessert.' So I also have the freedom to choose whatever I feel would be appropriate based on changes that are happening in the session" (C/1/228-236).

Firstly, it is notable that I/E therapists conceptualize their range of possible interventions

in these metaphorical ways. Therapists talked explicitly about "needing a lot of tools in your tool

belt," and "having multiple tools and options" to be an effective therapist. They acknowledged

that they used a wide range of interventions with "much variation". Elaborating this metaphor,

therapists further talked about "borrowing" interventions from "other" theoretical orientations for

specific purposes. The idea of "borrowing" was interesting because it implied that the therapist

did not consider that technique as permanently residing in his or her "collection" of

interventions, but instead implied that the therapist had identified a specific, somewhat unusual

client need that necessitated a particular tool. Perhaps because the tool is not used frequently enough to "own" it, it is temporarily "borrowed", but still seen as something separate. In considering flexibility as a treatment selection strategy, it raises the questions of: What range of interventions are therapists [flexibly] deciding among? What is not an option for inclusion? What is in that bag?

This category is primarily focused on the technique, or moment-by-moment level of intervention. However, therapists at times talked about "drawing from" larger-level intervention approaches without listing specific techniques or intervention behaviors that they used. Thus, some of the range of interventions are at the concrete level of what therapists 'do', and some would be explicit and observable to an outside viewer of the therapy, while others are implicit, consisting of a particular therapist 'stance' that the therapist decided to take.

For example, the range of flexibility included some specific, concrete interventions that were seen as part of the therapist's "tool bag". These included: using motivational interviewing techniques to help resolve ambivalence; using gestalt techniques such as 'empty chair'; teaching mindfulness; teaching DBT skills; using self-disclosure; communicating empathy; asking the client what change would look like for them; validating the real-world constraints impacting clients' problems; providing psycho-education; making interpersonal process comments; encouraging clients to exercise; identifying depressed behavior patterns, and identifying practical ways to do things differently; remoralizing via reminding clients of their strengths; brainstorming; cheerleading; problem-solving; inviting the client to look at a certain pattern; asking the right questions; observing non-verbal cues and providing feedback; using humor; using paradoxical techniques, here-and-now processing; and *not* providing answers for clients.

Also, the range of flexibility included some more stance-like, less-specific interventions

as well, that were seen as part of the therapists' "tool bag": focus on helping the client 'stay in balance'; taking on a detective role; altering the level of therapist activity/directiveness to best fit client's personality, presentation, and current needs; collaborating with client's family members when appropriate; using a feminist approach as an adjunct to CBT as a way to highlight counterproductive contextual factors emphasizing appearance in the client's work environment; "doing CBT"; using "vocational interventions" and [most broadly] "being familiar with most major movements since modern psychology."

While it is informative to have a sense of what it is therapists are integrating, it is even more telling to learn under what circumstances these interventions were selected, and for what reasons. This occurred in some ways that were similar across therapists (using the therapeutic relationship as a barometer to inform technique choice) and in some ways that were unique to each therapist more idiosyncratically (exactly how the therapist's understanding of the relationship contributed to these choices, and under which circumstances). The former, Cross-case similarities are discussed within this chapter on Cross-case analyses, and the latter, intra-therapist models of treatment selection are discussed in the next chapter. However, this review of the content of their "tool bags" provides a backdrop to better understand these contents in action.

ASSERTION III. I/E Therapists saw the therapeutic relationship as being inextricably linked to the treatment selection process.

III.1. Importance of the Therapeutic Relationship in Treatment Decisions

> "I think therapy rests on the relationship between the person with whom I'm working and me, more than it rests on any particular theoretical foundation."

> -Therapist B (1/171-173)

As a testament to the importance of the therapeutic relationship, two participants defined

their treatment selection processes in primarily relational terms. In fact, Therapist A found that

the term "treatment selection" held too many connotations/implications of meaning 'selection of

technical interventions for specific diagnoses.' When I invited her to choose a more accurate and

preferred label, Therapist A relabeled her therapeutic decision-making process as, "Relationship

Selection." However, she still felt that the term "selection" did not fit her experience of

intervening with clients. For her, "selection" connoted a conscious, moment-to-moment decision-

making process, which was inconsistent with her experience of therapy as related to "flow" with

clients, and not conscious choices about technique. She was able to describe that when treatment

selection does includes moment-to-moment decisions for her, they are most usually of the kind,

"do I follow up on that emotion or do I let you sit with it…?" or, making conscious decisions

around confrontation versus support; thought shifting vs. attending to affect, or more generally,

how she "steers" interactions in therapy by choosing which aspects of client's material to pay

attention to in a given moment. In this way, she associated treatment selection with "positioning"

herself as a therapist in relation to a particular client. This also included other variables/clinical

decisions about her interpersonal stance on issues such as: amount of physical touch, whether to

allow after-hours phone contact, level of formality, rigidity of boundaries, and varying the

amount of self-disclosure for different clients' needs, based on the criteria of "if they will find it

useful." She further moves between "close" and "distant" stances at different times in the therapy

hour, and does so based upon what she described as deeper connections with clients leading to an

intuitive understanding of the therapeutic process. She generally uses the relationship as a

barometer to indicate "where to go next" with a client.

Similarly, Therapist B re-defined the research question in terms of his own process: "An

interpersonal selection process." During the interview, he made the self-aware comment that

after I had asked him about his treatment selection process, "my response had not mentioned any treatments." He had instead explained that treatment selection starts with the client-- it is an "interpersonal selection process." What he doesn't do is explicitly match client to approach.

In addition, all participants discussed, in detail, the importance of the therapeutic relationship. They discussed it in four ways in relation to treatment selection decision processes. Different participants highlighted different aspects of these four sub-categories, although these themes were widely present in the data of each participant to varying degrees. First, they talked about why and how the relationship is important, and how it impacts what they do in therapy.

Value of the therapeutic relationship

Relationship is important in itself as a curative factor. Some participants more or less explicitly fleshed out the mechanisms by which they believe/have seen this to happen. Here, they described it as an intervention in itself, an active ingredient. Regarding those mechanisms, Therapist A explained that it's through the mechanism of therapist authenticity, and the unique property of the therapy relationship (as opposed to many other social relationships) where one can receive direct, candid feedback. Similarly, both Therapist B and Therapist E referred to a mechanism by which the relationship is a "mirror" for the client, thus giving it potency in the change process in itself. She also referred to the mechanism of allowing clients to experience positive regard. Therapist A also noted that benefits come from a more global mechanism, "sharing the human condition" that seems similar to therapeutic elements such as normalization or universality (Yalom, 1995).

Relationship is a means by which to do valuable interpersonal/personality assessment of the client. This in turn leads the therapist to have data on which to base further treatment decisions. Therapist E noted that understanding client personality helps predict how they'll

respond to treatment suggestions, and where areas of resistance may be. As a private practitioner without the means (time, money) for formal personality assessment measures, the relationship becomes the most important way for the therapist to assess this. (Although, of course, even with access to these means, which she had at a prior agency, there are important data in the relationship). She further explained that she uses the dynamic between herself and the client to make decisions about how and when to introduce techniques, and how and whether to follow up on previously used techniques.

Relationship is a prerequisite for treatment. Without the relationship, either a) as participant B noted, "*No* technique or approach will be effective," or b) *certain* interventions will not be possible or effective. Related to the first version, Participant B noted that it is crucial because "the foundation of therapy is whether there's grounds for common understanding," and this is found/created within the relationship. Therapist C also focused on this function, explaining that the relationship is 'necessary' for any change, and that it "comes first" in her treatment approach. Related to the second version, Participant E explained that the interventions she chooses change as the connection and alliance increases. For example, once the alliance is well established, she is more apt to focus on client emotion, and select interventions based upon that.

Relationship is explicitly related to one or more core theoretical orientation(s). It is important to note here that each participant's view of the relationship was consistent with his or her core orientations, but some made this link explicit, and stated its salient to them as a way they conceptualized their approach to therapy. Therapist C explained that developing the therapeutic relationship is integral to her core theoretical orientation, and is a constant across cases. She summarized that in the flexible world of I/E treatment selection, "the relationship

grounds me." Therapist E stated that for her, the relationship *enables* interventions based on

transference/counter-transference, which is consistent with her psychodynamic core. In contrast,

in the negative example vein, participant B stated that "more than a theoretical orientation,

relationship is important." He defined it as being super-ordinate to theoretical orientation.

Of note, therapists discussed the above aspects of the therapeutic relationship seamlessly.

For example, in his case example, Therapist D described how the power of the relationship itself,

combined with a specific technical, but relationship-based intervention--confrontation-- was a

turning point in treatment for the client. Therapist D confronted the client about withholding key

information from him. Then, they processed the client's motivations for doing so, and the

implications for the therapy relationship. This was then related to the client's larger interpersonal

patterns. In this example, there was healing both in the relationship itself, and in its role as a

prerequisite condition for other interventions chosen based on the therapist's theoretical

orientation.

Second, therapists talked about what goes into creating the therapeutic relationship in the

first place. In this way, they treated the "good therapeutic relationship" as a separate (sub-)

therapy goal, and then had decision-making strategies, (either implicit, or explicit) and/or

strategies by which they moved toward that goal flexibly with each individual client. Therapists

noted the important facets of successfully attaining this goal:

Factors affecting the therapeutic relationship

Time. Therapist A acknowledged that she might be "an outlier" with regards to her longer-

term therapy. She explained that the relationship takes time to develop, although it begins in the

first interaction with a client. "There's no shortcut for getting to know a client well".

Respect. Therapist A gave evidence of this not only in the content of the case she

discussed, (explicitly stating it was important) but also in the process by which she talked about it in our interview. For example, prior to beginning discussion of the case content, Therapist A took a long time to get to the story, and provided a lot of qualifiers such that I would not have the 'wrong' impression of the client. She also evidenced great care for client confidentiality, as shown by asking me detailed questions about how the interview/transcript would be used, who would see it, and desiring to be sure to change recognizable case details. The effect of this on me as an interviewer was of Therapist A having great respect for the client, related to her overall valuing of the therapy relationship.

Being Trustworthy. Participant B identified this as a core requirement of an effective relationship, and earns clients' trust by being transparent, respectful, not making assumptions about one's trustworthiness in the client's eyes, and not taking trust for granted early in therapy. However, it is important to note a potential contradiction/area of nuance here: Participant B also says, "building trust and rapport are not technique-based". Thus, although he talked about some facilitative conditions of trust, he does not experience them as "techniques," or use them that way, as part of the trustworthiness is based upon genuine human connection, and all of the subtlety involved in creating that with each unique client.

Collaboration, being non-directive, power-sharing. This particular category of facilitators of the therapeutic relationship may be unique to those therapists who espouse some theoretical orientations, but not others. For example, for a CBT therapist, collaboration would be key, but being non-directive would not be.

Empathy. For Therapist D, empathy is the basis for all connection and understanding in therapy. Empathy is fundamental, because "getting it" involves an emotional connection, and clients want and need to be understood.

Client expectations. Related to the therapeutic relationship, Therapist D explained that for him, alliance and rapport in service of the relationship are based on clients' beliefs that, "the therapist understands their suffering, and that the therapist has knowledge, expertise, and training to support a client's hope for positive change."

III.2. Mystery- Implicit clinical decisions based upon Intuition, Instinct, and Experience

Awareness of, and participation in the therapeutic relationship was a major influencing factor on treatment selection "in the moment" when therapists were sitting with clients. Indeed, when asked to describe their treatment selection process in the broadest terms, therapists at first expressed that it was so automatic that it was difficult to put into words. As it was difficult to describe concretely, therapists brought in references to other 'ways of knowing' that they use.

In the therapists' experience of treatment selection, they described this decision-making process alternately as being based upon "intuition" (Therapist A, C) "instinct" (Therapist E) and "spontaneity" (Therapist B). In fact, at times it felt so implicit as to be "mysterious" (Therapist C, D) and did not feel like conscious 'decision-making' at all. Instead, therapists spoke of "just doing it" (Therapist E) or having their decisions "come naturally" (Therapist C). This was especially so at the moment-to-moment time scale of intervention:

> "Right, it is a mystery. Being a therapist is a big mystery, because you're with human beings, and they each share their unique story. And it's hard to--you know, if you're in the moment--it's hard to dissect, like, ok, what's going on right now, and adhere exactly to what you're supposed to adhere to, if there is such a thing" (C/3/141-144).

However, therapists acknowledged that these "automatic" therapeutic responses were in fact specifically rooted in the therapeutic relationship. This is why I chose to place the "Mystery" Merged Finding under the larger Assertion of the importance of the therapeutic relationship. Therapist A described her in-the-moment decision-making this way:

"…Most of it truly isn't cognitively driven. It's intuitive, it's relationship-driven, it's empathy-driven. But the things that I consciously make decisions around are things like, how confrontational do I want to be, versus supportive. How much do I want to sort of encourage something to shift their thinking, as opposed to paying attention to affect. Right. So it's that kind of decision-making. But even that, I don't even think that happens on a conscious level. I think it's very, very intuitive" (A/1/258-265).

For Therapist D, these "mysterious" parts also have to do with the nuances of

interpersonal interactions in therapy.

"So, anyway, treatment selection is a--mysterious process in some ways. Because, it's not something that, after one, two, three or four sessions, after I've really gotten to know someone, at least minimally, that I can kind of understand their life circumstances and their goals for coming in, and you know, what really is going on--it, you can have kind of a preliminary notion, but eclectic/Integrative allows me to bring into each session the skills and tools drawing on a number of different models and therapy approaches" (D/1/320-325).

Therapist E also acknowledged that clinical decision-making is "difficult to describe as a

heuristic or algorithm," but she did not imply that such processes do not occur, or that they are

un-knowable. Instead, she suggested an alternate means of studying the phenomena: that if she

and I were to view videos of her sessions, we could likely retrospectively deduce, and make

explicit her implicit decision-making processes. Her best current understanding was that the

decisions were based upon her experience with assessment of personality, and the subsequent

ways that she would interact to complement or counter clients' styles. In parallel, Therapist A

made a similar suggestion for a follow-up study, to better elucidate the implicit, or mysterious

aspects of treatment selection:

"It makes me wonder if you did--if you did this kind of study using an actual videotape of the session, and had the therapist editorialize after the session, first I did this, then I did that…that kind of deconstruction. Which would be another way to approach this question" (A/3/550-554).

In addition, Therapist C felt there were "mysterious" aspects to how other therapists

made treatment decisions as well. Therapists did not make the assumption that the way they

themselves approached the process was necessarily the "norm," and expressed curiosity about

how these processes looked for their peers.

> "I guess--it's this whole mystery, you know? [*laughs*] What really happens behind closed
> doors! Nobody tells you…yeah, I'll be curious what their ideas are about therapy, and
> how they integrate the theories and interventions" (C/3/114-118).

ASSERTION IV: Conflicted disavowal of ESTs made I/E therapists feel like a silent

majority

IV.1. Conflicted Disavowal of the Empirically Supported Treatment Movement

I/E therapists repeatedly defined their approaches to treatment selection in opposition to

what they saw as incompatible approaches: namely, choosing and using "ESTs" directly from

manuals or from the research literature. They saw I/E practice as their relationally based answer

to this model. Each of the five participants at some point discussed ESTs as being, to some

degree, the antithesis of Integrative or Eclectic practice. By using the Merged Finding name

"conflicted disavowal of ESTs" I am referring to within-therapist ambivalence about what the

Empirically Supported Treatment movement means for their individual practice. On one hand,

therapists stated they aimed to keep abreast of the psychotherapy literature, and noted that for

some presenting problems (particularly anxiety disorders) they did in fact look to research

outcomes in selecting interventions. But on the other hand, they felt that the movement to

privilege certain interventions by placing them on an official list of Empirically Validated

Treatments was artificially constricting, and not at all part of their experience of doing

psychotherapy.

For Therapists A and D, disavowal also took the form of specifically naming, and

disagreeing with the Medical Model of psychotherapy, upon which the EST movement is, in part,

based. Therapist A said,

"This is not a medical science, and it's not a medical procedure, it doesn't follow, it doesn't fit, it doesn't work well to think of it that way. And I think that a lot of us get kind of caught up in this sort of wanna-be medical thing, and it's just really unfortunate. Because the power and the effectiveness of therapy is the relationship. It's the human connection. And that [a medical way of viewing therapy] separates-- that's a very primitive way of just kind of separating ourselves from the people we work with. Because you say, well, you have this disorder, and therefore that explains everything about you" (A1/231-242).

Likewise, this view of therapy led her to question the appropriateness of the term "treatment selection" itself: "I guess probably part of the problem is the word 'treatment.' Because once again, I don't believe this is a medical procedure" (A/3/165-166). Similarly, Therapist D stated,

"Even though we're in a medical clinic [practice setting] they're not going to get a standard medical model with me. And I think there's been a bit of a shift, in psychology maybe wanting to use more of a medical model, you know, with evidence-based therapy…and I'm not terribly on board with that" (D/1/288-294).

At the same time, Therapist A also expressed approval of, and seeing the usefulness of research on psychotherapy. She cited research that supported her approach to therapy.

"…As far as the process research was at the time I was most involved with it, we know that effectiveness [of psychotherapy] does not correlate with any thing except individual variables, with the therapist and something about the relationship between the therapist and the client. So, it turns out that all this good stuff isn't going to guarantee that you're a good therapist. And that really fascinated me as a researcher myself. You know, and when my intuition was confirmed [laughs] in a small way, I think that also helped too, to free me to be myself, because that's the most powerful agent of change that I can bring to the interaction" (A/1/397-408).

Other therapists also at times pointed to specific studies they were aware of as examples of their approach, or perhaps to give evidence that they do, in fact "keep up with the literature."

When discussing ESTs, therapists often called upon Cognitive-Behavioral Therapy, and particularly its manualized forms, as a counter-example of what they themselves do as I/E practitioners. At times, Doriane and I (researchers) felt there seemed to be a straw-man-argument quality to this juxtaposition (putting up manualized CBT as the straw man--or as an effigy of the

EST movement). However, this observation is not to discount the many ways therapists also, at other times, treated this issue with nuance.

There were varying degrees of conflict around ESTs, with therapists having resolved the dissonance to different degrees, and in different ways. At one end of the spectrum, Therapist B expressed disapproval for the EST movement, but a low amount of conflict around this view. That is, he did not express a great deal of dissonance that he "should" be doing, or was expected to be doing more EST-based practice. He clearly stated his view that "therapy is an art more than a science." This position was different from the other participants, who took more a view that there were significant aspects of both art and science in the practice of psychotherapy. He further questioned reliance on ESTs due to doubts that psychotherapy process and outcome can be reliably measured in the ways that fully and accurately represent the benefits of therapy:

> "…So, it isn't like outcome is disregarded, or it's irrelevant, but how we arrive at--see, I think this whole notion of evidence-based therapy, or evidence-based therapy outcome, is really--it's an effort to out-strip ourselves with respect to what we are capable of measuring. Now, that again can lapse into--the counter to that is, well, that's irresponsible, you know. You're not being aware of what's going on--and I don't agree with that. I mean, I think there are ways--first and foremost the person with whom we're working, again, gets priority in terms of whether they feel that what is going on is meaningful to them. That's the first priority. But beyond that, I think that for the therapist, that doesn't mean to be thoughtless about what's going on. But it does mean the importance of recognizing our limitations. And I think it's dangerous to presume that we have the tools to measure outcomes with the precision that sometimes--a person comes in here who's depressed, or is socially isolated. And the quality of their life improves over the course of time. We, we get it, we know it, if the person is being--but we get a sense of it. You know, when we attempt to measure it precisely--and of course this brings in political aspects too, and economic aspects in terms of insurance companies and so forth and so on. I think we're creating a pseudo-science in terms of what we have available to us" (B/1/640-655).

Therapist D placed his concern with the EST movement into the context of his own training and development as a therapist.

"Um, being imbedded in an academic environment, I do read and pay attention to the

scientific literature. I do. So, over all the many years that I was in training, and in recent years, I've kept up to a degree, with some of these very thorny issues around evidence-based practice, of which treatment selection can certainly fall under--fall into that category. And I--I'd have to admit that I feel some conflict about this. The conflict comes in that, as a scientist, I think that evidence-based practice is very important, and represents an advance. And I have been heavily influenced by [psychologist] who actually has taken a leadership role in terms of the science of clinical practice. And he likes to think of the--of us out on the front lines who are doing our clinical practice as being clinical scientists of sorts, you know…So the conflict that I feel is that, my real-world experience, sitting in the room with a patient, and bring to bear all the things I learned, is actually very difficult to--adhere to those evidence-based guidelines. Because people come in, and they're complex" (D/3/87-106).

He further noted the reasons for his current position on the EST debate:

"So, I've been kind of a side-line observer of this for the last 20 years, and I cannot be counted among the people who…would feel comfortable adhering real closely to evidence-based guidelines. In some cases, it's too prescriptive in a limiting way. It forces you to not have the flexibility to roll with what's going on with a particular person" (D/3/140-145).

Therapist D had seen that others in the field are similarly conflicted about ESTs and evidence-based practice. (And, his observation was certainly further supported among the present group of participants.) In relation to treatment selection, he perceived a wide distance between what is taught or prescribed for therapists to do, and what is actually done in practice.

"And what I discovered with CBT--and I of course had training both in courses, and in practicum, and even in my internship, and post-doc--it was hammered and hammered and hammered. I took one course…and [name] was teaching it. And he used to kind of teach the CBT in a way that there was kind of a little gleam in his eye, like, 'well, this is CBT, but this is not quite the way that you really want to be doing your therapy.' But he had to teach it, you know, in the way it's described in Beck, and in other books and manuals and so forth, but he's another example of someone that kind of knew what really goes on behind the closed door in the therapy room is not strictly adherent to what the 'master therapists' advise us to do" (D/1/338-348).

At a further, meta-level, Therapist D also made a point to specify that his overall approach to treatment selection and to psychotherapy integration itself, (in addition to the use or non-use of specific ESTs) was different from the models proposed in the psychotherapy

literature. He began an email correspondence to me with this clarification:

 "I should note that there are multiple and diverse influences on my therapeutic approach and I'm not sure that my overall approach neatly falls into any of the four "modes" of psychotherapy integration espoused by some authors, namely technical eclecticism, common factors, theoretical integration, or assimilative integration" (Therapist D, personal email correspondence, July, 2011).

Therapist E was among the participants who expressed both conflict around this area, and strategies by which she had begun to resolve the conflict. She explained that for her, there is indeed a "tension" between selecting what she believes may be useful for client, and selecting empirically supported treatments per se. She stated that, "despite solid training and good clinical intuition," there have been times in her practice when she still felt hesitant about "going with" what she thought was the right intervention at a particular time, because it was not an EST. However, she seems to have resolved the EST conflict through several strategies. First, as described above, she sees different theoretical orientations, and the interventions based upon them, as being readily reinterpretable through different mechanisms of action. Recall that it was Therapist E who recounted the vignette of being reluctant to use the Gestalt empty-chair technique until a colleague suggested that she reframe the intervention in her mind as a form of "exposure therapy." (Specifically, to consider that by using this technique she was "exposing" the client to his feelings about the absent person "in" the chair). Second, she notes that although she feels that she "would be remiss in not using cognitive and behavioral strategies because there is empirical support for them" she also acknowledged "there's empirical support for using CBT with eating disorders, but using it as a rigid, manualized approach can backfire." Thus, she feels that there is not a hard distinction between "using ESTs" and "being flexible." The two behaviors are not mutually exclusive. Finally, Pp E seemed to hold a wider definition of ESTs than other participants. She noted that, "there are empirically supported relationships as well as treatments;

and focus on the relationship is not counter to empirically supported treatments." Thus, while she

reported experiencing conflict around ESTs earlier in her career, it seems that she currently has

an understanding of their place in her treatment selection process that feels resolved. Of note, in

spite of this greater comfort with ESTs and non-ESTs, Therapist E still expressed concern that

her I/E orientation would be looked down upon by others in the field, as described in the next

section.

IV.2. A Silent Majority

> H: "What's your theoretical orientation? How would you describe that?"
> B: "The dirty word. Eclectic."
> > - Therapist B (1/133-135)

> "So in some ways, I feel like those of us who are willing to do Eclectic and Integrative, we're kind of mavericks. We're mavericks--at least those of us who are willing to admit this is what we do."
> > - Therapist D (3/759-762)

In confidential surveys of therapists' theoretical orientations, those who identify as

Integrative or Eclectic are the numerical majority. But due in large part to their disavowal of

ESTs, I/E therapists in this study perceived that "others" in the field viewed their theoretical

orientation negatively, and thus expressed some self-consciousness, or self-protectiveness around

being "out" as an Integrative/Eclectic practitioner. Thus, they may accurately be described as a

silent majority. They felt disenfranchised and marginalized by professional organizations, the

research literature, and insurance company mandates based upon the EST movement. In fact,

therapists felt that by the very nature of I/E practice, their work did not lend itself to being easily

researched, and would thus be unlikely to ever win favor in the EST community.

> "And there's always this, I think, push or pressure on doing empirically supported treatment, and what does it really mean, and…how can you…[*sigh*]…you know, it's not very, I don't know, manualized or very broken-down in pieces that you can research and then look at. For example, as you're doing right now, like having more Integrative

therapy, and how do you research that? How do you say this is effective or not effective if it's not very, you know, to the point I guess" (C/3/118-123).

Another main theme was one of conflict, feeling self-protective/defensive, and concerns around how others perceive Integrative/Eclectic practice. These "others" differed for each therapist, but interestingly, each individual mentioned Evidence-Based Practice (EBP), or Empirically Validated/Supported Treatment (EVT or EST) proponents as those most likely to judge them.

There were consistent references to needing to be I/E on the down low, so as to avoid criticism and negative judgments for being I/E. This was well summed-up by Therapist B, whose quote opened this section. We continued,

> H: And you called it a "dirty word"--eclectic-- how do you--
> B: Well, yeah. Dirty in the sense that I think it has come to connote not knowing what one is doing, of having a haphazard--not really conceptualizing. Sloppy. So, I meant these are free--I'm free-associating here (B/1/155-158).

Therapist B identified what he believed was the flawed underlying assumption in these judgments of Eclectic practice: "Eclectic can sound thoughtless, but that is based on an assumption that thoughtfulness in conceptualization requires thinking in terms of diagnostic categories and ESTs." He feels that negative connotations come from the evidence-based practice movement, and feels there is pressure placed on therapists to be more precise in their descriptions of what they do than is possible. (As an interviewer, I wondered if he was also making a reference to what it was like to participate in this research interview-- that it would be quite understandable if he were perhaps feeling that I was a representative of "researchers" and was placing pressure on him to be more specific about his treatment selection approach than he felt he could be. Unfortunately I did not process this with him during the interview to check my hypothesis.)

Therapist D highlighted a related need to remain secretive, or at least not to publicize, that one is I/E. "I/E therapists need to be under the rug with their approach because of insurance," and also because of concerns that he would be looked down upon. He explained that he had heard from supervisors and colleagues that while they rarely adhere to one exclusive theoretical orientation, they were reluctant to overtly identify as Integrative or eclectic.

> "Well, you asked me about colleagues and others I've talked to over time, and some of them said they had to kind of stay under the radar about their approach, because insurance companies were beginning to make noise about requiring CBT for depression. If you diagnose depression, you much provide CBT. That's scary" (D/1/315-318).

Against this backdrop was part of Therapist D's motivation to participate in this research study.

> "And I'm so glad you're doing this work, because those of us who have these particular views about treatment selection, and the treatment process, and more eclectic-Integrative approach--which we, I, obviously that is my approach--I--you know, I feel that sometimes we're kind of marginalized in a way. Because, we're not practicing, necessarily in an evidence-based way" (D/3/166-171).

He described a feeling of being an outsider, and not being integrated into the professional world as an I/E therapist, and gave the example that Integrative/Eclectic therapists don't fit into the American Psychological Association (APA). He further commented upon what this means for the next generation of therapist currently in training:

> "So, APA is--guess what--at the forefront of evidence-based treatment! So, I don't know where those of us who are eclectic/Integrative are going to fit in, necessarily. There are professional societies for those of us who are eclectic/integrative….So, for a young trainee, my hope is that they're fortunate enough to have a supervisor, someone--not necessarily like me--but someone maybe similar in thinking and open-mindedness about what really goes on in the practice of psychotherapy. It is a--a tremendously inexact science. There is art and science in the practice of psychotherapy" (D/838-851).

Therapist E explained that the way she labeled her own theoretical orientation was in reaction to concerns about the negative ways that I/E therapists are seen. But interestingly, it

seems she was not as concerned about the way clients may see her, but perhaps the way other

therapists would see her approach.

> "I used to describe my approach as 'informed eclectic' because I was afraid that saying
> you were 'eclectic' often communicated to people that you just didn't know what you
> were doing. And that's not the case [*laughs*]. So I think I'm very thoughtful about what
> I'm doing, and I have training in a lot of different areas, so it's informed. So, but I don't
> say 'informed eclectic' to potential clients, because I think it would be confusing"
> (E/1/566-575).

ASSERTION V: Therapists described the concrete, specific things on which they

based treatment selection decisions

V.1. Timing of Interventions

Therapists talked about the "when" of treatment selection. This included both when they

felt their treatment selection process itself starts, when it continues to take place, and how they

consider timing in the use of specific interventions. Therapists reported that what they

understood to be 'treatment selection' begins at the first contact they have with a client, which

could include a continuum of time, from client 'contact' second hand through a referral source, to

the triage phone call, to the waiting room, or to the first session. Therapist A said, "This whole

treatment selection process is from the first minute." Therapist D likewise noted that it begins "in

the first few seconds." Therapists meant that their assessment of the client, and thus their thought

processes about how to best intervene, are what begin at this early stage. Therapist D continued,

"Assessment begins in the waiting room, with how they handle the administrative tasks of

beginning therapy." Therapist C indicated that the treatment selection process for her begins even

earlier, in the triage phase at her agency: the first step is matching a client to a therapist, and the

second step is for the chosen therapist to begin his or her treatment selection process. To do this

client-centered triage, she takes into account the client's needs and preferences, and at the same

time does a less tangible assessment of the client's "energy" to intuit which staff member he or she might work best with. Likewise, Therapist E also stated that her clinical assessment of a client's personality style occurs "from the very beginning."

Experientially, therapists perceived that 'treatment selection' most often takes place "in the moment," or "on the fly" as they are making adjustments moment-to-moment based upon perceptions of clients' immediate needs. This is in contrast to experiencing it, for example, as taking place at some time outside of the therapy session hour. (One hypothesis related to this finding is to wonder if Integrationist trainees would have a similar experience-- perhaps a lot of treatment selection early in one's training would be experienced as taking place in one's supervisor's office, instead of in one's own office, "in the moment" with a client.)

Therapists further noted that timing was once again, like other aspects of treatment selection, inextricably tied to the therapeutic relationship. Therapist B linked his timing of interventions to the overall "pace" of the development of the therapeutic relationship. He indicated that his choice of interventions changes depending upon the client's comfort with sharing sensitive material at different points in the therapy (greater comfort in later stages of therapy than earlier stages). Similarly, Therapist D also said that his treatment planning and conceptualization changes the longer he has been seeing a client. He expressed the importance of being attuned to the client's progress in therapy, and acknowledged that the process of therapy is non-linear. That is, that clients may "make mistakes, feel discouraged, and also make gains" throughout therapy. Because of this, he focuses on when it is important to "provide challenge," and when to "back off." He identified ill-timed interventions, and in particular those that are delivered before a client "is ready for it," as clinical errors.

Therapist E described timing as a central focus of her treatment selection process. This

was in contrast to other therapists, for whom timing was certainly important, but was not talked about as a central, organizing principle of treatment selection for them. Therapist E primarily integrates CBT and psychodynamic approaches. She said that she "always" incorporates CBT at some point, but "the biggest decision is *when* to introduce CBT." For her, the 'when' at times correlated with the stage of therapy. She explained that she tends to use more humanistic, supportive, validating, and normalizing interventions early on, in the service of building rapport. Or, she may immediately employ CBT interventions to reduce the severity of distressing symptoms, or may begin with CBT earlier when a client comes to therapy "asking for it by name." She may further time interventions to coincide with outside events in clients' lives. For example, introducing more interpersonal and psychodynamic elements of examining family patterns and clients' usual reactions, as a client prepared for an upcoming stressful visit with family. One hypothesis for the difference in salience of "timing" for Therapist E compared with other therapists in the study, relates to their respective differences in models of integration. Therapist E draws from fewer primary theories in her integration than did other therapists. She was unique in stating that although she is open to using interventions and techniques from a wide range of theories, she *primarily and consistently* draws from only two: CBT and psychodynamic theory. Perhaps it is the case that for therapists with narrower integration bases, their treatment selection process is more variable based on *when* an intervention will be introduced, versus *what* intervention will be introduced. One thing that therapists were similar on, related to timing, was the importance of early assessment--primarily in the form of "getting to know your client well" which is elaborated in the following categories: "Diagnosis" and "Assessment."

V.2. Diagnosis

In psychotherapy literature, clients' DSM diagnoses are often the first or main variable

discussed when talking about treatment selection. In contrast, for therapists in this study, formal diagnosis played a relatively small role in the ways they talked about treatment selection. However, there was a wide range of viewpoints on diagnosis. One participant actively expressed dissent for the idea that diagnosis is even a useful part of the process. (The following category, on assessment more globally, discusses what therapists *did* see as important for them). Another expressed conflicted attitudes about diagnosis (Therapist A). At the other end of the spectrum, still other participants acknowledged that it was a very important part of the process, although it was not what they spontaneously identified as the largest part.

Therapist A used a quote from Irvin Yalom to illustrate that focusing on formal assessment and diagnosis is important early in therapy, but becomes less so the better the therapist knows that client as a person, over time. She said, "the better you know someone, the harder it is to diagnose them." She also mentioned a general view that although diagnosis can be necessary due to insurance reimbursement requirements, "there's nothing therapeutic about diagnosis." However, in line with flexibility, she also described exceptions to this. She described a case in which the client very much resonated with his diagnosis of social phobia, and found it useful in going forward in treatment. This therapist also described ways she has reconciled the practical need for diagnosis with her doubts about their usefulness. Because she feels that clients have complexities and contradictions that diagnosis cannot accurately capture, she addresses diagnosing in part by being open and transparent with clients about their diagnosis, and exploring their reactions as part of therapy. Thus, she uses diagnosis in the context of a collaborative/empowering interpersonal process intervention. Therapist B expressed a similar view. He noted that his goal is to "meet clients on an individual basis rather than seeing diagnostic categories." Thus, when meeting clients for the first time, he is not focused on giving

a formal diagnosis. However, he did provide the caveat that he does see the usefulness of diagnosis for non-clinical settings, such as in the context of education and training.

Interestingly, Therapist A also used her approach to diagnosis as a barometer for the state of her usual treatment selection process. That is, she realized that her own views about the usefulness of diagnosis (or not) seem to correlate with her assessment of how therapy is going with a client at different points in time. Specifically, she explained that when her confidence in her own process drops, she is more likely to value diagnosis more highly, and refer more to symptom checking, and "technical aspects" of the treatment selection process. In contrast, when she has higher confidence in her conceptualization, and feels a strong therapeutic relationship, she tends to devalue the usefulness of formal diagnosis. This is because in that situation, it does not seem to be adding additional information that would change her approach. Therapist A described her "usual" approach as more of the latter: feeling free to choose interventions in the moment, based upon the interpersonal atmosphere in the room, and her confident conceptualization of the client's concerns. (Although Therapist A was unique among participants in spontaneously describing this relationship to formal assessment and diagnosis, I would be curious to test if therapist comfort/confidence/assessment of the working alliance did tend to correlate more generally with times therapists made the choice to do re-assessment, or with times they returned to working in more structured, training-prescribed ways.)

Therapist D expressed the view of diagnosis as one imprecise tool that can be useful clinically, but that is more practically relevant as a necessity for insurance purposes.

Therapist C did not express a contradiction, or conflict around being flexible and client-centered, while at the same time making a formal diagnosis. She noted that she begins therapy with a standard assessment, and feels it is helpful to come up with a solid diagnosis because it is

a jumping-off-point for treatment. She varies her approach (interventions, theories highlighted) depending upon the presenting concern and symptom assessment. In addition, her Integrative/Eclectic flexibility is present in how she understands and communicates the diagnosis to the client. Thus, the consistent process of diagnosis itself becomes tailored through the therapist's client-centered lens as an intervention choice point that differs from client to client (i.e. she may talk with two clients very differently about a similar diagnosis depending upon other client variables, and the state of the therapeutic relationship). Diagnosis is part of the initial treatment selection process, and then that process in turn tailors the way the therapist would discuss the diagnosis with a client. In addition to the importance of initial diagnosis, Therapist C also stated that assessment for her is on going throughout treatment.

Therapist E expressed that some diagnoses were more immediately and consistently influential on her treatment selection process than others. Eating disorder diagnoses, as well as anxiety disorders, were most likely to lead to choice of using CBT interventions "because it is clearly effective." However, the severity of symptoms, and clients' readiness for change might also influence and modify when or how these CBT interventions were first introduced to the client. Diagnosis was one first indicator of treatment selection, but the final choices were also made in connection with other client variables.

V.3. Early treatment selection: Assessment

This Merged Finding responds to the question, if not diagnosis, then what does guide therapists' thinking and interventions early in therapy? What are therapists doing in terms of their usual initial stance towards a first session with a client? Four of the five therapists mentioned the same important assumption they bring to a first session: that the client's initially stated presenting concern may or may not be the "real" reason they are seeking therapy. Thus,

therapists believed they must maintain an open-minded stance towards all incoming information, while also beginning to respond to the current content that the client brings in. For example, Therapist A expressed that a client's initial presenting concern is often not their main concern (A/1/77-79), and Therapist B expressed that it may not be a client's whole reason for seeking therapy (B/1/425-438). Therapists D and E each indicated that this assumption has implications for the way they work. Therapist D highlighted that his early stance is "open-minded" because "the heart of" issues may not be revealed until the middle or later in the relationship. Similarly, therapist E expressed that when there is an indication of a shift in client concerns, she shifts the focus of treatment interventions as well (E/2/324-337).

Therapists further expressed that they saw the early stages of therapy as a bi-directional assessment: they are assessing the needs of the client while the client is assessing the likelihood that the therapist will be of help. Thus, at the same time they are gathering information for use in treatment selection decisions, they are also of course already selecting/implementing interventions that will strengthen the early therapeutic relationship. Therapist D described the beginning of therapy as "a process--like a dance" involving gathering information, and also building trust in the relationship. He further shared his goal of trying to communicate that he is "there" for the client within the first few moments of a session, and gave examples of providing reassuring words, a handshake, and good eye contact (D/3/308-312). Therapist A talked about building trust in part by not assuming trust from the client. At the same time, she tends to be active, transparent, and collaborative in the first session as a way to make this trust more likely. Similarly, Therapist B, in the first session, focuses on fostering equality and freedom of expression in relationship with therapist, which can be building blocks for trust.

Therapists reported a combination of assessment "styles" and differentiated between

using "formal" (more explicit or pointed questions; questionnaires) and "informal" (more implicit, less directive) assessment strategies. Formal clinical assessment, and indeed, "psychiatric interviewing" was one part of Therapist A's approach to the first session. She described doing this not by using particular forms or standard questions, but by the more heuristic, but still explicit strategy of thinking about "quadrants" of client's lives and presenting problem areas (i.e. mood, cognition, relationships, functioning, etc.) Therapists D and E described how they integrate both formal and informal assessment early in therapy. Therapist D explained that before the first session, he asks clients to complete a formal intake questionnaire, which "Streamlines the technical aspects of intake… [and is important] because the client has a story to tell and wants to get to what is troubling him or her emotionally, relationally, academically, and so forth" (D/1/238-251). Thus, the assessment structure includes the intake questionnaire and using open-ended questions as a way to both understand facts of a client's life history and make interpersonal connections through empathically hearing clients' stories in their own words. Similarly, Therapist E explained that she has a specific approach for working with new clients. The first session includes "an extensive intake," then based on goals discussed in second session, she develops a treatment plan. At the same time, she uses informal assessment (clinical assessment) of a client's personality style from the very beginning to inform therapy (including the content of a treatment plan, and the ways in which she might present a chosen treatment plan to the client).

In addition to describing their assessment styles and stances, therapists discussed what they tend to assess *for* early in therapy. For therapist A, this included two goals: to develop a holistic assessment of the client's functioning, and "to map out where the client has anxiety" (A1/292-293). During first few weeks of therapy, she looks for "common cascades" [themes]

related to client anxiety (A/1/295-261). Therapists D and E listed the clients' current level of insight and their psychological mindedness as factors to assess, and to base treatment decisions on. For example, Therapist E noted that for clients with lower psychological mindedness, she might focus initially on more psychoeducation (versus insight-oriented) interventions. However she also described remaining flexible to re-assessing this client characteristic at different points in therapy. She noted that if psychoeducation is effective, clients might then be more open to, and find more use from pattern-recognition, or insight-based treatments. Therapist E said that she works to assess "symptoms from the client's perspective." She gave the example of working with a client with eating concerns, and being careful to assess what the client herself considered to be "a binge," as opposed to assessing only from the perspective of what might technically be counted as binging behavior. A broad level, Therapist E attends to personality spectrum issues to inform how to intervene with clients. She described paying attention to client personality style, transference, counter-transference, and the state of the current therapeutic alliance to determine techniques of how she might intervene.

Therapist C was the only participant to talk about assessment of client factors that would determine if the client is appropriate for the scope of services offered by her agency or for assignment to work with a particular therapist within the agency.

Having observed that therapists talked about their general assessment styles (formal and informal), and what they find to be important types of information for which to assess, this writer--to be transparent in disclosing my research bias, and preconceived idea of the data at this point--was eager to find evidence of therapists answers to a next 'logical' question: What do therapists do with that assessment information? That is, how does having that information (versus not having it) impact treatment selection? And further, how does having a particular

value of a client variable (versus some other value for that variable) impact choice of interventions? Across interviews, therapists did not generally discuss their practices in ways that directly answered these questions. As described earlier, this is because there were no (or very few) situations when intervention choice was approached in this type of if-then manner or, indeed, even as an explicit "choice." Instead, as an analogy, rather than describing a full view of an elephant, participants collectively pointed out details of its skin texture, the size and shape of tusks, and the agility of its trunk. Therapists shone light on particular aspects of these types of if-then, assessment-to-intervention questions. Below are some examples:

Therapist D noted that treatment selection depends upon the severity of clients' symptoms. Of course, when safety is at risk, this is the primary focus. Further, when the client has severe symptoms, therapy focuses on basic, day-to-day functioning (i.e. eating, hygiene, sleeping), as higher-level therapeutic work would not be useful for someone who is decompensated emotionally, or not caring for their basic needs. Interestingly, Therapist E noted the same variable, "severity" but provided a different interpretation of what the appropriate intervention might be in that case: When clients present in more distress, she indicated that she allows for a longer period of validation, and focuses more on empathy and understanding of a client's struggles versus immediately moving to work on changing them. Likely, the difference is that Therapist D seemed to discussing "severity" in the realm of functional impairment, and Therapist E discussed it in the realm of subjective emotional distress. Finally, Therapist E noted that one category of intervention, validation, is something she uses carefully depending upon her early assessment of the client's personality structure and features. For example, she noted that individual experiencing more Borderline Personality Disorder-like features may tend to respond well to validation, whereas clients expressing Passive-Aggressive or Paranoid Styles may have a

paradoxically negative reaction to validation. Therapist E also observed that the assessment-based predictor and the associated intervention are at times interchangeable. That is, the intervention may act as a tool for assessing clients' personality, just as an assessment of a client's personality may act as a tool for choosing an intervention. In the above example, if she notes that a particular client does not respond well to a validation-based intervention, she may further assess (or re-assess) the client's personality style to understand why their response would make sense.

V.4. Treatment Goals

Three of the five therapists interviewed spoke about the role of treatment goals in their treatment selection process. Therapist C chooses techniques and approaches from multiple areas of her core orientations based upon treatment goals. The techniques fit the goal and are complementary to her conceptualization (2/264-271). In addition to explicit goals discussed with the client, her interventions (based upon case description) also seemed to address the implicit goal of helping clients be more accepting and compassionate towards themselves, and of course the ultimate goal, "for clients not to need treatment anymore." Therapist D similarly described several general goals for therapy, which applied across clients. He said, 'the purpose of therapy is to help people recognize and change dysfunctional patterns, be more interpersonally effective, and to increase positive affect.' He also noted another goal that is in itself a mechanism of change: positive risk-taking. (Through reaching the goal of supporting clients' positive risk taking, they are then in a position to continue gains from different lived experiences and outcomes). He summarized that "therapy is to help people get past their neuroses and become more effective." Both therapists A and D also highlighted the importance of helping clients have realistic goals, such as not expecting that they would have "zero anxiety" or be "100% free of

depression all the time." Therapist E noted that she believed goals can be explicitly interpersonal or psychodynamic, in addition to behavioral, concrete and measurable. In the simplest terms, she indicated that the first goal is always to "decrease distress." To reach these ends, she employs specific treatments early in therapy: CBT to reduce symptoms, and Rogerian/humanistic approaches to instill hope and provide support.

V.5. Treatment selection does not occur in a vacuum: Larger contextual influences on treatment selection:

Two therapists reported that institutions, agencies, systems, and even their own developmental and professional status at different career points have influenced the way they select treatments. Therapist C noted that because she works in an agency which functions from a brief treatment model, she adapts the types of treatments she uses with clients. She notes that the agency at times challenges therapists with expectations of what types treatments are favored. Therapist E noted that some practical constraints impact what she bases treatment selection on. When she worked in a larger hospital setting and had access to formal personality and symptom assessment measures (i.e. MMPI, PAI), she used those and incorporated the results into client conceptualizations and approaches to intervention. But once she was working in private practice, her focus shifted to more "clinical personality assessment" which was based upon interviewing, and experiencing the client in sessions without formal data. Less concretely, she also indicated that as she is farther away from being an "early career psychologist" she feels less outside pressure to "prove yourself as competent and good." Specifically, she does not feel the same pressure to "prove myself" with regards to using particular techniques once she was outside of an academic training setting. For Therapist E, these included more structured CBT interventions, or even use of treatment manuals. For her, the stage of career also interacted with the types of

settings she worked in at different stages. Earlier on, she was working in a public hospital, and only later changed agencies to work at a large group private practice and eventually to her own solo private practice. Thus, she experienced greater levels of autonomy both because she increased in her experience, but also because her career trajectory happened to move from more formal to less formal settings.

ASSERTION VI: Participants' Reflections

V1.1. Meta-process: Making the Implicit Explicit

As part of the final interview, I asked each therapist about his or her experience of participating in the study. In addition, therapists at times spontaneously made process comments, or talked about what it was like to be discussing their treatment selection process. They talked about the challenge and opportunity of trying to describe their approach, in detail, to someone else. One participant suggested/half-joked that "everybody should have to do this every 10 years," and all participants stated that they felt they had learned something in the process of participating in the interviews. Participants reported being surprised by how much they did know about what initially felt "just natural" when they thought about it more; about the degree to which they still did rely on technical training/formal assessment processes in their approaches; and about the degree to which they were more consistent and coherent in their approaches then they initially might have assumed. The detailed evidence of this Merged Finding was reported and discussed in depth in the preceding chapter, which reported results from the Intra-case analyses.

CHAPTER SIX: DISCUSSION

In this chapter, I briefly review the main findings, and then locate them within the context of relevant literatures. In case study research, generating working hypotheses is another key "lesson learned" (VanWynsberghe & Khan, 2007). I offer several such hypotheses for future research based upon results. Finally, I note limitations of this study and discuss implications for the research-practice gap, and for the training of therapists.

Returning to the original research question, based upon the results of this study, how do I/E psychotherapists make treatment selection decisions? Intra-case analyses based upon in-depth interviews of four Integrative/Eclectic therapists--those who completed all research interviews--revealed nuanced accounts of each therapist's approach to treatment selection. A further, Cross-case analysis (which also added data from a fifth participant who completed only one interview) yielded six Assertions (themselves comprised of 18 Merged Findings) about these therapists' treatment selection process. To briefly review these: 1) Treatment selection decisions emerged from the context of therapists' I/E orientations: What this orientation meant to the therapists, why it was chosen, and how it developed. They discussed how, why, and by what names they are Integrative/Eclectic, and how their approaches to treatment developed from 'eclectic' origins. 2) Therapists' treatment selection processes were informed by stable theoretical or philosophical cores, plus ample flexibility. Participants each reported a "core" of humanistic, relational, dynamic, or interpersonal approaches. They named flexibility as a fundamental distinguishing aspect of their approach to treatment selection, and stressed it over stability. 3) The therapeutic relationship was inextricably linked to the treatment selection process, and impacts it in complex and subtle ways. Therapists attributed their "intuitive" or "instinctive" decision-making to an implicit awareness of relational dynamics. 4) Therapists' conflicted disavowal of Empirically

Supported Treatments (ESTs) led them to feel like a silent majority. This "outsider" status

affected their treatment selection processes more earlier in their careers, and less later on, when

their experience or treatment setting allowed more permission to deviate from prescribed

approaches. 5) Therapists did base treatment selection on certain concrete, specific variables:

timing, diagnosis, formal assessment, treatment goals, and larger sociopolitical contexts. But,

these 'matching' type variables were relatively unimportant compared to other influences. 6)

Reflecting on their study participation, therapists noted feeling "surprised" at their abilities to

clearly describe their approach to treatment, and/or at their difficulties with this task. This

seemed to underscore the implicit nature of their decision-making processes.

Comparison, and situating of results within prior research findings

To understand these results in context, I discuss areas of convergence and divergence

with the larger research literature on treatment selection and therapist decision-making. I also

look to research from other traditions (i.e. cognitive psychology and decision-making) to provide

perspective on findings.

Convergence with prior research. Vervaeke and Emmelkamp (1998) advised that

therapists should place more emphasis on assessing clients' interpersonal patterns, expectations,

and preferences. These were, in fact, important factors discussed by the present participants as

influences on their approaches to treatment. Thus, there were some areas of concordance with

prescriptive treatment selection literatures. Similarly, the current study's findings were much in

line with Kessler and Goff (2006) and Kessler et al. (2004), who conducted qualitative research

with expert therapists treating adult survivors of childhood sexual abuse (CSA). That study

addressed the questions of how experts (who were not I/E therapists) determined the treatment

focus (i.e. on current trauma-related symptoms or on the specifics of past trauma) and how they

determined the treatment modality. Throughout, therapists in these studies based their decisions on the larger goal of providing an empowering, safe, and warm relationship with appropriate boundaries. In particular, this finding coincides with the theme that I/E therapists intervene from a place of both stability and flexibility. The present I/E therapists described having a "core" philosophy of treatment, which included both core theories, and core therapeutic stances-- which coincided with similar humanistic, feminist, or relational therapeutic ideals of collaboration with the client as a move towards supporting empowerment; the importance of safety and trust-building; and the idea that the creativity and flexibility of I/E therapy only works because it is ensconced in the appropriate, formal boundaries of the helping relationship.

Also similar to participants' reports of decision-making in the present study, Zuber (2000) found that formal diagnosis did not predict therapists' treatment selection decisions (here, the dichotomous choice between recommending symptom-focused or insight-focused treatments) but subtle cues about how clients conceptualized their own concerns (the amount of space, in millimeters, they took up on a page in writing out their presenting problem) did. Longer client descriptions predicted assignment to insight-oriented treatment, whereas shorter descriptions predicted assignment to symptom-focused treatments.

Further consistent with the present study, O'Donohue, Fisher, Plaud, and Curtis (1990) conducted structured interviews with 25 practicing therapists, and found that a large majority (90%)--perhaps a similarly 'silent majority'--of therapists did not report their treatment selection decisions in terms of explicit rationality (particularly defined here as formal inductive or deductive reasoning). Instead, they responded to questions about why they had chosen certain interventions for a hypothetical case in ways that "begged the question". That is, they either responded by indicating that their conclusion was obvious, or they indicated that they were *not*

aware of the processes that led to their decision. Implicit reasoning was equated with irrational reasoning. The authors themselves expressed "concern" over this finding, but further noted that perhaps therapists did use rational decisional processes, but did not happen to describe them in ways that explicitly met the study's criteria. Of note, differently from the current study, these authors used structured interview protocols, which did not allow for follow-up questions or a process of co-construction to assist therapists in the process of making the implicit explicit.

Divergence with prior research. I/E therapists in the present study infrequently discussed the treatment selection variables that are widely discussed in the psychotherapy literature (i.e. initial diagnosis, matching variables). For example, Vervaeke and Emmelkamp (1998) reviewed psychotherapy literature and made inferences about what may be most important for therapists to consider when making treatment selection decisions. These authors concluded that overall, empirical evidence should be the primary guide for making treatment selection decisions. Interestingly, the present participants were well aware that this was an expectation set by psychology research and practice organizations such as APA. But they felt these guidelines mainly concerned research that espoused manualized treatments, and was not broadly applicable to their own complex clients.

Some key assumptions upon which psychotherapy literatures are based ran contrary to key assumptions held by participants. First, nearly all of the 5 I/E psychotherapists made the observation that many times in their experiences, the first problem presented by the client is not necessarily the "real" problem, or the problem around which they would organize treatment strategies. This has implications for symptom-focused or diagnosis-focused models of treatment selection, as it contradicts the basic tenets that diagnosis happens early and is likely to remain stable throughout the treatment process. Instead, early in therapy, I/E therapists most often used

relationship-building, client-centered or humanistic approaches, and clinical interviewing assessment techniques to determine what the "real" problem may be.

The finding that clients' initial presenting problems are often not seen as the "actual" problem also raises further questions about how I/E therapists navigate the process of obtaining agreement on the goals and tasks of therapy, when these tend to be fluid and may evolve over the course of treatment. Agreement on goals and tasks is described as an important component of the therapeutic alliance (Horvath & Bedi, 2002), and Frank (1991) includes providing a credible account of the problem and method of solving it among the core "non-specific" ingredients of therapy. The present study focused on how therapists described their treatment selection processes to a researcher, but did not fully address the question of how, when, and if I/E therapists provide a rationale of their treatment approach to clients. At the same time, it should also be noted that current participants often did spontaneously report that they described their overall approaches to clients (e.g., see Therapist D's detailed description of a typical opening session). This leads to a related question: how specific does the non-specific factor of providing a rationale for therapy need to be to "qualify" as having provided the necessary common factor? Is there reason to believe that a description of one's composite approach, including specifying that "at times in therapy, we may need to shift focus as some issues become more important, or as we learn more about the problem"…would be less effective in terms of being a bona fide rationale?

The emergence of the "poly-theorism" assumption among I/E practitioners diverges from theories of psychotherapy integration, and in particular from the category of Assimilative Integration (AI). As a reminder to readers, this assumption focused on the commonalities between theories, and how therapists saw theories as readily reinterpretable in one another's terms. It further included therapists' view of theories as having flexible boundaries, which

supported their ability to work from a core nucleus of theories, and also to selectively "borrow" from other approaches in ways that are logically consistent. In AI, case conceptualization and the majority of strategies and techniques are informed by one primary theoretical orientation, while selective techniques from other orientations are judiciously added. Ideally, Assimilative Integrationists use an empirically supported "home" therapy, incorporate empirically supported complementary techniques, and ensure that all components are compatible with the original rationale, therapeutic stance, and philosophical underpinnings of the home treatment (Lampropoulos 2001).

I/E therapists in the present study followed AI in only the broadest strokes. Their approaches fit the pattern of having a type of stable "home base" (captured in the theme of stability/flexibility) into which they integrated additional techniques, but this home base was itself comprised of several theories. The overall picture was one of much greater flexibility and permeability of the "home" theories than AI suggests. Further, there was less concern among participants about "borrowed" techniques being initially compatible with their core theories, than is recommended in literature describing AI. Therapists in the present study were more likely to flexibly reinterpret other techniques in light of their home theories, and have them gain legitimacy for use in that way, than to limit their practice to techniques that, at face value, initially coincided with their home theories. (Recall the anecdote about Therapist E using gestalt therapy techniques with a CBT "base" and finding this quite compatible when she reinterpreted the empty-chair technique as an exposure paradigm.)

Situating themes of Implicit/Explicit decision-making in the literature. One main Assertion was that these I/E therapists experienced their clinical decision-making processes as implicit rather than explicit. Participants had some difficulty explicitly stating how treatment

selection decisions are made. Throughout, in the process of making such attempts they spoke of perceiving their psychotherapy interventions as drawing upon "intuition" or "instinct," and occurring "naturally," "fluidly," and "freely," "in the moment." Participants expressed the view that (their) intuition-based decision-making is unfairly and inaccurately portrayed as being "less scientific" and less effective than explicit decision-making. However, from another perspective-- for example, from that of proponents of evidence-based practice--one could reasonably question the utility and effectiveness of an intuitive or adaptive approach to treatment selection. Here, I briefly explore both viewpoints.

On one hand, intuition has been identified as a component of expertness (Dane & Pratt, 2007). While there has been controversy among researchers around the benefits of rational versus intuitive methods of decision-making, "for certain people under certain conditions, intuition may be as good as, or even superior to, other decision-making approaches" (Dane & Pratt, 2007, p. 41). These authors delineated key properties of intuition, and reviewed the literature for the most influential definitions of this construct. They arrived at a composite definition of intuition as "affectively charged judgments that arise through rapid, non-conscious, and holistic associations" (p.33). Perhaps especially relevant for the process of treatment selection in psychotherapy, is the component of intuitive decision-making characterized by speed. Given that therapists in this study defined treatment selection as an on-going process of moment-to moment choices made in real time, it makes sense that their choices would indeed be made "in a flash" and thus benefit from an implicit basis.

None of the above, however, indicates that intuition is the most *effective* strategy for decision-making. What happens if there is faulty error-detection? How accurate are therapists at judging the effectiveness of their own interventions? These questions lead to consideration of a

second perspective. Proponents of ESTs recognize that practitioners tend to prefer intuitive

decision-making, but note that intuition is often fallible. A recent study indicated that while

experts may be more able than novices to "get away with" use of intuitive decision-making

strategies, both experts and novices performed significantly more effectively at a complex

cognitive task (chess moves) when using explicit, "slow deliberation" than when using intuition

(Moxley, Ericsson, Charness, & Krampe, 2012). Further, because therapy outcomes are at least

partially unobservable, therapists lack objective cues to their own effectiveness. Under the

circumstances of psychotherapy--ambiguous outcome data, difficulty with discerning causes for

even objective outcomes, --individuals are understandably quite capable of self-deception (either

unjustified self-enhancement, or unjustified self-deprecation). Given this, perhaps it is reasonable

to be relatively suspicious of "clinical intuition." Perhaps it is more effective to rely upon an

approach that has been tested, than to rely upon one's own intuition and error-detection abilities

when choosing treatments. Further research could address under which circumstances explicit

versus implicit decision-making is used by therapists, and the benefits and liabilities of these

processes for therapeutic effectiveness under different conditions or clinical situations.

Hypothesis generation

The current study's results (six Assertions and 18 Merged Findings) led to working

hypotheses about the nature of I/E treatment selection and clinical decision-making processes. As

an initial step, hypotheses about the generalizability of the current findings (to both I/E and

single-orientation therapists) could be tested. It is hypothesized that I/E therapists would be more

likely to endorse these treatment selection attitudes and processes than would single-orientation

therapists. Further, because I/E therapists in this study reported "core" theory bases of

Psychodynamic, Interpersonal, Humanistic, and relational approaches, it is predicted that single-

orientation therapists who work from one of these theories would have greater similarity to I/E

therapists' decision-making than would single-orientation therapists who work from another

theory (i.e. CBT). The following set of statements is offered as one example of the types of items

(based on Assertions) that could be posed in Likert form (e.g. Strongly Agree to Strongly

Disagree) to test hypotheses and assess the generalizability of these findings:

> On the whole, different theoretical orientations seem to have more in common than they have differences-- it is mainly the specific terms that change. (Assertion 1)

> Clients and their concerns are too complex [or unique] to benefit from therapy that is based upon only one theoretical orientation. (Assertion 1)

> The first problem a client presents is often *not* what the client and I eventually focus on in treatment. (Assertion 1)

> My approach to practice has become more Integrative/Eclectic over time. E.g. I draw on more theories and approaches at this point in my career than I did earlier on. (Assertion 1)

> Flexibility as a therapist is more important than adhering to a stable plan. (Assertion 2)

> Many of my therapeutic decisions are based upon intuition. (Assertion 3, 6)

> I feel like an "outsider" or "maverick" because I deviate from prescribed therapeutic approaches (such as Empirically Supported Treatments). (Assertion 4)

> Whether or not I strive to base my treatment decisions on empirically supported variables (e.g. diagnosis, formal personality assessment), relational factors are ultimately most important in determining how I intervene. (Assertion 5)

Again, as the aim of this study was not survey development per se, the above are instead offered

for the purpose of illustrating how Assertions could plausibly be re-framed as self-report items.

In addition to broadly testing the generalizability of findings, further specific hypotheses

can be made about the mechanisms by which I/E therapists select treatments. It is hypothesized

that in addition to being a theoretical orientation per se, Integration/Eclecticism can be

conceptualized as a 'developmental track' that a therapist might choose. Given certain

"predisposing" variables related to the therapist's prior educational and personal background, he or she may be more likely to begin on this track. Based on the current study, these would include: beginning one's education/training in a field other than psychology; experiencing training in a wide variety of practice settings; working with individuals facing complex and multi-diagnosis problems; attending a graduate program where there was no one dominant theoretical orientation; and being (or becoming) comfortable with ambiguity. Further, this 'track' would not seen by therapists as having an end point or destination, but is related to continuing to add, adapt, integrate, and "borrow" approaches in an ongoing way to meet clients' perceived needs.

Related to the idea of developmental decision-making, therapists who are farther into their careers (compared to earlier-career therapists) would be expected to describe their treatment selection processes as more implicit or "intuitive" (versus explicit). Alternately, it may be that the relationship between implicit decision-making and therapist development is a U-shaped curve (with time on the X-axis and "implicitness" on the Y-axis). Very early in a therapist's training, he/she might report highly "implicit" decisions about how to intervene. The therapist would, for example, make an intervention with a client but be unable to fully explain his/her motives or explicit thoughts to a supervisor afterwards. Later in training/earlier in a therapist's career, he/she might report much more explicit decision-making than implicit decision-making (at the "bottom" of the U). Finally, late in a therapist's career he/she might again report high levels of implicit decision-making, but for a different reason. At this stage, decision-making may feel more fluid and "intuitive" because after years of practice, there is a form of mental (implicit) statistical averaging across cases, where the therapist has seen differential outcomes with different clients and different interventions. Decisions would be based upon "data" but would not be experienced as the therapist explicitly running through all the possible variables of a given clinical situation

and all the varied interventions to make a "match." This pattern was, for example, demonstrated by Therapist D, who described feeling as if he were "flying by the seat of [his] pants" early on, focused on specific explicit approaches (CBT) later, and finally, fluidly integrating from several theories. The hypothesis was also drawn from the observation that the participants who were most recently out of training (earlier in their careers) such as Therapists C, D and E reported less difficulty with describing their approaches to treatment selection than therapists who were farther in their careers such as Therapists A and B, who made more reference to implicit experiences.

As noted, I/E therapists in this study were "poly-theorists" who viewed different theories as having both permeable boundaries and as being, at their base, more alike than different. (Again, recall Therapist E's interpretation of the empty chair technique as exposure therapy.) Given this, therapists' theoretical orientations (I/E versus single-theory orientations) could be predicted by the degree to which they view different theories as being similar to one another/ interpretable in terms of one another: I/E therapists will view theories as more similar to one another than will therapists with a single-theory orientation (Assertion 1). Along these lines, it would be expected that there is greater likelihood of a therapist incorporating or "borrowing from" approaches outside his/her "core" theoretical orientation(s) if the new approaches were seen as--or presented as-- being able to be interpreted from the perspective of that therapist's current core. This would presumably be the case no matter how divergent the two theories' underlying philosophies or epistemologies are.

For example, imagine that there is psychotherapy research that demonstrates the effectiveness of Approach X for a wide variety of presenting concerns. If the originators or authors of Approach X wish to disseminate its usage among practitioners, they would be more successful at doing so if they were to present the Approach from many different angles and

orientations. For example, describing not only how Approach X is "new" but also how it could be understood from the lenses of Approaches U, V, and W. That is, what terms would the earlier theories use to speak about the mechanisms or interventions used in the new approach? While current I/E therapists appear to already be doing this, it is hypothesized that encouraging this conceptual flexibility may also be causally linked to incorporating new research findings into one's current approach to therapy. If this hypothesis were tested and supported, it could have important implications for the research-practice gap, and for finding middle ground between EST proponents and I/E psychotherapists.

Concrete, specific variables such as diagnosis, formal assessment, timing, setting factors, and explicit treatment goals are expected to have less influence on which interventions are used relative to relational factors. Further, the degree to which the above factors *are* described as important to treatment selection is expected to be negatively correlated with the degree to which the therapist adheres to the view that "the first problem a client presents is not necessarily the most important reason he/she is seeking therapy" as nearly all the current participants did. That is, if therapists believe the presenting problem is more the gateway to building the relationship (and thus reaching the 'real' problem) than it is the starting point for planning interventions, it would follow that variables such as diagnosis and goals (usually assessed early on) would not be seen as 'valid' indicators upon which to base treatment selection decisions.

A final set of hypotheses address the issue of I/E therapists' views of the EST movement. Interestingly, these therapists went beyond stating that they did not strictly adhere to ESTs. They described complex relationships with this movement, including both beliefs and meta-beliefs (beliefs about their beliefs) about the role of empirically validated interventions in their practices. To name (and thus assist in eventually testing) this phenomenon, I hypothesize a construct

referred to as the 'EST Disavowal and Conflict Grid'. In this framework, an I/E therapist could potentially locate him or herself within one of four quadrants created by two intersecting continuums (axes). Continuum one, on the x-axis, would range from Low to High Disavowal of ESTs. Continuum two, on the y-axis, would range from High to Low Conflict (about one's level of Disavowal). Thus, each quadrant would represent a different combination of beliefs (Disavowal level) and meta-beliefs (Conflict level) about EST practice. To illustrate, High Disavowal/Low Conflict I/E therapists (e.g. A and B) could be said to have "Opted-out"; High Disavowal/High Conflict I/E therapists (e.g. D) could be thought of as experiencing a "Maverick" role. Predictions about how and why therapists move--over the course of time and career development--from one quadrant to another could also be made. For example, perhaps learning new information, moving to a new practice setting, or experiencing certain outcomes with clients would be catalysts for movement.

Additional future research directions

Returning to the theme of intuitive versus explicit awareness of decision-making processes, Nuthall (2012) equated intuition with the concept of tacit knowledge, and quoted Polanyi (1966) in an elegantly stated definition: "Tacit knowledge is knowing more than we can tell…it is seen through an individual's actions rather than through specific explanations of what individuals know" (p. 70). Interestingly, two of the five participants in the current study offered similar observations, and suggested one potential method to more clearly see their knowledge through their actions. These participants suggested that future research on I/E psychotherapists' approaches to therapy might use videotaped therapy sessions, and cued recall techniques to stimulate reconstruction of decision processes. The therapists suggested that by doing so, therapists and researchers could work together to make the implicit explicit. Thus, they could

presumably gain more access to processes that had become, or were perceived to be, automatic.

Participants' spontaneous proposal of future research methods was interesting on several levels. It indicated that they believed closer scrutiny of their moment-by-moment behavior in session would help reveal something they were currently unable to fully explain. They presumable knew that "something" was there, but had difficultly accessing that information during the interview. This leads to the following questions: If intuition is the main cognitive process that guides in-vivo intervention decisions, would cued recall in fact be an effective method for learning more about how those decisions are made? Or, is it the case that intuition by definition in a complex process based upon unconscious statistical summation of numerous variables, and thus inherently incompatible with explicit, rational explanation? If the latter is true, then cued recall--or other explicit facilitating means--would perhaps not be getting at the actual implicit decisions. Nonetheless, future studies may find that it offers an effective method for better eliciting and identifying those aspects of clinical decision-making that are conscious, explicit, or rational.

The present study also has implications for research on the training of psychotherapists. All five participants noted that they were never taught treatment selection or psychotherapy integration strategies explicitly. Instead, they learned to use their current approaches gradually over time, through supervised work with their own clients in practicum, internship, and post-doctoral training. They reported acquiring their skills around choosing appropriate treatment approaches and moment-to-moment interventions more implicitly. This highlights a question about the generalizability of this non-didactic means of learning how to be an I/E practitioner. How are training programs currently addressing these issues? What theories or assumptions are these training models based upon in relation to I/E approaches? Moreover, is there evidence that

explicit training, implicit training, or some reasoned combination of both would be more effective than current training as usual?

Assuming that many practitioners have had similar training experiences to the present participants, perhaps we should not yet reach the conclusion that explicitly teaching treatment selection would be preferable to the current, implicit learning process. On one hand, research shows that skills that are learned via implicit practice are more robust against the phenomenon of "choking under pressure" than are skills that were learned via explicitly taught rules (Masters, 1992). Given that clinical work may be anxiety provoking at times, it would be important that decision-making skills stand up under pressure in this context. While this explicit/implicit learning has been tested primarily in the areas of perceptual and motor skills, it is plausible that it would also apply to complex interpersonal skills that combine perception, cognitive processing, emotional and postural attunement, and verbal components. Future research may test under which clinical situations it is most useful to rely upon intuitive, versus explicit, rational decision-making, and under which learning conditions these are best mastered. On the other hand, perhaps it is the case that there are more effective ways of teaching psychotherapy integration than relying upon implicit accrual of these skills throughout one's practice. These would be important questions to pursue to best provide training to future therapists.

Limitations

One important limitation is that the participant recruitment strategy did not focus on I/E therapists with any particular known effectiveness outcomes-- they were not, for example, recruited via techniques designed to find "experts". While the potential benefit of this is that these therapists were located just as a potential client might locate them, and thus be more consistent with Treatment As Usual, their effectiveness is unknown, and thus may limit the

degree to which their strategies may be modeled for training or practice. Further, due to challenges with locating participants via the initial invitation letters, recruitment methods were adjusted during the study to also include word-of-mouth referrals, and contacts within the psychotherapy community known to this writer. This familiarity, even through a third party, has the potential to impact the openness with which participants may have related to the interviewer. It would be understandable for participants to wish to portray themselves and their practice methods in a way they perceived would be socially acceptable in this situation.

There were also limitations around balancing 'thick description' and accurate portrayal of participants' contexts with concerns about participants' confidentiality. While this is always a challenging balance, it may be especially so given the limited geographical area from which participants were recruited. Thus, situating participants in a particular Midwestern city increased the challenges associated with reporting even basic demographic characteristics such as age, race or ethnicity. In particular, because not all participants were of the majority group in this region (Caucasian, European-American) I did not want to subject participants from other racial/ethnic groups to undue risk of confidentiality breaches. In retrospect, one way to address this issue would be to collaborate more closely with participants, and invite them to write their own self-descriptions (and to choose their own pseudonyms) which they would feel comfortable including in the larger project.

However, situating participants in a Midwestern city also has the benefit of bounding cases geographically. That is, it is easier to examine possible geographical cultural idiosyncratic influences on data. That said, a possible limitation is that based upon sampling, the particular Merged Finding of "Conflicted disavowal of ESTs led participants to feel like a silent majority" may not have arisen, or have been as salient in other areas of the country with a less-strong "dust

bowl of empiricism" focus. Anecdotally, when I presented portions of this research to an audience of I/E psychotherapists in the Northeastern United States, several audience members expressed surprise at the words of participants practicing in the Midwest around feeling like "mavericks" for not focusing on ESTs. These audience members informally agreed that they themselves has also disavowed that movement in some ways, but they did not express the same level of concern around being "under the rug" about it. Of course, not all audience members shared their individual perspectives, and the goal and design of the present study was not to attempt generalizability. But it may be that there are differing norms of professional practice geographically.

Further, this study's use of two approaches to data analysis--having two researchers work together on the initial coding, and author-only analyses for the next stages of Intra-case and Cross-case analyses--may be a limitation. While the rationale for this method was to incorporate strengths of both approaches (by having an added element of triangulation for the most fundamental level of data analysis via dual coders, and by having the author, who had first-hand relationships with the participants, complete the additional levels of analyses) it may also be argued that the dual approach simultaneously left the study open to the pitfalls of both approaches. On one hand, not having the additional perspective of a second researcher for the latter analyses removed an aspect of triangulation, which would have strengthened the rigor of the study. On the other hand, not having the author conduct the initial coding alone was also potentially problematic, because the author was the only individual to have met directly with participants and thus to have access to non-verbal contextual cues and other interpersonal data not able to be captured via transcript.

Finally, and perhaps most importantly, the results of this study should be considered

within the intended scope of the project. Given participants' difficulty, at times, with making the implicit explicit, perhaps it is the case that these main findings answer the question of, "How do I/E Practitioners *believe* they make treatment selection decisions" instead of the intended question of how they indeed make such decisions. That is, due to the nature of the construct being investigated, one might argue that the results are based upon rationalizations versus direct knowledge. Second, if the approaches described are implicit, are the results useful in directing others towards using them? Can explicit narratives help teach implicit skills? Even supposing it is the case that the current narratives of I/E practice derived from these interviews are both accurate and useful, it is yet another research question--beyond the scope of the current study-- whether they are effective, and thus desirable for others to emulate.

Implications

Integration researchers suggested three hoped-for benefits of knowing more about therapists' in-practice treatment selection decisions: better understanding complex clinical tasks, addressing the gap between research and practice, and gathering data that could be used to support therapists in training (Eubanks-Carter, Burckell, & Goldfried, 2005). This study contributed to, and has implications for these aims.

Fording the research-practice gap. Stewart and Chambless (2007) reported a "research-practice gap" based upon their study showing that empirical studies were only incidentally used to inform therapists' treatment selection decisions. One Assertion from the present study provided information about how these practicing I/E psychologists viewed the EST movement. On one hand, this is not revelatory. But on the other hand, this study allowed for "hearing" therapists' detailed concerns (and varying degrees of conflict) around how their practice did or did not coincide with perceived expectations for use of ESTs. Having these descriptions from

therapists can inform future research (e.g. by testing hypotheses based upon them). This accomplishes the study's goal of carrying therapists' intervention methods to researchers as a compliment to the more frequent directionality of carrying researcher's interventions to therapists. These results can also have implications for communicating research findings to I/E practitioners. While proponents of ESTs would certainly advise taking into account all of the types of "implicit" information used by I/E therapists (e.g. Ruscio & Holohan, 2006), the reputation of ESTs among clinicians is that they provide for fewer opportunities to be flexible or to use other information sources (i.e. the therapeutic relationship) to adapt them to unique and complex client needs (Stewart and Chambless, 2007). This study's findings suggested that therapists' "poly-theorism" (as discussed within the hypotheses section, above) offered one suggestion for presenting research on ESTs in ways that counteract their current reputation: that is, to note how they may be understood in terms of other theories, and flexibly incorporated into what therapists are already doing.

Training therapists. This study's implications for the training of psychotherapists are not found in this writer's hypotheses, tables, or other summarizations. While these interpretations are important to connect current findings with past and future research, it is the Intra-case and Cross-case analyses themselves that can most usefully connect trainees to I/E practice approaches. As noted in the first chapter, Eubanks-Carter et al. (2005) contend, "students need faculty and supervisors who can model Integrative practice… the most effective way to teach integration is for students to observe the work of Integrative therapists" (p. 515). The current study contributed to this effort by providing access to one such window on I/E practice. In particular, it addressed Goldfried's (2001) suggestion that seeing the road towards integration as well as the destination was important: "Trainees may also benefit by reading about how seasoned therapists themselves

struggled in their early attempts to develop an integrated approach to therapy" (p. 450).

How or why might this particular type of vicarious observation be beneficial for learning-

-and in particular, perhaps uniquely so for training purposes? Flyvbjerg (2006) addressed these

questions in describing the unique properties of case study research:

> "Case studies often contain a substantial element of narrative. Good narratives typically approach the complexities and contradictions of real life... [And] 'Above all,' Nietzsche said about doing science, 'one should not wish to divest existence of its rich ambiguity' (1974, pp. 335, 373)" (p. 237).

Flyvbjerg goes on to explain why this kind of contact with "rich ambiguity" is especially

important for those learning a new and complex skill (such as I/E psychotherapy):

> "Knowledge at the beginner's level consists precisely in the reduced formulas that characterize theories, whereas true expertise is based on intimate experience with thousands of individual cases and on the ability to discriminate between situations, with all their nuances of difference, without distilling them into formulas or standard cases. The problem is analogous to the inability of heuristic, computer-based expert systems to approach the level of virtuoso human experts, even when the systems are compared with the experts who have conceived the rules on which these systems operate. This is because the experts do not use rules but operate on the basis of detailed case experience. This is real expertise. The rules for expert systems are formulated only because the systems require it; rules are characteristic of expert systems but not of real human experts. In the same way, one might say that the rule formulation that takes place when researchers summarize their work into theories is characteristic of the culture of research, of researchers, and of theoretical activity, but such rules are not necessarily part of the studied reality constituted by Bourdieu's (1977) "virtuoso social actors" (pp. 8, 15). Something essential may be lost by this summarizing—namely, the possibility to understand virtuoso social acting that as Bourdieu has shown, cannot be distilled into theoretical formulae—and it is precisely their fear of losing this "something" that makes case researchers cautious about summarizing their studies. Case researchers, thus, tend to be skeptical about erasing phenomenological detail in favor of conceptual closure" (2006, p. 239).

By providing access to I/E therapists' self-described approaches to treatment decisions, trainees

can gain a sense of the "nuances of difference" in this process-- even when these therapists did

not provide explicit heuristics or formulas by which they "do" treatment selection. Or, more

accurately from participants' perspectives in the present study-- how they approach

"interpersonal" or "relationship selection" by flexibly drawing on their core theories and

additional "tool belts" to "meet" clients "in the moment," and "where they're at."

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Appendix A

Treatment Selection Processes of Eclectic and Integrative Psychotherapists
Study Overview and Invitation to Participate

[Date]

Dear Dr ,

We are inviting you to participate in a research study investigating how Eclectic and Integrative clinicians select treatments, techniques, or theoretical approaches for working with their clients. You have been asked to take part in this study because you are a licensed psychologist who may identify your theoretical orientation as Eclectic or Integrative.

I am interviewing participants with the following characteristics and experiences: (1) licensed psychologists (2) currently doing outpatient psychotherapy (3) who identify their theoretical orientation or approach to treatment as "eclectic" or "integrative" and (4) have been doing psychotherapy for at least 5 years.

Those clinicians who give consent to participate in the study will be asked to share their perspectives during three interviews, each lasting 45-60 minutes. Each interview will focus on a different facet of your approach to treatment selection:

- Interview one will focus on participants' own conceptualizations of "treatment selection".
- Interview two will explore participants' treatment selection practices in the context of a de-identified case. No detail whatsoever about the case will be included in the final report—only the thoughts of the participants as they relate to clinical decision-making.
- Interview three will involve the interviewer checking to ensure that she accurately understood participants' meanings, and will include follow-up questions.

I plan to audiotape the interviews in order for me to make an accurate transcription. Before the transcription is analyzed, you will have the opportunity to review it and make changes. To ensure that your transcripts are confidential, all identifying information will be removed. In the final report that is written about the study, no names will be included.

If you would like more information about this study or have an interest in participating, please contact Hayley Shilling (303-884-2243 or hshilling@wisc.edu).

We hope that it will be an opportunity for you to share your perspectives and experiences about clinical decision-making with an interested interviewer. We also feel that your insights can help bridge the gaps between psychotherapy theory and practice, and have training implications for beginning therapists.

Sincerely,

Hayley Shilling, M.A.	William T. Hoyt, Ph.D.	Mary Lee Nelson, Ph.D.
Doctoral Student Researcher	Professor	Professor
Dept. of Counseling Psychology	Dept. of Counseling Psychology	Dept. of Counseling Psychology
University of Wisconsin-Madison	University of Wisconsin-Madison	University of Wisconsin-Madison

Appendix B

UNIVERSITY OF WISCONSIN-MADISON
Research Participant Information and Consent Form

Title of the Study: Processes Used by Eclectic and Integrative Psychotherapists to Make Treatment Selection Decisions
Principal Investigator: Dr. William T. Hoyt (phone: (608) 262-0462) (email: wthoyt@education.wisc.edu)
Co-Investigator: Dr. Mary Lee Nelson (phone: (313) 516-5711) (email: nelsonmary@umsl.edu)
Student Researcher: Hayley Shilling, M.A. (phone: (303) 884-2243) (email: hshilling@wisc.edu)

DESCRIPTION OF THE RESEARCH
You are invited to participate in a research study about the processes psychotherapists use to determine which treatment(s) or approach(es) to use when working with their clients. This study specifically attempts to understand the decision-making processes of clinicians who identify their theoretical orientation or approach to treatment as "eclectic" or "integrative".

You have been asked to participate because you are (1) a licensed psychologist (2) currently working in a community mental health or private practice setting, (3) identify as "eclectic" or "integrative" in your treatment approach, and (4) have been doing psychotherapy for at least 5 years.

The purpose of the research is to explore how Eclectic and Integrative therapists decide which treatment approaches to use with their clients. This study will include licensed psychologists currently working in a community mental health or private practice setting, who identify as "eclectic" or "integrative" in their treatment approach, and have been doing psychotherapy for at least 5 years.

WHAT WILL MY PARTICIPATION INVOLVE?
If you decide to participate in this research you will be asked to engage in a series of three 45-60 minute interviews conducted approximately 2-4 weeks apart. This research will be conduced at a time and place that is convenient to participants. Audiotapes will be made of your participation. Each participant's recordings may be heard by the researchers (Hayley Shilling, Dr. Mary Lee Nelson and Dr. William Hoyt) and that participant only. The tapes will be retained for a minimum of five years. They will be stored in a locked file in a locked building.

All interviews will be conducted and transcribed by the student researcher. During the interviews you will be asked to share your perspectives on three areas related to your practice of treatment selection:
- In the first interview, you will be asked about your conceptualization and approach to "treatment selection" in general.
- In the second interview you will be asked to relate an example of your treatment selection process in the context of a de-identified case. No information about specific clients will be included in the final report—only your thoughts as they relate to clinical decision-making.
- In the third interview, the student researcher will share her perceptions from the first two interviews, and check with you to ensure that she accurately understood your responses and intended meanings. You will also be asked some follow-up questions, and asked to clarify responses from the first two interviews as necessary.

Your participation will last 45-60 minutes per session and will require 3 sessions (requiring 2 ½ to 3 hours in total over the span of approximately 6-8 weeks). After each of the three interviews, you will have an opportunity to review the transcript to ensure that it accurately reflects your perspectives. You may also request the addition or removal of any material from your transcript.

ARE THERE ANY RISKS TO ME?
There is the possibility that participants may be uncomfortable with having their direct quotations transcribed and included in the final report. To reduce this risk of discomfort, you will have the opportunity to review the final draft

of the report so that you can change or request removal of any content, including your quotations. After each of the three interviews, you will also be given a copy of your transcript. This way, you may make changes or request removal of information or quotations during the interview stage as well as in the draft of the final report.

ARE THERE ANY BENEFITS TO ME?
No specific benefits are anticipated. However, we hope that it will be an opportunity that allows you to share your perceptions and experiences of treatment selection processes with an interested interviewer. We also feel that your insights will contribute to the field of counseling psychology and will have training implications for counseling psychology programs.

HOW WILL MY CONFIDENTIALITY BE PROTECTED?
While there will probably be publications as a result of this study, all identifying information will be removed from your transcript. In the final report that is written about the study, participants' names will be replaced by code names. No detail whatsoever about the deidentified case discussed will be included in the final report. You will be asked to review each of your transcripts and the final report for comments and requests for exclusion of information. If you participate in this study, we would like to be able to quote you directly without using your name. You will also have the opportunity to review the final draft of the report so that you can change or request removal of any of the content, including your quotations.

WHOM SHOULD I CONTACT IF I HAVE QUESTIONS?
You may ask any questions about the research at any time. If you have questions about the research after you leave today you should contact the Principal Investigator Dr. William Hoyt at (608) 262-0462 or wthoyt@education.wisc.edu. You may also contact the Co-Investigator, Dr. Mary Lee Nelson at (314) 516-5711 or nelsonmary@umsl.edu, or the student researcher, Hayley Shilling, M.A. at (303) 884-2243 or hshilling@wisc.edu. If you are not satisfied with the response of the research team, have more questions, or want to talk with someone about your rights as a research participant, you should contact the Education Research and Social & Behavioral Science IRB Office at 608-263-2320.

Your participation is completely voluntary. You may withdraw at any time during the interview and transcription stages of the research process without penalty.

Your signature indicates that you have read this consent form, had an opportunity to ask any questions about your participation in this research and voluntarily consent to participate. You will receive a copy of this form for your records.

Name of Participant (please print):_____

_____ _____
Signature   Date

Appendix C

Interview 1: Contextual Questions

– Gender, age, cultural background/race/ethnicity?

– Educational and training background: degree/type of program?

– Number of years in practice/which kinds of settings/populations served?

– Clinical areas of interest/focus?

– Approximate number of clients seen/hours per week in practice?

1. What is your theoretical orientation? Please describe. How did you come to identify with this orientation?

2. How do you think about "treatment selection"-- what does this mean to you related to your practice?

3. How do you usually go about selecting treatment/treatment plan [or participant's own words/conceptualization] for a client?

4. What factors go into the treatment-selection decision-making process?

5. What do you use to help you make decisions about what treatment to use, if anything?

6. For you, what aspects of therapy/treatment selection vary the least? the most?

7. Has your treatment selection process changed or evolved over the course of your career? How?

8. How did you come to use the process you use now?

9. What does your usual "time line" of treatment selection look like? (i.e. before first session, during first session, after first session, further into treatment, moment by moment in sessions?)

10. What is the client's role in treatment selection?

Interview 2: Details of the treatment selection process for a single psychotherapy case

1. What led you to choose this particular case?

2. What approach(es) to treatment did you eventually use?

3. Beginning with your first awareness of this client (referral, intake, first session, etc.) walk me through your treatment selection process.

4. When did it start? With this client, when was the first time you thought about/considered treatment selection issues?

5. What did you initially think?

6. Describe the first session. What role did this first session play in your decisions? Were any aspects especially important for your eventual decision?

7. What was this client's role in selecting an approach to treatment?

8. When did you know you had "selected" a treatment? Or, was it not like that?

9. With this client, how did you know if you were "on track" with the treatment approach you selected?

10. What were the "mile-stones" or benchmarks during this case with regards to treatment selection? (If any). What did you do when you reached them?

11. Did you change course at any point in this therapy? How?

12. How was your process of treatment selection similar/different compared with what you "usually" do?

13. How did the outcome of the case relate (or not) to your treatment selection choices?

Interview 3: Meanings, reflections and follow-up

1. Given what you described about your theoretical orientation, view of treatment selection, and your case example, how do you understand your approach to Integration/Eclecticism and treatment selection?

2. What does "treatment selection" mean for you in your daily practice? This project has focused on this aspect of practice, but where would you couch treatment selection among other therapeutic issues?

3. What have the interviews been like for you?

4. Is there anything else that I did not ask about?

5. [Time for either of us to ask additional questions, clarify responses from previous interviews, or return to any "loose ends".]

Appendix D

Case Findings and initial codes, by Case

Case Findings are in bold type and are notated by a letter and a number. The letter (A-E) indicates from which of the five participants' transcripts the Finding was derived. The number, here, is simply a place holder distinguishing the different Findings. Numbering starts over for each of the five participants.

Initial codes are listed below their associated Case finding, using the notation of a letter/number/number. As with Case Findings, the letter (A-E) indicates from which of the five participants' transcripts the code was derived. The first number indicates from which of the three interviews it was derived (first, second, or third), and the final number indicates from which specific transcript line(s) the code was derived.

A1 Treatment selection as Relationship Selection process: interpersonal stance, interpersonal behavior choices
A/2/25-27 Related to flow with client not conscious choices about technique
A/1/466-470 Rarely, client and therapist are not viable match
A/1/213-215 Deeper connections with clients will lead to an intuitive understanding of the therapeutic process
A/1/361-161 Choosing what to focus on is more clear with knowledge of client's narrative
1/309-318 Treatment selection includes moment-to-moment decisions (i.e. "do I follow up on that emotion or do I let you sit with it…?")
A/1/365-372 Choice of what to follow up on guided by: Knowledge of overall narrative; what is client's emotion
A/1/447 Matching goes on between people (therapist and client) more so than between client and a chosen theoretical approach
A/1/260-265 Makes conscious decisions around confrontation vs. support; thought shifting vs. attending to affect
A/1/358-360 Steers interactions in therapy by choosing which aspects of client's material to pay attention to
A/1/210-212 Therapist uses where to go next as barometer of relationship
A/1/641-645 Varies amount of disclosure for different clients' needs: if they will find it useful
A/3/157-159 Associates "treatment selection" with "positioning" self as a therapist
A/3/95-100 Treatment selection is not about the technical interventions for specific diagnosis
A/3/32-33 Moves between "close" and "distant" stances at different times in the therapy hour
A/3/94 Treatment selection is about where to position yourself in relation to the patient (*interpersonal)
A/1/647-673 Other variables/clinical decisions may include interpersonal issues such as: amount of physical touch, whether to allow after-hours phone contact, level of formality, rigidity of boundaries

A2 Importance of therapeutic relationship

A/3/402-404 You can't let your conceptualizations carry everything, needs to be in addition to relationship

A/3/125-129 More effective when knows client well over long time period, because can begin to predict their tendencies

A/2/245-250 Compassion for client's discomfort in first session of therapy (*relationship building)

A/3/129-130 No shortcut to getting to know the client well

A/2/p.8 and throughout: [meta: from coders: Took a long time to get to the story, lots of qualifying…maybe indicates great respect for client, great care over client confidentiality-- related to valuing of relationship]

A/2/50-53 Therapeutic relationships that end are the ones that never fully developed

A/2/40-53 Therapeutic relationships never end

A/1/408-418 Therapist authenticity and unique directness of therapy relationship are agents of change

A/2/all p.5 Focuses on clinician's value of relationship within psychotherapy

A/2/118-121 Relationship is active ingredient in psychotherapy

A/1/196-202 Client-therapist relationship is important part of therapy

A/1/236-237 Power and effectiveness of treatment is the relationship, human condition

A/2/704-707 Shift in treatment seemed to reflect a shift in client-therapist relationship. Stronger relationship got, things shifted and began to click more in therapy (*Consistent with relational approach)

A3 Therapist has a core approach to treatment, and additional interventions that are used with it

A/2/709-764 Details of how case fits in with typical approaches/what it demonstrates

A/2/289-295 Initial questions/hypotheses about presenting problem: Wonders about impact of possible trauma/abuse history; client sexuality issues; family of origin issues; developmental context of the problem (*consistent with core of psychodynamic, developmental, relational)

A/2/326-329 Notes counterintuitive pattern that client was v. comfortable discussion "sensitive" subjects in there, v. uncomfortable discussing mundane topics in daily life (*Consistent with psychodynamic)

A/2/320-322 Believes there's no such thing as a [totally] happy childhood/family (*consistent with psychodynamic)

A/2/319-320 Trying "anything I can think of" to "get behind the iron curtain" of memories from childhood (*consistent with psychodynamic)

A/2/312-317 When client reports "not knowing" or "not remembering" certain past details about life, the intervention is to "engage client around the not-knowing" itself

A/2/360-361 Notices escape pattern client uses to avoid anxious situations at work and at home (*consistent with relational/psychodynamic)

A/2/419-443 Uses ability to connect, and awareness of how she's responding to client to question other clinical interpretations of the presenting problems and concerns (own anxieties/internal cues used to make decisions) (*Consistent with orientation, very relational way to use energy in the room therapeutically)

A/2/p.1&p.2 Addresses consistency with importance of relationship for clinician, and core of relational orientation

A/2/617-621 Importance of trusting the process and therapeutic relationship (*part of core psychodynamic/eclectic orientation)
A/1/153-155 Past and present are parallel tracks you refer back to in therapy
A/1/144-146 Having historical and current perspectives on problem are both equally important
A/1/139-146 Approaches clients' problems from 2 sides: How problem developed historically; how current life is affected
A/1/126-127 Strong developmental perspective in work
A/1/111-115 Approach has become more existential over time
A/1/186-190 Considers and uses the technique of working with transference
A/1/536-540 Core theory of orientation (*using core)
A/1/536-543 Consistent: clients engage in repetitive relationship patterns related to early relationships
A/1/513-526 Consistent across cases in existential issues related to human condition (*using core)
A/2/371-384 Two-part approach with interventions with social phobia: 1) education and behavioral strategies for anxiety management; distress tolerance 2) Relationship/interpersonal strategies using therapy relationship to experiment with new skills

A4 Intentionality, knowing own motivations behind interventions
A/1/407-411 Clinical intuition is most powerful agent of change
A/3/299-303 Novice therapists should wait to intervene until they know what their motivation is
A/3/p.6 Intentionality in the moment to moment aspects of therapy is also balanced with the intentionality that she calls ex post facto. Two kinds of intentionality going on.

A5 View/role of diagnosis in treatment selection
A/3/57-59 When therapist confidence in own process drops, more likely to refer back to diagnosis, symptom checking, and more technical aspects of treatment selection thought process
A/2/344-346 Client resonated with diagnosis given (*recognition of client's view of diagnosis)
A/2/335-338 Gave client diagnosis to comply with insurance requirements
A/2/340-342 Collaborative/empowering clients via showing them diagnosis and discussing why/client's reactions
A/2/348-353 Flexibility and creativity with diagnosis due to insurance limitations
A/2/297 By third session, made a diagnosis (social phobia)
A/3/15-16 The better you know someone, the harder it is to diagnose them
A/2/104-106 Agrees with Yalom quote that "there's nothing therapeutic about diagnosis"
A/3/20-22 Aware that clients have complexities and contradictions and diagnostic hard to capture individual experience
A/2/371-376 First step of assessment is understanding, accepting, and knowing diagnoses, second step is coming up with simple strategies of diagnosis
A/2/348-358 Changes diagnosis to panic disorder because: insurance, panic symptoms becoming more prominent at client's job
A/2/106-110 Uses Yalom quote to illustrate that focusing on formal assessment and diagnosis is important early on in therapy, but is used less as gets to know client better

A6 Treatment selection is fluid/flexible (and the boundaries/structure of therapy allow for

this)
A/3/224-228 Components of therapy are ambiguous, hard to differentiate or label, but the overall structure of therapy is well-defined
A/2/112-113 Structure from training provides freedom to be more fluid, so you can abandon structure (*training's specific impact on current practice)
A/2/312-317 Takes time with client, moves at client's pace (flexibility)
A/2/410-417 Response to client worries about un-recalled abuse history was to downplay importance of need to remember everything (*flexible with interventions)
A/2/554-563 Flexibility with treatment options and areas to explore--dreams
A/2/73-75 Defining treatment selection process feels like trying to put a taxonomy on something fluid
A/3/74-75 Treatment selection is fluid
A/3/115-116 Treatment selection is fluid and individualized
A/3/307-310 Not being rigid; flexibility

A7 Role of theory in treatment selection; how conscious use of theory interacts with counter transference, therapist's state of mind
A/2/131-137 Technical, theoretical notes not directly useful to client; only to therapist
A/1/385-390 Believes theories help clinicians have models to understand what's going on for the client but all theories are useful. Theories help clinicians think rigorously.
A/2/420-428 Relying on theory when stuck with client
A/1/162-169 Will only think theoretically with clients when working with difficult clients, or when less comfortable
A/1/219-229 Example of difficulty connecting with a client, and a theory-based conceptualization
A/1/213-215 Thinking about theory indicates to therapist that she is not having an intuitive connection with client
A/1/478-487; 495-501 Mentions importance of therapist comfort level and its impact on therapy

A8 Change, and what produces it
A/1/196-207 Uses interpersonal process and observation of non-verbals as avenues for change
A/1/370 Feelings are more fertile ground for change than thoughts

A9 Treatment selection as related to early therapy/assessment process [timeline?]
A/1/289-292 Less active; asks more questions at beginning of therapy
A/1/309 "This whole treatment selection process is from the first minute"
A/2/257-263 Building trust, transparency; collaborative style; not expecting or assuming full client trust initially
A/2/247-255 Approach to first session is active, collecting information & engaging client
A/2/330-331 Holistic assessment of current outside functioning as well as exploration of past-current jobs
A/2/67-80 Got rigorous training in psychiatric interviewing on internship at inpatient site. Still does essentially psychiatric interviews at first session.
A/2/p. 12 The clinician's process of assessment--everything has care and respect, but not clear on factors involved or decision tree

A/2/82-87 Global assessment of client at intake helps therapist choose/helps to direct focus of treatment

A/1/80-81 Clients enter therapy not knowing exactly what is wrong diagnostically, so therapist starts with exploration

A/1/77-79 A client's initial presenting concern is often not their main concern

A/1/295-261 During first few weeks of therapy, looks for "common cascades" [themes] related to client anxiety

A/1/292-293 Early in treatment, therapist's goal is to map out where client has anxiety

A/1/91-94 Thinks about "quadrants" of presenting problem areas, i.e. mood, thinking, relationships, etc.

A10 Identity as an I/E therapist; impact on scope of practice (generalists)
A/1/66-68 Intentional generalist, enjoys range of client presenting problems
A/1/84-86 Not having a specialization keeps her "sharper"
A/1/389-390 Like a "polytheist" believes all ideas offered by theories have truth ("polytheorist")
A/1/116 Doesn't identify with a school of thinking anymore
A/1/392-396 Feels liberated with Integrativeprinciple that all components matter (i.e. thinking, behavior, choices, dreams, relationships, family)

A11 Balance: dialectics of different treatment aspects in treatment selection
A/3/45 Balance of technical and relational during treatment selection depends on comfort or anxiety of therapist
A/3/20-26 Affect vs. cognitive; abstract vs. concrete
A/3/204-206 Therapy is a dual process of cognitive and relational; Therapy is guided by a sensory process and not a cognitive one
A/3/198-200 Difficult to discuss the different between intuition and technical/scientific aspects of doing therapy
A/2/89-95 Balance of intuition/relationship and technical clinically-focused diagnostic thinking
A/3/28-30 Hard to balance the closeness and empathic with distance and objective (*participant observer?)

A12 How treatment selection works related to impasses in therapy for I/E therapist
Note:***Positives of Eclectic approach is having a back-up plan if nothing is working. At impasse, trigger to pay with more tools, to be more flexible
A/2/604-608 Flexibility with trying new techniques based on non-movement with client (coder note: *seems to be driven by clinician's anxiety, not client-focused, feels haphazard)
A/2/? Explores treatment options with movement (observable) is not occurring in therapy

A13 Facts about Participant A
A/1/14 Ph.D. Counseling Psych 1995
A/2/70 Training/background in inpatient setting
A/1/61-64 15 Years of doing therapy at doctoral level
A/1/69-71 Sees adolescents, adults, older adults, couples
A/1/16-19 Experience in the humanities in BA and MA
A/1/70-71 No specialization in clinical concerns

A/1/97 25 hours therapy per week

A14 Views about length of treatment
A/2/60-63 Believes in a spiral model of clients returning to similar issues over and over at different levels through life
A/2/38-42 Rarely ends therapy. Clients often return for booster sessions.
A/1/265-267 Feels more free and effective with clients with a longer-standing relationship
A/3/137 Limited sessions with clients can lead to symptom reduction sessions and not therapy
A/3/137-138 Perceives self as outlier due to longer treatment time than evidenced-based therapy suggests
A/3/147-150 18-24 months of consistent therapy bring clients to a different base level (coders note:*had strong reaction to this)

A15 Process/Meta aspects: What like to participate in IVs, reflections from coders
A/3/447-452 It's worthwhile to try to articulate ambiguous concepts of how to do therapy
A/2/172-217 Therapist's concerns about client anonymity discussed with interviewer before case example
A/2/63-65 In reading treatment notes for the example case, was struck by how technical they are
A/3/219-220 Articulating own process in therapy is difficult because part of the process itself [of therapy] is non-verbal (e.g. visual, empathic)
3/91-92 In interview, is self-conscious of "how this will all sound" (*anxiety around sharing work)
A/2/21-23 Process of articulating process used in therapy is useful
A/2/168-169 Interview process led therapist to reinvest in idea that both technique and relationship are necessary/important
A/1/171-177 (coders comment: *name dropping in IV: maybe issue of insecurity re: being eclectic??)
A/2/142-148 (coders comment: *sounds very academic--part of identity, or impression management?)
A/2/93-94; 126-128 Felt surprised by own realization that approach includes technical/diagnostic-based elements (*self-awareness of clinical decision-making process)
A/3/465-484 Compared interview process and miscommunications to therapy process and parallel of potential miscommunication
A/3/436-441 Therapists can deconstruct what they are doing with a client via video, after the fact, but cannot (and should not) be explicitly making those decisions in the moment

A16 Mystery/"intuition" in treatment selection process
A/1/258-261 Moment to moment decisions about interventions are not cognitively-driven, but intuitive
A/1/260-265 Therapeutic process is intuitive, empathy-driven, relationship-driven
A/1/320-321 Over the years, learning to trust clinical instincts
A/1/348-351 Sometimes feels as if she has a mysterious, intuitive sense of what the client is talking about
A/1/320-321 Trusts own thoughts about what is relevant to the therapy

A17 Case specifics

A18 Resistance to talking about treatment selection (??)
A/3/65-66 Unsure what treatment selection is
(line numbers?) Treatment selection is something that can't be explained to outsiders, and that describing the treatment selection process doesn't help the process of therapy- futile

A19 Treatment selection as Intervention, Technique, Technical Approach Selection
A/1/448-455 Some approaches that therapist uses are more comfortable for some clients than others, so does consider match in that sense (i.e. with mindfulness interventions)

A20 Early training and impact of evolution of current I/E approach; Developmental change
over time
A/1/29-30 Lots of training in learning particular theoretical orientations
A/1/381 Farther from training, better get at doing therapy
A/1/429-435 Over time, increased confidence in not following exact theories, and saw as sign of "integration vs. ignorance"
A/1/37-40 Learning related to treatment selection came more in practicum, internship, experience with clients
A/3/536-544 Speculates that earlier-career therapists might "still have a [one] theoretical orientation", but more seasoned therapists may not
A/1/102 Theoretical orientation first formed with psychodynamic ideas
A/1/53-58 Internship setting was where connecting theory to practice happened
A/1/53-54 Went to different faculty in dept. for different theoretical perspectives
A/1/48-49 Originally dynamically oriented, then self-psychology
A/1/50-51 Graduate dept. did not have one unified theoretical culture
A/1/42 Learning about treatment selection is difficult in the abstract
A/1/125-126 Still draws from theoretical ideas was exposed to in training

A21 Role of knowing/keeping up with research in treatment selection
A/2/139-167 Mentions research indicating "real" relationship is more important to clients that to clinicians
A/1/397-405 Aware of process research indicating that effectiveness most correlates with client, therapist, and relationship values (coder note* legitimizing what she does/impression management?...)
A/1/407-408 Knowledge of research on psychotherapy effectiveness increases confidence/freedom as therapist

A22 Treatment selection and the medical model
A/1/231-233 Medical approach doesn't fit psychotherapy; there isn't anything therapeutic about diagnosis
A/1/235 Field of psychology gets "caught up" in having a medical identity (*maybe related to legitimacy of eclectic)
A/1/238-239 Sees medical model as a way of separating from clients

A/2/54-55 Mental illness is not illness, it's life, and there is no cure
A/3/112-114 Goals in therapy are fluid, harder to define than in medicine
A/3/165-169 "Treatment selection" is inaccurate because therapy is not medical
A/3/395-396 Therapy is not a medical procedure, the most powerful tool is how you use yourself as the therapist

A [uncategorized]
A/2/562-565 Collaboration/consulting with peers
A/1/254-258 Comfort and client movement and intuitiveness go together (causality unclear?)
A/3/387-389 Therapy is not advice giving
A/1/549-550 Differences across cases: People are v. different in how they deal with relationship patterns and existential issues
A/3/411-418 In-vivo observation of therapists doing therapy is a useful, but under-used training tool
A/2/60-65 Movement is important for successful therapy, but movement is dependent on the person and their circumstances/where they are in their life
A/2/419-420 Client progress operationalized as, "becoming more emotionally expressive" remaining in treatment, but notes still no job
A/3/224-228 Is it that since the goals of what you're working on is clear, that you can observe and measure?

B1 Parallels of "eclectic"/diverse training and pre-training education & current I/E theoretical orientation [evolution/dev. of I/E orientation]
B/1/41-42 Psychology fit career criteria of being engaging, enjoyable, and matching abilities
B/1/71-75 Diverse training background
B/1/16-17 Took a circuitous path to filed of psychology
B/1/52-58 Perceived having many career interests, and difficult to narrow them down
B/1/23-38 Broad graduate-level educational background in the humanities before studied psych

B2 Being I/E and being a generalist
B/1/82-87 Being a generalist because specializing limits flexibility, and makes you assume more narrowly what you're looking at
B/1/84 Generalist

B3 Description of won theoretical orientation from Pp [core?]
-How parts work/fit together
-How evolved over time
-What approaches/parts make it up; what it entails
1/135-136 Explaining multiple theoretical influences
1/576-577 One important principle (from Jung) is the dialectic
1/569-576 Example of common theme therapist has seen in clients: dichotomous thinking
1/335-359 Relational/transference
1/553-555 A main intervention: exploring alternatives to the client's current themes and patterns
1/545-547 Free expression early in therapy allows themes to emerge from the client
1/p.17; 592-594; 586-587 A lot of relational aspects of this treatment; also brining in cognitive

interventions
1/549-550 Therapist's role is to identify the themes client returns to again and again
1/551-557 Identifying themes in client's stuck points could be cognitive or emotional
1/147-154 Although CBT techniques don't "come naturally," is open to using if helpful to a client
1/139 "Existential over-lay" [thinks of theoretical orientation as having overlapping layers??]
1/135-142 Lists components of theoretical orientation: client-centered, psychoanalytic, and existential
1/135 Theoretical orientation has evolved over time

B4 Overall view of therapy
1/486 "It's complicated."
1/223-226 Therapy is going on all the time--friendships and outside things are therapeutic. Not just confined to the formal structure of therapy.
1/171-172 Therapy is an art more than a science.

B5 Timing of interventions as important treatment selection component
1/201 Time-pacing client-driven, respect for client-timing, importance of what the client doesn't share
1/196-197 Timing is important to therapy, timing of intervention and pace of therapy

B6 Initial session/Assessment
1/425-438 Sometimes the initially-mentioned presenting concern is the client's whole reason for seeking therapy, and sometimes not
1/438-440 There are always surprises in people's stories, so therapists should avoid assumptions/constructing a story before it unfolds
1/233-234 No pre-set approach to the first session
1/235-237 Asking, "why here now" is often a starting point
1/408-418 First session focuses on fostering equality and freedom of expression in relationship with therapist

B7 View/role of diagnosis in treatment selection
1/110-111 When meeting clients first time, not focused on giving a diagnosis
1/86-87 Meets clients on individual basis rather than seeing diagnostic categories
1/105-107 Flexibility with understanding client concerns and not abusing diagnostic label--respectful
1/117-118 Sees usefulness of diagnoses in education and broader contexts

B8 Importance of being individualized and client-driven
1/407 Starts where client starts
1/93-94 Meets clients where they are
1/389-397 Client-driven, meeting them where they are at
1/184-189; 191-194 Client-driven, specifically tailored to clients' needs, no template for doing therapy
1/160-162 Client-driven in which threads to accentuate

1/107-122 People are unique so need client-driven work
1/p.14 Seems to strongly suggest flexibility and client-driven approach
1/147-154 Can meet client where they're at, even with not varying theory/orientation
1/103 Individualized and client-driven

B9 The structure of therapy comes from client themes
1/539 The structure of therapy emerges from the themes in the client's material
1/545-555 Client-driven therapy--themes that emerge, no pre-determined structure from therapist
1/604-607 Client's themes are the unifying structure (is this what is used for conceptualization selection?)

B10 Importance of therapeutic relationship
1/239-240 Building trust and rapport is not technique-based
1/316-323 Therapist is attuned to therapeutic climate or atmosphere
1/341-342 Creating a therapeutic environment where client can express themselves is prerequisite for treatment
1/246-251 Building relationship is pre-requisite before any technique will be effective
1/242-246 Relationship is fundamental to work with clients, at core
1/242-246 Trust is a gift (transparency, respect, no assumptions that they will open up…trust must be earned)
1/242-246 Building a relationship includes not taking trust for granted
1/305-310 Foundation of therapy is whether there are grounds for a common understanding
1/169-173 The relationship is most important in therapy--more than theoretical approach
1/408-418 Not directive, collaborative, sharing of power
1/502-504; 510-511 Self-disclosure; transparency important

B11 Treatment selection as Relationship Selection: "An interpersonal selection process" [vs. matching client to "treatments" or "interventions"]
1/370-373 Expresses what he doesn't do--doesn't explicitly match client to approach
1/367-371 Notes that his response to interviewer's question about treatment selection did not mention treatments
1/303-330 Treatment selection starts with the client--"an interpersonal selection process"

B12 View/role of theory in treatment selection
1/349-353 Important for therapist to recognize own interpersonal impact on relationship and not "hide behind" theoretical models
1/596-602 Theoretical orientations complement each other and are not mutually exclusive

B13 Facts about Participant B
1/130 30-35 hours psychotherapy per week
1/92-93 Experience with trauma survivors
1/66-69 Serves population with diverse SES, race, age
1/64 Practiced psychotherapy 25 years

B14 Perceptions of others' views of "I/E" and own perceptions of I/E

1/135 Term Eclectic is a dirty word. Perceives that for others, Eclectic has a negative connotation
1/156-158 Eclectic approaches are associated with not conceptualizing or not knowing what you're doing as a clinician
1/160-162 Eclectic approach is a synthesis of other approaches that is tailored for a particular client and his/her set of concerns (flexibility, client-driven approach)
1/659-660 Regarding evidence-based practice, feels there is pressure put on therapists from outside sources to be more precise [with measurement of outcomes/interventions] than is possible
1/135-136; 146 Therapeutic orientation is Eclectic
1/160 In contrast to negative connotations, sees Eclectic theoretical orientation as a synthesis and weaving together different threads
1/373-380 Eclectic can sound thoughtless, but that is based on an assumption that thoughtfulness in conceptualization requires thinking in terms of diagnostic categories of approach to therapy

B15 Meta: Process Reactions to participation in IVs
1/177 Not apt to "conceptualize own conceptualization process"

B16 Change and what creates it in psychotherapy
1/215-229 An important part of therapy is hearing self in a different way, as reflected by the therapist. (*Mechanism of how relationship can lead to change)

B17 Intuition, spontaneity, aspects of treatment selection other than conscious, moment-to-moment decision-making process: 1/179 Experiences doing therapy as spontaneous

Grounded and Stable AND Flexible (C1 & C2)
1/232 I have a plan but also make changes on the fly to choose interventions/be flexible
1/70-77 Overarching theoretical foundation that's one of two orientations (combo of stability and flexibility)
C1 Fluidity and flexibility are hallmarks of Integrative approach [client is the 'constant' therapist moves to meet them, then help them move]
2/249-251 Flexibility to shifting therapeutic focus when needed
3/130-137 Believes there is a lot of overlap with theories, wonders how other clinicians work with just one theory (*flexibility, not understanding how others could be rigid)
1/361-365, 317 Experimenting with different approaches to see what works
1/358-359 Creativity with intervention
1/419, 438-443, 456-469 Flexibility with treatment
1/511-521 Culturally sanctioned or informed flexibility with clients (freedom because of international piece)
2/583-587 Flexibility with regard to new challenges that arise for client
3/230 No specific rules for termination (*flexibility)
C2 Has a core theory into which she integrates everything else [goes against Integrative stereotypes]
2/277-278 Interpersonal or Integrative orientation is seen as the basis of Integrative orientation
2/(**shows full understanding of client's story, deep understanding of client's specific family, culture, goals --maybe consistent with narrative approach, or a general competency thing??)

1/88 "It's just kind of pillars to the treatment"

1/418-419, 421-423, 427-436 Little variation in conceptualization

1/670-671 Importance of being grounded in something, not flying by seat of pants

2/417-418 Story in treatment just like in clients' lives. Therapist checking in to see if technique and the event match the affect (*consistent with narrative orientation)

2/57-58 Overall umbrella for treatment was multicultural understanding

3/167-172 Termination differs depending upon the client

2/50-61 Core theory is foundation of treatment (*consistent)

3/152-190 Termination is an opportunity for intervention, and is also tailored to clients needs (*consistent with client-driven core ideation).

3/207-210 Prefers termination that is more formal (discuss and process end of treatment (*related to core)

2/313 Noting importance of talking about a topic day in and day out as a cue to focus on it differently (*client-driven)

3/214-215 Unique relationship

1/141-158 When assesses, assesses it from the client's experience of it (prioritizing what the need at the moment and what's pressing)

1/141-146, 163-168 Client-based. What client needs, understanding client's world, meeting client where they're at

3/172-174, 180-182 (*consistent with core theory, example of how relational core is consistent throughout process of therapy)

C3 General treatment approach level: relational stance/beliefs/worldview

2/224-225 Stay curious about client

1/208-212 Believes therapy really happens outside the treatment room, giving client something to reflect on

2/441-444 Working within client's cultural lens/worldview

1/400-406 Educating clients about concern

2/191-194 Therapist curious about client's cultural context related to concern

3/72-73 Treatment selection should take the whole person into consideration

3/482-487 Therapist careful not to impose own values onto client

1/448-450 Understanding client context/needs

1/667-679 Being present with your clients and not being in your head

1/664-665 No right approach for treatment, always, "it depends"

2/643-672 Understanding client within their cultural context

1/222-223 Thinks about own assumptions and counter-transference issues

1/212-216 Client has agency in treatment, therapist is the guide

2/614-615, 617-618 Tries to tell clients a rationale for interventions, which was helpful in this case

2/147-150 Relying on client resources/empowering (*fits with feminist, empowering, description from previous interviews)

1/90-92, 126-129, 141-146 Client-driven approach

2/624-630 Giving rationale to clients allows them to take agency

1/289-292 Educating clients about process of change

C4 Collaboration, techniques to facilitate collaboration [client's role in treatment selection]
1/203-207 Client-driven, further factors that influence treatment selection
1/361-365 Client role of saying which techniques are used in therapy (*client driven, based on trying to build it equality, flexibility with treatment)
2/517-519, 521-529 Working within client's spiritual beliefs, understanding problem through client's cultural lens
1/173-174 Educates client how to be a client
1/329-336 She's educating the client how to be a client working w/ Integrative therapist. i.e. client has to be flexible, therapist models flexibility in change process (*universal-setting client up in therapists' change paradigm)
1/276-278 Understanding what change means to the client
1/448-469 Importance of negotiating focus of sessions with client (e.g. when client is avoiding)
2/605-610 Cooperates with client for treatment planning
2/200-201 Collaboration of treatment is important (one way is to "check-in") checking in facilitates collaboration
2/359-351(?) Collaborating and working together to make meaning
2/25-30 Treatment approach is collaborative (*client's role in treatment selection)
3/218-230 (*consistency with core theory and client-directedness/focus on collaboration)

C5 Mysterious aspects/unknowns of treatment selection/"intuitive" parts
3/141-144 Mystery to the process of how therapy is conducted
3/47-51 Thought of initial triage decisions as "coming naturally"
1/409 "intuition?"
3/116-118 Unsure how other therapists engage in treatment selection (mystery)

C6 Therapist's own overall description of how different aspects of the treatment selection process work together to create her approach
1/90-92 Commonalities to approaches used, don't use one more than another
1/79-81 Good fit with techniques, approach, and conceptualization based on client needs
1/259-271 Discusses role of stages of change in choosing interventions, understanding that with client
1/227-228 Treatment selection process itself is ongoing (*matches idea of flexibility, meeting client where they are)
1/70-77, 68-70 Also a fluidity between approaches used; theoretical orientation continues to evolve, incorporate additional components (*combo of stability and flexibility)
1/546-550 The more tools you have, the more flexible you can be with your treatment, and matching it to your client's needs
1/333-336 Example of therapist having high consistency with feminist approach and empowerment, and client agency, as well as collaboration (*How different components of approach come together)
1/367-395 Example of using two core approaches to be with a client, what actions she takes or doesn't take (i.e. relational) (*How theory/orientation trickles down to moment-to-moment interactions in a session)
2/44-48 Draws on core theory to understand client's needs, then uses other techniques to achieve treatment goals (*consistent with own description in first interview)

C7 Experiential piece of doing therapy: What it feels like to be an I/E therapist for this participant
1/112-113 "It all kind of fits together for me." Grounding- (*for her it seems to be very integrative- pieces coming together, flow together, not fragmented)
1/79 Orientation feels natural
1/235-236 Feels freedom to choose whatever I feel would be appropriate

C8 Treatment selection as impacted by larger systems, institutions, culture [treatment selection decisions not made in a vacuum]. (Maybe triage and therapist matching would go here??]
1/571-642 Agency-specific procedures
3/63-66 Agency challenges with therapists having autonomous say in treatment selection
3/39-43 Brief treatment model not appropriate for certain clients, may select them out
1/427-4f30 Example of how agency's brief treatment model affects treatment selection

C9 View/role of theories more generally
3/132-133 Overlap between theories is obscured because of using different definitions
3/132-133 Other therapists use different definitions for treatments
3/132 Thinks all theories have something in common

C10 Views of term/concept "treatment selection" and Meta: reactions/comments about thinking about treatment selection/participation in IVs
3/70 Term treatment selection sounds medical, dry, and isolating
3/46-47 Meaning of term treatment selection focus on which interventions therapist would use
3/72-73 Thinks term treatment selection implies not taking the entire client into consideration
3/80-82 Treatment selection sounds too finite or rigid, takes out personal choice
3/33-35 Agrees with scholarly definition of treatment selection
3/88-90 "Appropriateness of treatment" is used more than term "treatment selection"
3/142-144 Hard to dissect what is going on in therapy in the moment
3/84-86 Not familiar with term "treatment selection" from training
3/100-102 Reflecting on own approach to clients can increase rigor in practice
3/80 Term treatment selection does not encompass fluidity of interventions
3/100 Saw participation as opportunity to reflect on own style

C11 First treatment selection decision: who the therapist will be; client-directed triage [Related to time-line of treatment selection]
3/36-38 Treatment decisions can include the triage phase, as noted in academic definition
3/47-51 Determines if client is appropriate for agency and therapist assignment
2/579-583 Process of therapy: assess problem, develop relationship, then allow client to lead
3/51-55 Considers client's energy and if there is a preference for type of therapist (i.e. age or gender) (*client-directed triage)
3/53-55 Make sense that treatment starts the moment client arrives at agency seeking help
3/59-63 Matching needs/preference for therapist is part of treatment selection
3/59-63 Matching is a two step process, first matching to therapist then matching to treatment

1/70 Certain clinical issues that work well with her orientation
3/37-38 Thinks about treatment selection prior to client entering the system

C12 Therapeutic relationship as change factor/core approach to treatment
1/100-105, 116-124 Components that lead to therapeutic change: relationship (*ways change happens in relation to interventions' mechanisms)
2/25-30 Developing relationship is important to treatment approach
1/427-436 Therapeutic relationship used in a therapeutic way is constant (*relational approach part of core)
2/373 Sensitive to ways culture impacts their relationship
2/25-30 Change occurs or can be created if therapeutic relationship is there/necessary for change
1/95-98, 100-105 Therapeutic relationship (*foundation of orientation. "grounds me."
1/254-255 Relationship building
2/25-30 Relationship/alliance building comes first in treatment approach

C13 Treatment outcome
1/215-216 More agency client has, better their outcome (*seems very consistent, seems to be internally valid, goes against view that people doing anything)
2/511-512 Outcome of case was not perfect
2/541-543 Another outcome of treatment was symptom reduction of presenting problem

C14 Role of diagnosis/presenting concerns and impact on chosen approach [assessment]
1/239-243 Begins with standard assessment, important
2/577 But approach does differ based on presenting concern
1/250-259 Helpful to come up with a solid diagnosis, because it's a jumping-off point for treatment (*universal?)
3/37-46 Considers the appropriateness of treatment based on diagnosis
2/80-85 Assess symptoms for diagnosis, diagnosis
1/187-193 Decision-making for clinical process (*describes intake process, importance of assessment of many areas/client variables) (*note: universal process of all approaches for intake)
1/245-250 Integration of orientation in how she understands and communicates the problem to the client, in addition to how she understands the diagnosis herself (*orientation influences how you describe the diagnosis to the client)
1/221 Assessment of client is ongoing in therapy

C15 Technique level treatment selection: What treatment tools are in the bag, and when to use them
2/315-318 Using client needs to guide treatment at technique level
2/308-310 (*cues to do certain interventions)
2/341-347 Aware of big picture in terms of potentially contradictory coping styles for client
1/348-352 Example of how she would interweave process comments into flow of change process (*you need a lot of tools in your belt, wide range of interventions)
1/367-395 Doesn't provide answers for clients
1/280-285 Example of how to ask what would change look like to client
1/418-419 Much variation in interventions

2/139-140 Open to client's spiritual beliefs as a coping skill

2/276-279 Treatment approach fits with client's clinical needs even if outside of traditional approach (*flexibility/client driven/needing lots of tools)

2/127-134 Acknowledging real world constraints in client' s life/working with system

3/600-602 Using psycho-education as a strategy to get client buy-in to treatment

2/278-279 "borrowing" another treatment approach because I know it works well with a particular problem

2/320-321 Looks to previous knowledge of what specific techniques can be helpful in general

2/120-123 Understanding family and cultural influences

2/325-334 Example of using interpersonal process comments

1/228 Therapist has multiple treatment tools/treatment options

C16 Reasons for being Integrative[relates to underlying core view of need to adapt treatment and tailor it for different clients]

3/133-135 Feels adhering to only one orientation would not work for every client

C17 View/metaphor of client concerns broadly, is connected to treatment selection approach i.e., concerns are "multilayered"

2/402 Saw client's concern as multilayered

C18 Knowing you're on the right track with treatment selection [client directed/centered?]

2/356-357 Knew she was on track with client by looking at outcome measures

2/448-462 Using client's narrative and culture to guide gauging milestones

2/437-438 Notes that mismatches in affect and event point to something bigger that immediate concern

2/215-220 Stay curious about client, looked to client's lack of improvement as cue to be curious abut unknowns

2/256-257 Looking for change within first 2-3 sessions; draws on past experience to judge how long intervention should take to work

1/270-271 Consequences of choosing "wrong" intervention at wrong time (i.e. push change too fast) can be premature termination

2/189-191 Noted client was not getting better after acute crisis phase

2/365-369, 372-379 Checking-in (directly asking client about treatment progress)

C19 Person of therapist level: ways who she is/what she values as a person is consistent with core and Integrative orientation (e.g. humor)

C20 Role of goals in treatment selection/ Relation between goals and techniques: Has a set goal; path to goal is flexible

1/48-54 Multidimensional clinical experience- likes wearing different hats (different roles in practice)

1/61 Refers to prior info on background as "my story," "my journey being here." (*consistent with narrative approach. Ways who she is, what is valued to her shows up in clinical work)

2/633-641 Felt she grew a lot from case, including learning about culturally normative grieving and suicide, and ways culture, religion, and gender intersect for client (*consistent with her core approach/egalitarian)

1/177 Aware of how own cultural background (accent) impacts way she is seen by clients
1/156-157 Self-awareness of own views of psych problems/own perspective as well as client's view of what they need
2/388 Use of humor to develop rapport
2/471-475 Willingness to joke/show own personality, even in context of rapport with writer/interviewer

C20 Relationship between treatment goals and techniques [does have a set goal, but path to reach that goal is flexible]

1/15, 38 Decision-making re: clinical focus- what a person doesn't like
2/36-42 Choosing techniques/approach from multiple areas is based on treatment goals
2/264-271 Techniques fit goal and conceptualization of clinical problem (*various techniques that are being used are very intentional and complementary to her conceptualization, using core approaches. Always seems to fit).
2/339-340 [maybe implicit?] Goal of helping client be more accepting and compassionate to self
2/585-586 Does have a destination and overarching goal, but cannot predict everything along the way to goal
1/285-287 Notes some client goals are not feasible (like zero anxiety)
3/210-212 Goal for clients is not to need treatment anymore!
2/500-509 Notes not always knowing exactly how to accomplish goal of increasing client's flexibility with imposing own values

C21 Relation of integration to ESTs: Pressure towards them/Role in own practice/ role of research lit to own practice [conflicted about ESTs]

3/128-139 Pressure to do ESTs
3/118-119 Feels there is pressure on doing empirically supported treatment (*related to earlier aspects of 'throwing in' references to research literature when they seemed out of context with rest of her approach?]
1/440-442 Again notes use of evidence-based interventions, especially for anxiety and panic
3/119-123 Notes non-manualized treatments are more difficult to research, thus harder to validate empirically
3/116-124 Hard to fit various theories into a researchable study
1/137-139 There is a role for evidence-based treatments and research literature in her treatment selection approach (coders note:*inconsistency??)

C22 When therapist selects termination as an important intervention

3/194-198 If client reports feeling better, and has little to discuss in therapy, then termination may be initiated
3/152-155 Termination is not discussed very often

C23 Treatment selection as a balance among different (competing?) goals/elements/options

3/146 [Therapy] is an art and a science at the same time
1/525-529 Balancing out of the box multicultural approaches with appropriate boundaries and being intentional with interventions
2/494-497 Balancing helping client increase her flexibility without breaking her values

2/201-209 Example of balancing supportive interventions with change interventions
1/121-127, 126-129 Balances change strategies with clients values/culture and preferences (*client-driven flexibility)

C24 Part of treatment selection is prioritizing what client issues to work on
2/36-40 Attends to crisis first
2/103-105 Deal with immediate stress and crisis first
2/104-105 Therapist's first thoughts about treatment focus are based on client symptoms
2/69-73 Crisis comes first

C25 Therapist's level of comfort/discomfort, informs treatment selection [therapist factors]
2/136-137 How therapist's own feelings/empathy guided treatment selection
2/553-557 Awareness of own counter-transference
1/531-538, 535-544 More comfort in providing therapy leads to more flexibility with treatment approach (ex. of CBT comfortable at first)

C26 View of I/E orientation in general [maybe also how defines own orientation w/in this]
1/86 Feels Integrative and Eclectic may be similar labels

C27 Development, precursors to Integrative orientation
1/554-555 Becoming more comfortable with ambiguity over time (*universal development piece)
3/98-100 In practice, thinks about how she approaches treatment in less detail than did in training
1/13-15, 17-24, 26,30, 32, 28, 40-41, 45-56 Clinical background and training
1/63-66 Evolution of theoretical orientation
1/34-36 Sought multiple experiences to figure out clinical interests
1/666-668 Consulting with a diversity of supervisors and mentors
1/658-665 Not fearing exploration of theories and different approaches
1/681-682 Trusting yourself comes with experience
1/661-663 Developing what works for you based on clients and your experience
1/557-566 Self-awareness and having intentions with clients; Role of supervisors in training program modeling differing orientations
1/500-506 Training program offered classes from various theoretical orientations
1/508-510 Actively encouraged t explore different theories
1/500-506 No focus of theoretical orientation in training/diversity in training
1/508-518 Training history of flexibility of treatment for clients, and for theoretical approaches
1/528-533 Thoughtful about approach to treatment, but at the same time, encouraged to think outside of the box

C28 Case specifics

C(alternate A) Curiosity as approach to treatment selection/relational stance/orientation

C(alternate B) "What is Integrated": All the different levels: Worldview, theoretical orientation, stances, individual techniques and moment-to-moment interventions

1/63-66 Specific components making up theoretical orientation

C [uncategorized]
2/97-103 Ethical considerations
1/86 Unsure of how to label
1/400-406 Supplementing work outside of therapy with other sources (*universal?)
2/532-533 Struggle to help someone buy into something outside worldview
3/204-206 Thoughtful about multiple reasons why clients end treatment
1/299-301 Dealing with fear of change **D1 Initial/early aspects of treatment selection/assessment**
3/40-45 Gather thorough history of client to understand life story
3/23-30 Obtained clinical notes for this client and gathered prior therapy experience for client - maybe part of treatment selection process?
3/57-59 During treatment selection process, the first session may be informative as a way to understand client's life history and make interpersonal connections
3/56-59 Selection process involves formal intake questionnaire
1/238-251 Streamlines the technical aspects of intake because the client has a story to tell and wants to get to what is troubling him/her emotionally, relationally, academically, and so forth
1/138-141 Need to stay open-minded when initially working with clients, because the heart of issues may not come until the middle or later in the relationship
1/224-230 Assessment structure includes intake questionnaire and using open-ended questions
1/217-224 Different clinical settings/populations call for different assessment styles (more or less structured/formal)
1/208-211 Treatment selection depends heavily on on-going assessment: rule in or rule out, open questions like a qualitative researcher
3/335-340 Assessment of client begins in the waiting room (e.g. how they handle administrative tasks of beginning therapy)
3/355-360 Beginning of therapy is a process--like a dance, involving gathering information, and also building trust in the relationship
3/344-353 Almost always knows something about client before first session, from the physician who referred them to his clinic
3/308-312 During first moments of session, tries to communicate that the therapist is "there" for the client (e.g. reassuring words, hand shake, good eye contact)
3/389 Therapy begins in the first few seconds

D2 Therapeutic relationship: Empathy and importance of trusting therapy relationship
-ways therapist facilitates this
-what are important aspects of building this
1/443-446 "Getting it" involves an emotional connection; clients want to be understood
1/696-698 Repairs relationships with clients when conflicts arise
13510-513 Believes therapy relationship, with its firm boundaries, is "for the duration"
2/401-406 Turning point in therapy was directly confronting client about withholding key information, and processing client's motivations, and the implications for the therapy relationship
1/439-448 Empathy is the basis for connection and understanding in therapy; empathy is

fundamental

2/303-308 Seems to suggest the importance of relationship; not explicitly said

1/122-133 Importance of trust and rapport material that clients will share

1/249-255 Compassion for anxiety/discomfort of initial session for client

1/448-454 Alliance and rapport are based on client's belief that: therapist understands their suffering; therapist has knowledge, expertise, and training to support client's hope for positive change

D3 Mysterious parts of therapy

1/320 Treatment selection process is mysterious

3/492-493 Mystery of treatment selection involves reaction to clients or the degree to which they are likeable; unlikeable clients are harder to work with and therapists don't always know why they don't like a client

3/471-488 Mysterious parts of therapy are emotional parts/countertransference, reactions to clients

D4 Core/worldview, philosophical approach to therapy style [collaborative, reducing power differential, client directed, client-centered]

3/568-577 Very collaborative approach, reducing power differential

1/460-463 Important to understand client and instill hope

2/48-49 Mentions client's strengths, bright, good sense of humor

2/166-168 Assigns homework that is not overwhelming for client; matches task to client's functioning level

2/163-164 Collaboration to come up with what the first step will be; engage client to be less withdrawn

2/250-253 Treatment approach relies on asking the right questions, believes in power of self-discovery and doesn't want to give client the answers

2/231-233 Finding meaning in life is critical to client's survival (flexibility in treatment selection based on client's needs??) (coder's question: *Is this what you would've done with all depressed clients, or was it specific to how this client was presenting, and that's what she seemed to need?)

2/329-334 Believes there's a strong connection between mind and body; anxiety and depression impact physical movements, so observe these in session

2/361-368 Transparency with reasons for note-taking; content of notes; facilitates equality

1/724-729 Internalization of therapy/therapist ("My voice goes with you" quote)

1/573 Nurturing self-discovery process in clients in important approach to therapy

1/p.20 Seems to be another example of "my foundation is relational but I'm not saying it"--talks about things like repairing relationships, collaborating, instilling hope, building trust

1/277-285 Provides psycho-education about therapy to clients; invites them to discuss their own ideas about therapy, this contributes to client comfort with the process

1/578-587 CBT too inflexible and the goal of therapy is to get at the right question to elicit emotions, memory or thoughts, you hit a nerve

1/129-130; 132-133, 143-144 Clients are more cautious during initial therapy and will be more open as therapy progresses

1/484 Builds on clients' strengths

1/558-560 Core notion in conceptualization of cases is "balance" in life, and what may be out of balance for them

1/508-528 Example of collaborative approach; being responsive to client input

1/394-396 Importance of emotion (as opposed to cognition or relational aspects of material)

1/703-706 Worldview as therapist: People adopt patterns of behavior based on what "nature" (life) gives them, some are dysfunctional and repetitive, but new patterns can be learned

1/603-613 (*speaking client's language/down to earth)

3/204-205 Humility is a key part of success

3/563-570 There's no protocol for therapy. Other forms of healing (massage/acupuncture) have more structure to the treatment plan

3/207 Self-awareness of own limits, frailties, and strengths is important

3/255-259 Being with patient in therapy room is "a very complicated information processing task" → includes perceptual field of listening, watching, picking up clues, information, history, and current happenings

3/351-353 Transparency with clients about what information he has about them already (before first session)

3/431-439 Cautions about not being over-confident about what doing as a therapist

3/* Style seems to be very egalitarian, sharing of power, almost like a feminist approach, almost like equals collaborating

3/392 Therapists are healers that represent hope for people

3/p.17-18 Examples of fostering collaborative relationship; each person (therapist and client) bring something important to the task

D5 View of diagnosis
1/154-165 Diagnoses are not precise, but are necessary for insurance reimbursement

D6 Facts about Participant D
2/469-475 1/3 of current clients are returning after several years for work on new issues

1/59-61 Licensed in 1999

1/59-61 Some longer-term clients, some short-term cases

1/50 Practicing since 2001

1/67-69 Practiced psychotherapy for 10 years since licensure

1/51-57 Currently works 90% time in research center position, 10% clinical work at outpatient health clinic, usually 10-20 clients on case load

1/63-69 Does psychotherapy in medical, primary care setting, and work environment provides lots of interdisciplinary collaboration on cases

D7 Treatment selection as timing of interventions
1/122-125 Treatment planning and conceptualization changes the longer you're seeing a client

3/539-549 Therapist needs to be attuned to client progress (the client will make mistakes, will feel discouraged, and will also make gains) and so therapists need to challenge at the appropriate time, and back off at times, clinical errors can occur when something is brought up before the client is ready for it

D8 Perceptions of how I/E practitioners & approaches are viewed, and own perceptions of

I/E

1/112 Secrecy around acknowledging Integrative style

1/730-733 Process of therapy: Identify/help make sense of problem→help client make sense of own problems→self-insight→experiment with new and better patterns (*sounds consistent with psychodynamic or relational/interpersonal)

1/108-118 Heard from supervisors and colleagues that while they rarely adhere to one exclusive theoretical orientation, they seemed reluctant to overtly identify as Eclectic or Integrative

1/177-178, 180-182 Focus on evidence-based practice in 1990s led therapists to be reluctant to say if they did something else

1/315-318 Clinicians need to be under the rug with their approach because of insurance

3/284-290 Doesn't talk about Integrative approach freely with others because it is looked down upon

3/745-746 Eclectic/Integrative therapists need to be comfortable with uncertainties

3/166-171 Glad for research on Integrative/Eclectic therapists because feels he/they are marginalized for not practicing Empirically Validated Treatments

3/p.24-25 Example of how Integrative/Eclectic people could be marginalized/not integrated into professional world. Eclectic Integrative people don't fit into APA because it is evidence-based; thus feel marginalized

3/748-751 Students can't start out as Eclectic or Integrative in their approach (*more of a developmental stage?)

3/759-762 Therapists who admit they are Eclectic and Integrative are mavericks

D9 Pp's own description of how components of treatment selection process fit together
-What he does
-Understanding/view of what treatment selection is, more generally

2/101 No limits on types of interventions when the relationship alliance is strong

2/56-68 During history gathering, therapist determines complexity of case for treatment selection

2/256-258 Underlying hypothesis for therapy→if client could connect to meaning of life→would raise the whole level of things [allow for better coping in many contexts]

1/145-153 Narrowly focused problems call for less-deep, more behavioral therapy; more complex cases call for more multi-strategy interventions (*complex individuals→multi-strategy intervention)

2/336-349 Nonverbals are not only an information channel, but part of therapy as opportunity for therapist to combine current observations with knowledge of client's history to ask a good, thought-provoking question

1/272-275 *Question about order of operations: is there some sort of pre-formulation that's going on? Maybe like a parallel process going on--not linear. As talking they're formulating and thinking and it's free to change online as new info comes in, and Treatment selection begins in first session with formulation of case, thinking about possible treatment options

1/287-289 "Clients won't get a standard medical model with me"

1/254-256 Connection with client and putting them at ease→allows open communication of the problem→allows for obtaining information needed for treatment selection

1/360-365 Complex interplay of effective listening, putting information together, drawing on experience, intuition, and knowledge of treatment models and diagnoses

1/456-476 Rational/general goals for therapy as described to clients: Understand how got to this

point of difficulty, gain courage to do things differently, make and evaluate changes

3/12-16 Believes treatment selection is a process and not something that can be defined

3/20-22 Treatment selection is not a recipe

3/259-263 Complicated information processing done in therapy is cognitive and emotional and subjective, brought from therapist's life experiences, intellect, and based on training

3/24-27 Treatment selection involves objective and subjective parts: 1)assessment→diagnosis which argues for a treatment selection (this part is objective). 2) knowing client well enough to know if a particular treatment you select (based on diagnosis) is a good fit or not (this part is subjective)

3/20-21 Treatment selection process is interplay of careful assessment and beginnings of therapeutic relationship

D10 Lived experience: what it is like for Participant to be doing I/E therapy

2/93-94 Therapist felt he was "in for the ride of my life" with client's complexity

1/642-646 More comfortable with practice style now; more efficiently gets to the heart of the matter (*increase in comfort level over time)

D11 Change and what leads to it

1/82-85 Interested in mechanism of change and immersed self in literature

1/613-618 Trusting relationship, empathy is key, and asking right questions helps someone evaluate their lives in a therapeutic way

3/360-361 Trust in therapeutic relationship is fundamental for effective change

D12 Examples of interventions used: What is integrated :
-Techniques
-Things the therapist does
-These are tied to worldview, philosophy, theoretical orientations, training

2/207-217 Treatment selection included making meaning of life/reason to live (*how did this happen? what did it look like?)

2/172-174 Initial plan/goal was for client to walk every other day

2/166-168 Collaboration with client to come up with action plan to make therapy less overwhelming

2/181-182 Worked with client to identify sources of social support

2/174-181 Identified depressed behavior pattern with client, and examined practical ways to break it pattern

2/141-146 Part of treatment for severe anxiety or depression is re-moralization; reminding clients of strengths and resources they have

2/123-130 Therapist noted/acknowledged real environmental/outside barriers to client's goals (e.g. ex-partner's behavior)

2/127-128 Client shared letters with therapist; therapist had phone contact with ex-partner [use of outside information to inform therapy]

2/240-256 Noted strength of not using drugs/alcohol as a way of coping

2/121-123 Noted client's strengths/what was most important to client

2/222-227 When client directly asked why she should want to live, therapist did 2 interventions: one, collaborative/matter of fact inviting client to examine that, brainstorm, problem-solve, and

two, cheerleading, reminding of strengths

2/209-215 Acknowledging/empathizing with life events of client, and impact on client's sense of self

2/310-313 What does in therapy: Asks right questions, observes non-verbals

1/710-714 Encourages discovery of, and trial of new patterns of behavior and thinking

1/313-326 Attends to non-verbals and provides feedback as part of intervention

1/651-671 The client's symptoms, narrative, history, etc., are clients to their problems, and therapists are like detectives to ask the right questions. Probes until client gives some sort of affective reaction/causes some internal shift (probably non-verbal); also foster's client's own self-detective skills

1/603-610 Interpersonal process is introduced in non-threatening, down-to-earth way (i.e. "time out on the field"); this benefits building trust in the relationship

1/592-603 Elicits feedback from clients regularly

1/673-674 Sometimes hit and miss, trial and error when asking questions

1/568-572 Helps client connect life circumstances and own behavior to distress and symptoms they're experiencing

1/582-592 "Asking the right question" to encourage deep reflection is another tool frequently used

1/530-556 Examples of "staying in balance"; some tools in tool bag are mindfulness, breathing and relaxation exercises, encouraging self-care, and walking

1/678 Uses a lot of humor in therapy; this helps clients gain perspective

1/689-694 Uses paradoxical techniques

3/555-561 Taking time-outs to process when you recognize they had a reaction to an intervention (time-out on the field)

3/248-261 Therapist doesn't focus on dysfunctional thought patterns; attends to client's dysfunction as a whole, and has to be attuned to pick up a variety of cues within the perceptual field

3/317-335 Provides psychoeducation to clients; carefully discusses informed consent, etc.

3/418-423 Provides psychoeducation to clients about the process of therapy

3/579-583 Provides psychoeducation about what therapists and clients bring to therapy, such as expectations of the client, and modeling how to be in therapy

D13 Views about/role of empirically validated treatments [conflicted]

1/104-106 Patients believe CBT doesn't get to the heart of the issue

1/87-96 CBT is safe and researchable

1/291-292 More discussion about medical models, ESTs and how the filed of psychology has shifted to this (*assumptions about meaning of evidence-based practice for eclectics?)

1/291-309 Does not agree with evidence-based therapy that leads to CBT being required by some insurance companies for all depression diagnoses

1/343-348 Believes faculty/supervisors taught CBT with 'a gleam in their eye' indicating this was not what therapists really do in practice (*perceived distance between what is taught/prescribed for therapists to do, and what is actually done in practice)

3/101-106 Difficult to adhere to evidence-based treatment when clients are complex (*conflict with EVP)

3/141-145 EBT can be too prescriptive and not allow flexibility to roll with what a person needs

3/90-92 Has kept up with literature and "thorny" issues around evidence-based practice
3/284-290 Insurance companies prefer EVTs
3/p. 4 (*** Seems to be a link with treatment selection and EVPs in all interviews--also legitimacy of their approach (eclectic/integrative) comes up in that discussion)
3/753-760 Training programs want student to be training in empirically validated treatments
3/94-106 Feels conflict around evidence-based practice: on one hand, believes EVP is important, and is an advance, is heavily influenced by faculty under clinical scientist model of training, believes in science on one hand, practice on the other hand. Real-world experience with complex individuals makes it very difficult to adhere strictly to EVP guidelines (*conflicted around evidence-based practice)

D14 View of psychotherapy research and relation to practice
3/87-88 Academic environment keeps therapists up to speed with scientific literature
3/31-33 Difficult to do psychotherapy research because can't control subject variables

D15 Treatment selection as balance among different elements [including big one: Therapy as Art v. Science]
3/311-316 Walk like between allying anxiety too much and not enough
1/478-487 Understanding, emphasis on relationship, but not "touchy feely", also problem-focused, finding solutions
3/263-271 Challenges with testing subjectivity, however the subjective component of therapy is very important to the process of therapy
3/688-689 Therapist stance: not be over-or under-emotionally involved
3/471-477 The mystery of treatment selection involves balancing how therapists monitor feelings and monitor thoughts
3/848-855 Therapy is both an art and a science, it's hard to know when someone becomes an effective therapist

D16 Treatment goals/purpose of therapy
3/634-640 Purpose of therapy is to help people recognize and change dysfunctional patterns, be more interpersonally effective, and increase positive affect
2/183-188 Therapist and client agreed on expectations: client would probably never be 100% free of depression all the time
2/429 Last 2 years of therapy, client underwent significant transformation, including new relationships, new connections, spirituality
1/485-488 One goal of therapy is positive risk taking: one mechanism of behavior change
3/634-640 Purpose of therapy is to help people get past their neuroses and become more effective
1/366-378 Goals in therapy shift due to "life happening" i.e. crises

D17 Aspects of therapist as a person that relate to I/E orientation or treatment selection approach
2/460-461 Therapist believed client helped him be a better therapist, thanked client for that
1/129-130 Clinician disclosed in interview they've been in therapy before
1/404-439 Believes own personal history/experiences led to capacity for empathy (i.e. father modeled empathy, own experiences as a client)

1/380-389, 404-405 Therapist brings to therapy strength of empathy, which is foundation of his understanding, which is first step to intervening, and also, therapist must feel empathy for therapy/treatment to be effective

1/p.12-13 Discusses personal experiences with therapy. By him sharing this with me, it's in line with transparency, empathy, openness, quality of being empathic, knowing you've been 'on the other side of the couch'. Speaks to his character, how he is with clients. Humanness, or humility towards approach to therapy

3/225-229 Therapist transparent about his own struggles with mental health

3/181-193 To be an effective therapist, one needs to be smart, and have natural emotional attunement in order to be genuine "can't teach someone to be emotionally attuned".

3/59-62 Motivated for clinical work so that he can help people

D18 Views of why/when integration is necessary; why he is an I/E practitioner

2/96-97 This type of case, therapist does not want to take a narrow approach, due to complexity

1/134-136 Adhering to strict CBT framework hinders adaptation of treatment to new client material

1/117-118 Therapists use different models and theories because people are too complex to use just one

2/475-480 It is the rare patient who has narrowly-defined problem that responds to narrow approach and brief therapy

1/172-173 Is solidly eclectic/Integrative

1/296-299 He said it's a disservice to clients to think that only one theoretical approach can work

1/337-338 Bottom line: eclectic-Integrative allows flexibility to roll with what client brings into sessions

1/96-99 Hard to connect with client while using CBT

1/320-326 Treatment selection process is challenging because client problems change and treatment has to adapt to the change

3/502-503 Being Integrative/Eclectic gives license to be self-correcting

3/151-161 Less complicated cases can be more prescribed, however more complex cases may require more Integrative approaches

D19 Importance of flexibility [links to complexity]

1/167-171 "With complex mix of history, symptoms, and goals, eclectic/Integrative gives greatest flexibility to use all therapist's knowledge and experience to help"

1/232-236 Flexibility with questions during assessment, from the beginning there is flexibility to get to the heart of distress

1/332-334 Flexibility with treatment planning as client discloses more (*parallel to developmental path--early in career, more structure/formality, that decreases significantly over time/experience)

1/694 Knows what he can get away with in session

1/495-497 People are complex, and need flexibility of approaches

1/481-482 Collaborative approach, flexible in degree of directiveness, "if the situation calls for it"

3/374-379 Rigidity in applying theories doesn't do justice to the complexity of people

1/144-145, 170-173 Integrative/Eclectic = flexibility

3/374 Practicing therapy over time is an ongoing experiment where you gather data
3/439-451 People are complex and need flexibility
3/505-509 Rigidity in treatment, or excessively structured treatment plans don't allow for flexibility with client
3/455-460 Individual treatment plans for clients/tailoring treatment to their needs/flexibility
1/171-172 One narrow therapeutic model is not flexible enough
3/p. 20 Seems like (example of client who was closeted); one reason flexibility is important is that without that, you might miss a very important part of the client's problem; examples of consequences of what can go wrong if you're not flexible
3/642-647 Therapy can be oversimplified, and therapists need flexibility; "not like Beck said it was!" (*conflating flexibility with complication??)

D20 Signs for needing to change/re-select a new treatment in therapy
1/639-646 Anxiety is important to pay attention to; it can be healthy, but can also be a signal to take action in directing therapy
3/524-526 Therapists can tell when things are getting worse for client, and needs emotional attunement to provide support for the client
3/405-416 Discusses with client when he sense they don't "click"
3/297-302 Sometimes, if something is not clicking early in therapy, wonder if missed crucial information, either due to won assessment or lack of sufficient client trust to disclose information
3/524-526 Signs for needing to change approach in therapy are 1)experience/instinct, 2)client resistance 3)client getting worse
3/511-522 Each session, learn more information about client, and trying to facilitate change. Over time, new information may indicate that the first approach is not working, and you need to shift

D21 Cues/presence of variables that indicate selection of certain treatments or approaches
2/47-52 Client's level of insight may shape the treatment selection process
2/112-115 Treatment selection approach depends on severity; safety first for clients who are suicidal
2/103-107 When client has severe symptoms, therapy focuses on basic functioning (i.e. eating, hygiene, sleeping) (*universal? some continuum among specific/Eclectic *behavioral activation techniques)
2/103-107 Treatment selection depends on severity of mental health, higher level therapeutic work won't be useful for someone who is decompensating emotionally
2/156 Treatment focus on day to day functioning when symptoms are severe
2/135-136 Focus on keeping client alive when risk of suicide
2/284-287 During risky times and in response to legal issues, therapist consulted with supervisors and colleagues
2/255-263 Therapist attuned to life crisis and existential struggles, and used that to know how to proceed in treatment

D22 Evolution/development of theoretical orientation; developmental process of an I/E therapist

1/73-75 Examples: trained in "all the usual suspects": CBT, psychodynamic, interpersonal, motivational interviewing, object relations

1/72-73 In clinical program, exposed to many different models and theories of psychotherapy and psychopathology

1/20-25 Background in addictions

1/34-38 Varied practicum and intern settings; forensic inpatient and counseling center

1/23-32 Re-specialized in clinical psychology as a post-doc because "wanted to do clinical research but was not trained as a clinician"

1/10-13 Educational background in personality and social psychology/studied relationships

1/8-21 Indirect path to doing psychotherapy

1/99-100 Acknowledged that perhaps he used CBT too rigidly due to own anxiety as beginning therapist

1/78-80 Mentor influenced development of an Eclectic approach

1/328-330 Initially more pragmatic, formal, structured in treatment planning (early in career)

1/635-637 Developmentally, therapist felt like "flying by seat of pants" first year, took time to develop comfort

1/615-617 Learned techniques in therapy from experience, making mistakes

1/211-215, 214-215 Very structured with initial client assessment as beginning therapist due to own anxiety

3/p.2 Seems to focus on training and narrative of becoming a therapist. Themes: trial and error, maturing over time, getting increasingly more complex case loads, after licensure, not being in an environment where he could learn the nuts and bolts of therapy

3/371-372 Early on in career, experimented with being faithful to training

3/378-382 Read about Integrative/Eclectic approaches with seeking more flexibility→ Saul Garfield and other resonated

3/693-702 Believes students often have misperceptions of what being a therapist entails; don't realize how complex it is

3/717-723 Therapist had an unconventional path to being a therapist, believes that contributed to his open-minded approach to therapy

3/552-553 Getting better at noticing client's immediate reaction to moment-to-moment interventions

3/69-77 Training program had few cases, intensively supervised, versus many cases

3/55-56 Difficult cases early in career are a "trial by fire"

3/35-44 Maturation process for therapists over time, therefore treatment selection process matures over time/is more informed over time (parallel of therapist growing and treatment selection process growing)

D23 Case specific

2/19-20 Saw client "through thick and thin" knew her better than any other client

2/47-49 Client grew up in a large, strict family

2/43-45 Felt particulars of client story were very relevant, spent months doing historical work

2/13 Rich case with many elements

2/33-35 Client had specific goals for therapy: Address longstanding chronic depression since late childhood

2/10-11 Long-term case, recently terminated

2/8-11 Case chosen because it was challenging, forcing therapist to rely on training and use resourcefulness

2/15-17 Best-documented case, several volumes

2/106-109 Initial diagnosis was major depression, recurrent, moderate severity, later changed to "severe" after more info (*diagnosis)

2/116-119 Major issue was depression, but also goal to help client better navigate relationships

261-78, 91-94 Complexity of case involved client relationship issues, domestic violence, trauma/loss history, home and work conflicts, family of origin conflicts, legal problems

2/146-157 Noticed symptoms of severe depression in client, social withdrawal, problems with basic self-care

2/482-487 Client discussed in case challenged therapist in new ways: crises, multiple presenting problems, and counter-transference reactions

2/296-297 Because of consultation with others, felt was not "flying by seat of pants" with this client, but had a specific strategy

2/119-121 Examined how others pushed client's buttons

D [uncategorized]

3/293-295 Process of treatment selection is highly subjective, but get more comfortable with this the more seasoned you are as a therapist

3/651-663 Therapy focus can change unexpectedly when client eventually trusts therapist enough to reveal new, sensitive information

3/27-30 How much distress client can withstand

3/764-782 Notes difficultly for someone seeking therapy to wade through all types of providers out there, from many disciplines

1/530-535 Rise of mindfulness in therapy

3/727-737 Attending CE workshops is helpful because therapist-presenters are good role models

3/691 Usually advises against this a career choice

E1 Facts about Participant E

1/34-36 Generalist: training in may areas, comfortable to work with "anybody who walks in the door"

1/45 13-15 hours of therapy per week

1/41-43 Generalist with niches in anxiety disorders, eating disorders, pre-and post-partum disorders and work with physicians/professionals

1/23-28 Sees wide range of client issues/concerns

1/13-16 Practicing psychotherapy for 10 years

E2 [alt: client role in treatment selection]

1/637-651 Collaborative treatment planning helps the alliance

E3 Core, underlying approach to therapy; Philosophy; What is consistent across clients [What is integrated into?]

3/93-94 Underlying philosophy of "doing what is best for the client in the moment" guides intervention (*flexibility, person-centered)

3/296-299 Thinks of "feminist lens" as multicultural lens and philosophies or theories more than

empirical interventions
2/140-143 Integrates CBT components into therapy
1/218-220 Really thoughtful about everything I say, but still make therapeutic errors at times
2/155-156 Worked on eating disorder in a "clear cut cognitive behavioral manner"
2/500 Always proposes interventions before doing them
2/305-309 Incorporates understanding of both partners' family values and functioning, in conceptualization
2/155-157 Educates client about approach, shares conceptualization
1/168-174 Believes clients want an active therapist and clients want direction
3/294-296 Certain disorders need specific approaches (i.e. CBT with anxiety)
1/150-153 Therapist engages with clients differently "one size does not fit all" (*client-driven flexibility)
1/146-148 Likes that she chances approaches based on what client brings in (*client-centered)
1/537 Common thread in treatment: Always uses CBT in some capacity
1/255-256 Understanding what triggers and maintains symptoms is important for long-lasting treatment benefit (*brief vs. long-term)
1/701-708 Seems to take a contextual approach to understanding client history
1/663-665 Uses power in a therapeutic way
1/626-633 Regarding alliance, conveys openness to client feedback about what's working or not in therapy
1/577-581 Approach is a combination of CBT and psychodynamic
1/271-275 Gives client psychoeducation about what has been shown to be helpful re: treatment, then respects their choices (*flexibility?)
3/298-302 Uses feminist and multicultural lens to understand how the client views/makes sense of the world

E4 "Instinct"- challenge of describing decision-making process
2/545 Interventions are instinctual, and not conscious "I just do it"
1/133-135 Comment that there are probably many personality dependent interventions she uses, but they're not immediately conscious to list
1/333-334 No conscious, formal process by which her decisions are made, but may likely be am implicit process that could be deduced if we were to watch videos from her sessions
3/98-101 Decision-making is difficult to describe as a heuristic or algorithm but could probably be derived from viewing session recordings

E5 Role of diagnostic characteristics in treatment selection
1/374-382 Some diagnoses need longer treatment (e.g. eating disorders or individuals with long-standing issues)
1/246-247 Uses CBT for anxiety disorders because it is "clearly effective"
2/143-144 Eating disorder might require more CBT approach
2/143-144 Clinician needed to assess how severe eating disorder was before choosing intervention (*severity of diagnosis influences approach used)

E6 Participant's own description of how components of treatment selection factors come together/interact [causally?]

2/157-161 Cognitive behavioral interventions contributed to client insight about emotions as triggers for behavior

1/p.3 Training informs what tool bag consists of, then client characteristics lead to what she chooses

1/91-97 Training in personality informs how interventions are utilized within a session, particularly in selecting what should be held off for future session, pays attention to what client can hear in the moment

1/337-350 Treatment process is: Thorough intake, gives client impressions and recommendations, At first session: treatment plan/articulate goals, Goals are typically some combination of : 1. Symptom-reduction-based goals to be addressed with CBT, 2. Longer-term goals needing interpersonal work (i.e. "to process grief related to loss," or "to understand how early family dynamics are impacting friendships now"

1/328-329 Relies on theoretical orientation for treatment selection, but not formal schema for doing treatment

1/283-290 Listening for important relationship information does double duty: short term to solicit support for using new CBT techniques and long-term in psychodynamic conceptualization, and later therapy focus (i.e. how are relationships working/impacting anxiety and depression?)

1/560-562 Always uses a combination of psychodynamic/interpersonal and CBT, but timing of CBT is biggest part of 'selection' (*timing/relational/interpersonal base?)

1/587-588 Approach is integrated and does not use CBT for one client and psychodynamic for another client

1/591-599 Does not conceptualize in simple behavioral terms

1/556-558 Decision of when to begin CBT techniques is based on how receptive client will be. Client receptivity is judged/assessed based on their personality, symptom severity, and the therapeutic alliance

1/275-277 In early sessions, pays attention to client personality while teaching CB strategies (*How integrates)

1/249-257 Uses CBT strategies as initial ways to stabilize distress then will go deeper into understanding triggers

1/244-246 Interventions used based on combination of diagnosis and client personality (*flexibility/client-centered)

3/123-133 What is helpful for client is based on treatment plan, established goals, how the client is going about attaining those goals, and interventions used for a given client

3/83-87 Levels that influence intervention selection are 1. content 2. process 3. meta-level of differential diagnosis and hypothesis testing

E7 Perceptions of the views others have of acceptability of I/E orientation, and view/how Pp identifies her own I/E orientation

1/47-48 Theoretical orientation and conceptualization with "psychodynamically and developmentally-informed approach"

1/444-450 Theoretical orientation differences were ok/allowed, learning because of good supervisory alliance/relationship

1/513-516 Concern over not using approved ESTs in VA was that she would be challenged [in contrast to not using non-ESTs because of concerns other techniques wouldn't work}

1/479-487 Example of struggle with EST guidelines: Was concerned about using empty chair technique with a client, until colleague reframed it as exposure of client to his thoughts and feelings related to person in chair (as exposure is an EST, this made the intervention "ok".)

3/311-317 CEUs helps understand how own practice fits with other psychologists

1/573-575 Thoughtful about approach (*is this conscious thoughtfulness? Increased b/c stigma of being eclectic? So talking about being thoughtful combats it…)

1/568-574 Thought people would associate "Eclectic with not knowing what or why you are doing something (*perception of "eclectic" as negative ***assumption that term Eclectic needs to be qualified)

1/566 Describes approach as "informed eclectic"

3/250-256 Although it was more acceptable to be Eclectic in private practice, still didn't use that word explicitly. Eclectic orientation was only implied by colleagues' case descriptions. (*view of the perception others have of Eclectic orientation)

E8 Relationship itself as intervention

1/59-64 Therapeutic relationship important for change is influenced by humanistic and psychodynamic theories to provide a mirror for client, and positive regard

1/61-62 Lists specific ways therapy relationship can help lead to change: It's a mirror for client, Experience of positive regard, enables use of transference/countertransference

E9 What is integrated; Techniques/interventions used; tools in toolbox; includes interpersonal/relational stances as choices made

2/605-617 Considered/tried referral to couples therapy, but couple was not interested

2/516-537 Motivation interviewing for ambivalence

2/356-357 Also used psychodynamic, relational, interpersonal interventions

2/346-353 The PTSD treatment was like a separate mini-therapy within the therapy-- a few sessions, then returning to original goals/problems

2/246-251 Feminist approach integrated into work w/ eating disorders due to contextual factors such as working in a setting that was very appearance-focused (*flexibility)

2/234-237 Used feminist perspective with eating disorder perspective with eating disorder symptoms by exploring client's context and messages about weight and size

2/223-226 Linked symptoms with life events

2/182-183 Vocational counseling re: questioning career

2/185-187 Feminist unclear, because client wanted to be in math and sciences?

1/56-57 Indentifies strengths for resilience

1/50-52 Uses cognitive behavioral interventions for quick decrease of distress

1/76-80 Uses many techniques such as gestalt, mindfulness-based techniques, and here and now processing

1/82-84 Trained in DBT which informs practice, especially around emotion regulation issues/distress tolerance

1/203-209 Self-disclosure to build interpersonal connection

1/180-181 How much therapist bring self into room is depending on client (this is another continuum of behavior) (*flexibility)

1/157-166 One parameter that changes is how active therapist is (but never ranging down to the point of being passive) gives example of a passive-dependent client

1/321-322 Asks what clients have tried in the past that helped in order to suggest a direction for treatment now (*flexible, collaborative)

1/306-311 Often provides supportive psychotherapy/Rogerian techniques. Empathy and validation go a long way: "Talk therapy? Like the talking cure? It really works."

1/300-306 Most clients are interested in CBT, some even ask for it by name

1/653-676 Integrates feminist approach into work

1/682-683 Always integrates feminist and multicultural perspective

1/609-616 Explicitly describes to clients how they can use insight to make changes in current life

1/259-263 Uses self-disclosure as part of installation of hope, and installation of confidence in therapist expertise

1/237-239 Feels comfortable/familiar with "most major movements since modern psychology" and utilizes them

E10 View of Empirically Supported Treatments

2/94-96 Empirically supported treatment: digging it on the down-low. (*dig at empirically-supported/short-term therapy-- associated conflating them with each other) (*Is treatment selection based on the treatment model? Brief vs. longer term? Certain biases)

1/477-482 Tension between providing what may be useful for client and providing empirically supported treatment (*tension)

1/477-479 Despite solid training and good clinical intuition, felt hesitant about 'going with' what she thought was the right intervention at the time, if it was not an EST

1/543-545 There's empirical support for using CBT with eating disorders, but using it as a rigid, manualized approach can backfire

1/267-269 Would be remiss in not using cognitive and behavioral strategies because there is empirical support for them

3/286-294 There are empirically supported relationships as well as treatments; focus on relationship is not counter to empirically supported treatment

E11 Timing/when to do different aspects of treatment selection
-When does treatment selection happen?
-"In the moment"

2/469 Focus on most distressing symptom first

2/274-283 Exploring family dynamics in treatment was initiated based on client's situation: dealing with triggers during visits with parents (*client-centered?)

2/142-151 Began to address eating disorder symptoms with cognitive behavioral interventions, including client record keeping about behaviors, triggers, and related thoughts and feelings

2/120-122 First few session orient treatment to therapy, feel comfortable working with therapist and establishing relationship

2/117-118 Initial interventions= humanistic, validation, support, and normalization

1/362-365-368 With longer-term clients, it's different: revisit old goals less frequently because relationship is so well-established, both know what they are supposed to be doing

1/357-363 Uses recall of previous sessions to reintroduce issues that haven't been addressed-- once clients' initial goals seem to be going well (*timing?)

1/550-554 When treatment selection is introduced to client is important. e.g. with eating disorders, she always uses CBT, but the biggest decision is WHEN to introduce CBT (*timing)

3/97 Decision-making done on the fly, based on what feels right for the clinician regarding the client

3/86-87 Meta-level of therapy involves choices made moment-to-moment--what direction to go with the client

3/76-81 Be in the moment with the client

3/76 Is sorting through client's reactions to interventions, and implications for personality in the moment

3/179-215 Approach to treatment changed over different work settings and different presenting problems (Axis I vs. Axis II)

E12 Client=centered assessment: Identifying cues from/about client that would guide treatment selection variables
OR
[First session/Early in Treatment]
2/61 Initially thought client was not psychologically minded (*assessment of client characteristics: psychological mindedness)

2/590-601 Client distress level also a factor in which interventions are used. For more distress, allowed for longer period of validation, focused more on understanding of client's struggles versus immediately moving to work on changing them

2/359-375 When relationship is solid, clinician can be more blunt with client

2/324-337 As concerns of the client shifts, the focus of treatment interventions shifts as well

2/159-162 Client's psychological mindedness will influence intervention. Flexibility in choice of interventions, low psych mindedness leads to more psychoeducational intervention

2/145-146 Assessment of symptoms from client's perspective (i.e. what is a binge from the client's perspective)

2/130-133 Some clients respond well to validation or not, depending on personality

2/123-128 Assessed client's social support as low, which even increased the importance of therapeutic relationship

1/54-57 If clients willing to do more work, can do deeper into more long standing cognitive, behavioral, and relational patterns that influence distress

1/114-119 Informal assessment (clinical assessment) of personality style from very beginning →to inform therapy

102-108 Attends to personality spectrum to inform how to intervene with clients

1/193-209 Examples of thought process/variables that would indicate if self-disclosure is therapeutic/list of motivations for self-disclosure

1/198-200 Careful with self-disclosure for clients who pull for it

1/186-187 Before self-disclosing, always thinking, "is it useful for the client." Always about the client

1/144-146 Client personality style, transference, counter-transference, and alliance determine technique/how to interact with client

1/337-343 First session there is an extensive intake, then based on goals in second session, develops treatment plan

1/335 Does have specific approach for new cases

3/57-60 Counter-transference is a part, but not the most important part of personality assessment

E13 Goals and their relation to treatment selection
1/352 Goals can be explicitly interpersonal or psychodynamic
2/460-461 When client comes in, the first goal is to decrease distress
2/469-478 Brief vs. long treatment, symptom reduction vs. insight, and what approach is used
2/462-467 Initial goal-driven interventions is to decrease distress: accomplished with CBT to reduce symptoms, and Rogerian/humanistic approach to instill hope and provide support

E14 View of theories
1/86-89 Sees DBT as specific kind of CBT to use with specific client problems
1/488-490 Much of theory and intervention overlaps, and depends on how therapist or observer labels it

E15 Role of research literature in own treatment selection process
3/282-284 Research literature plays a big role in what treatments are selected
3/286-288 Some therapies do not lend themselves well to research

E16 Interaction of relationship/alliance with treatment selected, intervention/technique used
1/279-287 Uses Psychodynamic approach; attends to relationship and uses that for teaching interventions (*flexibility?)
3/103-107 Approach to treatment/intervention decision-making changes as the connection/alliance increases
3/107-109 Once alliance is well established, clinician responds to emotions, and selects interventions based on that

E17 Interviewer/coder reactions
3/239-248 (*reaction to material-- classism? racism??)

E18 Importance of flexibility
2/445-452 Saw client at different frequencies over course of treatment, less often later on
2/216-232 As client's concerns shift, interventions, approach shift as well (*flexibility? lack of boundaries/organization?)
1/137-142 Example of interventions used based on a narcissistic style: not competing with client (*flexibility/tailored interventions)
1/314-319 Empathy is not going to work with all clients (*flexibility)
1/303-312 Some clients benefit or want more CBT, some do better with supportive psychotherapy (*flexibility)
1/433-443 Worked with a psychodynamic supervisor who didn't originally recognize her CBT skills. Saw them as "nascent" because they were so different. (*Flexibility, natural inclination towards integration. Pieces of what this person can teach me is integrated)
3/328-337 As a supervisor, does encourage supervisees to use CBT and to consider personality dynamics together (*teaches flexibility to supervisees)
3/262-266 Those trained in a particular approach, or working with a specific disorder may lack ability to work with other types of cases or do basic things (like intakes) (*flexibility, the other side of the coin)

3/61-67 Client receptiveness to interventions in the beginning influence whether other interventions are used later on in therapy. (*flexibility-- if one approach isn't working, reconsider how to sell it to the client, or reconsider using it)

E19 How do you know you're doing the right thing/have selected the appropriate treatment -What to do at impasses
1/257-259 Does not belabor CB strategies if client is skeptical/not interested
3/60-61 Pays attention to how people respond to interventions in first few sessions
1/499-507 Now, confident in approaches used because clients give feedback that they're doing/feeling better
1/355 Frequently refers to initial treatment goals, especially if progress slows in treatment (*what does at impasses)

E20 Therapeutic relationship and treatment selection: How they interact
1/608-616 Relies on client characteristics for treatment selection (*client-driven approach)
1/604-608 Determines if client is psychologically minded enough and non-defensive enough to focus on insight regarding their relational patterns (*client-driven)
1/279-283 Uses dynamic between client and therapist to make decisions about how/when to introduce and tech techniques and follow-up with them
3/54-55 Client's personality influences the acceptance of treatment selection
3/52-55 Understanding client personality helps predict how they will respond to treatment suggestions, where areas of resistance will be

E21 Larger Developmental, social, cultural, professional influences on treatment selection (i.e. Influence of practice setting/agency on treatment selection)
1/121-125 Formal personality assessment more difficult to do because one doesn't own the testing material, can do in a larger private practice
1/520-526 Part of being early career psychologist is proving yourself as competent/good
1/497-500 Less pressure to "prove self" with regards to techniques used, once out of an academic setting (*practice setting influencing treatment selection)

E22 Development/evolution of theoretical orientation, and what Pp has learned about treatment selection itself, more generally, in training
1/ 4-7 Educational background in psychology
3/328-330 As a supervisor, does not explicitly supervise in terms of how to do treatment selection (*as a supervisor, how teach treatment selection?)
3/236-237 Varied training experience influenced range of interventions clinician would consider
1/405-411 Training in graduate program was primarily CBT
1/405-411 Did not get much treatment selection training in graduate program
1/405-411 "Everyone just teaches you their approach to therapy," [versus how to integrate]
1/470-472 Learned with experience about treatment selection
1/457-461 Through supervision, learned about treating personality disorders with psychodynamic theory and its underlying constructs of attachment, loss, shame, etc.
1/413-421 During training on practica (which were taught by professors) got some more exposure to humanistic and psychodynamic approaches (*diversity of training experiences)

1/492-495 Later, in private practice group, could balance being intellectually rigorous and knowing research, with less pressure to prove self with using only the "right" techniques
3/76-81 Takes time to develop attending to the multiple levels of therapy, and on-going meta-level of hypothesis testing and differential diagnosis
3/17-18 Consistently assesses right time to start introducing CBT-based on client factors
3/18-19 Unsure of how clients will receive CBT interventions
3/219-234 Had one supervisor who conceptualized family therapy from many theories, but no coaching with decision-making on what to use when (*Eclectic training background)
3/18-29 Anxious about when to introduce CB strategies to clients
3/24-26 Suggests what would be helpful, but does interventions at client's pace (*flexibility)
1/470-472 Early in career, wondered if treatment selection was empirically supported
3/24-26 Educates clients about advantages of interventions if clients are not receptive
1/430-431 "I got training in a lot of different areas, but no one said, 'here's how you should choose which one to use.'"
1/425-436 (*Diverse training experiences: this may be connected to the ability to be flexible or to be more Integrative when you have training in multiple approaches?)
3/28 Explores client's concerns if not open to treatment selected
3/28 When meets resistance, explores client's concerns
3/35-36 Not an error to introduce treatment selection [CBT?] too early--it is planting a seed if client is not open to it initially
3/224-229 Colleagues in private practice were also eclectic, and she learned from them
3/179-186 Early in career, goal was managing counter-transference and having self-preservation
1/223, 229, 239 Not well-trained in psychoanalysis and EMDR, ACT
3/349-351 Theme of Integrative approach is for someone more advanced. Need grounding in something to understand the process of therapy, then as you become more knowledgeable, can be more Integrative/Eclectic.
3/42 Uses countertransference as an assessment tool
3/42-49 Assess how client talks about other relationships as a way to understand how client will relate within the context of the therapeutic relationship (e.g. how they interact, how other people treat them).

E23 Case specific
2/75-76 Client did not disclose eating disorder symptoms until later sessions; although therapist saw these as most distressing to client
2/89 Short-term therapy fits this research study??
2/12-17 Clinician wants to use case that illustrates multiple orientations/approaches used
2/33-45 Client was referred via insurance to clinic and assigned to therapist based on age match
2/62-63 Thought client repressed emotions, ignored symptoms, and intellectualized to ignore emotions (*early conceptualization)
2/28-30 Client presented with depression/anxiety and clinician provided psychoeducation and supportive care
2/70-74 Initially presented with depression and anxiety symptoms, obsessing, worrying, sleep, appetite problems feeling overwhelmed, and problems with husband
2/580 Case is very similar to usual treatment selection process
2/19-22 Chose case knows well and is representative of who she typically sees

2/504-511 Example of client declining to work on family of origin issues, refused to discuss certain things and therapist respected that (*flexibility? how to account for resistance?)

2/484-495 Client became more psychologically minded and gained insight over course of treatment as she became more comfortable addressing emotions

2/422-438 Long-term goals are "healthy eating," improved relationship with husband, stress management, self-care, and increasing social support

2/202 Countertransference?

2/212-213 Career issues always part of presenting problem, but "more in background" in the first year of treatment

2/178-180 Saw anxiety about life situations as underlying eating disorder behaviors (*conceptualization)

E(alt) Client's role in treatment selection

E [uncategorized]

3/38-40 In the context of private practice, feels should have a specialty for business

Appendix E

Complete list of Cross-case Assertions, Merged Findings, Case Findings and initial codes

Overview:
There are 6 Assertions. Each Assertion has one or more Merged Findings (18 total). Each Merged Finding was created by a collection of Case Findings from across all 5 participants. Listed below the outline is each of the Merged Findings with a listing of all of the Case Findings that created it. In turn, all of the initial codes that went into creating that particular Case Finding are listed as well. Finally, each initial code is labeled with the interview number and line numbers from which it was derived. Thus, each level can eventually be traced back to the section of a participant's words that informed it.

Conventions of font, etc. distinguish each of the levels of analysis in this appendix:

Assertions: **ALL-CAPS, BOLD, UNDERLINED**
Merged Findings: Underlined
Case Findings: **Bold**
Initial codes: Basic font

As noted above, the initial codes maintain the notation of a letter/number/number. The letter (A-E) indicates from which of the five participants' transcripts the code was derived. The first number indicates from which of the three interviews it was derived, and the final number indicates from which line(s) the initial code was derived.

Outline of Cross-case Assertions and Merged Findings
    I.   Therapists were Integrative/Eclectic
           I.1. Integrative/Eclectic Theoretical orientation/identity and View/Role of theories
           I.2. Development of theoretical orientation
    II. Interplay between stability and flexibility characterized treatment selection processes
           II.1. I/E therapists have a core set of theories/worldview
           II.2. I/E treatment selection is about flexibility to best meet client's needs
           II.3. Impasses/reselecting treatments as needed
           II.4. Treatment selection as "balance" among different interventions
           II.5. Being Collaborative/Client-directed/Client-centered/Client's role in treatment selection
           II.6 What is integrated/Technical, Intervention level
    III. The therapeutic relationship is inextricably linked with the treatment selection process
           III.1. Importance of therapeutic relationship
           III.2. Mystery/Intuition/Instinct
    IV. Conflicted disavowal of ESTs, and for this reason felt like a Silent Majority
           IV.1. Conflicted Disavowal of ESTs
           IV.2. A Silent Majority
    V. Therapists reported some concrete, specific things they based treatment selection on
           V.1. Timing of interventions

V.2. Formal diagnosis
V.3. Assessment
V.4. Treatment Goals
V.5. Larger, distal variables that impact treatment selection, like agency factors
VI. Participants' reflections
        VI.1. Meta/Process level, what it was like to participate: Implicit reconstruction

I. THERAPISTS WERE INTEGRATIVE/ECLECTIC

I.1. Integrative/Eclectic theoretical orientation and identity:
A10 Identity as an I/E therapist; impact on scope of practice (generalists)
1/66-68 Intentional generalist, enjoys range of client presenting problems
1/84-86 Not having a specialization keeps her "sharper"
1/389-390 Like a "polytheist" believes all ideas offered by theories have truth ("polytheorist")
1/116 Doesn't identify with a school of thinking anymore
1/392-396 Feels liberated with Integrative principle that all components matter (i.e. thinking, behavior, choices, dreams, relationships, family)
B2 Being I/E and being a generalist
1/82-87 Being a generalist because specializing limits flexibility, and makes you assume more narrowly what you're looking at
1/84 Generalist
B14a Perceptions of others' views of "I/E" and <u>own perceptions</u> of I/E [Edited version: Here, the "positive" aspects of how Participant B defines his own I/E orientation. The "negative" segments, like how he thinks others view his orientation, are moved down to B14b, under "Feeling un-valued & looked down on as an I/E therapist"]
1/160-162 Eclectic approach is a synthesis of other approaches that is tailored for a particular client and his/her set of concerns (flexibility, client-driven approach)
1/135-136; 146 Therapeutic orientation is Eclectic
1/160 In contrast to negative connotations, sees Eclectic theoretical orientation as a synthesis and weaving together different threads
C7 Experiential piece of doing therapy: What it feels like to be an I/E therapist for this participant
1/112-113 "It all kind of fits together for me." Grounding- (*for her it seems to be very integrative- pieces coming together, flow together, not fragmented)
1/79 Orientation feels natural
1/235-236 Feels freedom to choose whatever I feel would be appropriate
C16 Reasons for being Integrative [relates to underlying core view of need to adapt treatment and tailor it for different clients]
3/133-135 Feels adhering to only one orientation would not work for every client
C17 View/metaphor of client concerns broadly, is connected to treatment selection approach i.e., concerns are "multilayered"
2/402 Saw client's concern as multilayered
C26 View of I/E orientation in general [maybe also how defines own orientation w/in this]
1/86 Feels Integrative and Eclectic may be similar labels
D8a and own perceptions of I/E

1/730-733 Process of therapy: Identify/help make sense of problem→help client make sense of own problems→self-insight→experiment with new and better patterns (*sounds consistent with psychodynamic or relational/interpersonal)

3/745-746 Eclectic/Integrative therapists need to be comfortable with uncertainties

3/748-751 Students can't start out as Eclectic or Integrative in their approach (*more of a developmental stage?)

D18 Views of why/when integration is necessary; why he is an I/E practitioner

2/96-97 This type of case, therapist does not want to take a narrow approach, due to complexity

1/134-136 Adhering to strict CBT framework hinders adaptation of treatment to new client material

1/117-118 Therapists use different models and theories because people are too complex to use just one

2/475-480 It is the rare patient who has narrowly-defined problem that responds to narrow approach and brief therapy

1/172-173 Is solidly eclectic/Integrative

1/296-299 He said it's a disservice to clients to think that only one theoretical approach can work

1/337-338 Bottom line: eclectic-Integrative allows flexibility to roll with what client brings into sessions

1/96-99 Hard to connect with client while using CBT

1/320-326 Treatment selection process is challenging because client problems change and treatment has to adapt to the change

3/502-503 Being Integrative/Eclectic gives license to be self-correcting

3/151-161 Less complicated cases can be more prescribed, however more complex cases may require more Integrative approaches

E7a how Pp identifies her own I/E orientation [split E7 into a and b 6/2/12]

1/47-48 Theoretical orientation and conceptualization with "psychodynamically and developmentally-informed approach"

1/444-450 Theoretical orientation differences were ok/allowed, learning because of good supervisory alliance/relationship

3/311-317 CEUs helps understand how own practice fits with other psychologists

1/573-575 Thoughtful about approach (*is this conscious thoughtfulness? Increased b/c stigma of being eclectic? So talking about being thoughtful combats it…)

1/566 Describes approach as "informed eclectic"

Role, View of Theories (a sub-Merged Finding of 1.1)

A7 Role of theory in treatment selection; how conscious use of theory interacts with counter transference, therapist's state of mind

2/131-137 Technical, theoretical notes not directly useful to client; only to therapist

1/385-390 Believes theories help clinicians have models to understand what's going on for the client but all theories are useful. Theories help clinicians think rigorously.

2/420-428 Relying on theory when stuck with client

1/162-169 Will only think theoretically with clients when working with difficult clients, or when less comfortable

1/219-229 Example of difficulty connecting with a client, and a theory-based conceptualization

1/213-215 Thinking about theory indicates to therapist that she is not having an intuitive

connection with client

1/478-487; 495-501 Mentions importance of therapist comfort level and its impact on therapy

B12 View/role of theory in treatment selection

1/349-353 Important for therapist to recognize own interpersonal impact on relationship and not "hide behind" theoretical models

1/596-602 Theoretical orientations complement each other and are not mutually exclusive

C9 View/role of theories more generally

3/132-133 Overlap between theories is obscured because of using different definitions

3/132-133 Other therapists use different definitions for treatments

3/132 Thinks all theories have something in common

E14 View of theories

1/86-89 Sees DBT as specific kind of CBT to use with specific client problems

1/488-490 Much of theory and intervention overlaps, and depends on how therapist or observer labels it

I.3. Development of Current Process of treatment selection is related to evolution of theoretical orientation

A20 Early training and impact of evolution of current I/E approach; Developmental change
over time

1/29-30 Lots of training in learning particular theoretical orientations

1/381 Farther from training, better get at doing therapy

1/429-435 Over time, increased confidence in not following exact theories, and saw as sign of "integration vs. ignorance"

1/37-40 Learning related to treatment selection came more in practicum, internship, experience with clients

3/536-544 Speculates that earlier-career therapists might "still have a [one] theoretical orientation", but more seasoned therapists may not

1/102 Theoretical orientation first formed with psychodynamic ideas

1/53-58 Internship setting was where connecting theory to practice happened

1/53-54 Went to different faculty in dept. for different theoretical perspectives

1/48-49 Originally dynamically oriented, then self-psychology

1/50-51 Graduate dept. did not have one unified theoretical culture

1/42 Learning about treatment selection is difficult in the abstract

1/125-126 Still draws from theoretical ideas was exposed to in training

B1 Parallels of "eclectic"/diverse training and pre-training education & current I/E theoretical orientation [evolution/dev. of I/E orientation]

1/41-42 Psychology fit career criteria of being engaging, enjoyable, and matching abilities

1/71-75 Diverse training background

1/16-17 Took a circuitous path to filed of psychology

1/52-58 Perceived having many career interests, and difficult to narrow them down

1/23-38 Broad graduate-level educational background in the humanities before studied psych

C27 Development, precursors to Integrative orientation

1/554-555 Becoming more comfortable with ambiguity over time (*universal development piece)

3/98-100 In practice, thinks about how she approaches treatment in less detail than did in training

1/13-15, 17-24, 26,30, 32, 28, 40-41, 45-56 Clinical background and training

1/63-66 Evolution of theoretical orientation

1/34-36 Sought multiple experiences to figure out clinical interests

1/666-668 Consulting with a diversity of supervisors and mentors

1/658-665 Not fearing exploration of theories and different approaches

1/681-682 Trusting yourself comes with experience

1/661-663 Developing what works for you based on clients and your experience

1/557-566 Self-awareness and having intentions with clients; Role of supervisors in training program modeling differing orientations

1/500-506 Training program offered classes from various theoretical orientations

1/508-510 Actively encouraged t explore different theories

1/500-506 No focus of theoretical orientation in training/diversity in training

1/508-518 Training history of flexibility of treatment for clients, and for theoretical approaches

1/528-533 Thoughtful about approach to treatment, but at the same time, encouraged to think outside of the box

D22 Evolution/development of theoretical orientation; developmental process of an I/E therapist

1/73-75 Examples: trained in "all the usual suspects": CBT, psychodynamic, interpersonal, motivational interviewing, object relations

1/72-73 In clinical program, exposed to many different models and theories of psychotherapy and psychopathology

1/20-25 Background in addictions

1/34-38 Varied practicum and intern settings; forensic inpatient and counseling center

1/23-32 Re-specialized in clinical psychology as a post-doc because "wanted to do clinical research but was not trained as a clinician"

1/10-13 Educational background in personality and social psychology/studied relationships

1/8-21 Indirect path to doing psychotherapy

1/99-100 Acknowledged that perhaps he used CBT too rigidly due to own anxiety as beginning therapist

1/78-80 Mentor influenced development of an Eclectic approach

1/328-330 Initially more pragmatic, formal, structured in treatment planning (early in career)

1/635-637 Developmentally, therapist felt like "flying by seat of pants" first year, took time to develop comfort

1/615-617 Learned techniques in therapy from experience, making mistakes

1/211-215, 214-215 Very structured with initial client assessment as beginning therapist due to own anxiety

3/p.2 Seems to focus on training and narrative of becoming a therapist. Themes: trial and error, maturing over time, getting increasingly more complex case loads, after licensure, not being in an environment where he could learn the nuts and bolts of therapy

3/371-372 Early on in career, experimented with being faithful to training

3/378-382 Read about Integrative/Eclectic approaches with seeking more flexibility→ Saul Garfield and other resonated

3/693-702 Believes students often have misperceptions of what being a therapist entails; don't realize how complex it is

3/717-723 Therapist had an unconventional path to being a therapist, believes that contributed to his open-minded approach to therapy

3/552-553 Getting better at noticing client's immediate reaction to moment-to-moment interventions

3/69-77 Training program had few cases, intensively supervised, versus many cases

3/55-56 Difficult cases early in career are a "trial by fire"

3/35-44 Maturation process for therapists over time, therefore treatment selection process matures over time/is more informed over time (parallel of therapist growing and treatment selection process growing)

E22 Development/evolution of theoretical orientation, and what Pp has learned about treatment selection itself, more generally, in training

1/ 4-7 Educational background in psychology

3/328-330 As a supervisor, does not explicitly supervise in terms of how to do treatment selection (*as a supervisor, how teach treatment selection?)

3/236-237 Varied training experience influenced range of interventions clinician would consider

1/405-411 Training in graduate program was primarily CBT

1/405-411 Did not get much treatment selection training in graduate program

1/405-411 "Everyone just teaches you their approach to therapy," [versus how to integrate]

1/470-472 Learned with experience about treatment selection

1/457-461 Through supervision, learned about treating personality disorders with psychodynamic theory and its underlying constructs of attachment, loss, shame, etc.

1/413-421 During training on practicums (which were taught by professors) got some more exposure to humanistic and psychodynamic approaches (*diversity of training experiences)

3/76-81 Takes time to develop attending to the multiple levels of therapy, and on-going meta-level of hypothesis testing and differential diagnosis

3/219-234 Had one supervisor who conceptualized family therapy from many theories, but no coaching with decision-making on what to use when (*Eclectic training background)

1/470-472 Early in career, wondered if treatment selection was empirically supported

1/430-431 "I got training in a lot of different areas, but no one said, 'here's how you should choose which one to use.'"

1/425-436 (*Diverse training experiences: this may be connected to the ability to be flexible or to be more Integrative when you have training in multiple approaches?)

3/224-229 Colleagues in private practice were also eclectic, and she learned from them

3/179-186 Early in career, goal was managing counter-transference and having self-preservation

1/223, 229, 239 Not well-trained in psychoanalysis and EMDR, ACT

3/349-351 Theme of Integrative approach is for someone more advanced. Need grounding in something to understand the process of therapy, then as you become more knowledgeable, can be more Integrative/Eclectic.

II. INTERPLAY BETWEEN STABILITY AND FLEXIBILITY CHARACTERIZED TREATMENT SELECTION DECISIONS

II. 1. STABILITY I/E therapist have a core worldview/philosophy/collection of theoretical orientations that forms the basis for treatment selection decisions

A3 Therapist has a core approach to treatment, and additional interventions that are used

with it

2/709-764 Details of how case fits in with typical approaches/what it demonstrates

2/289-295 Initial questions/hypotheses about presenting problem: Wonders about impact of possible trauma/abuse history; client sexuality issues; family of origin issues; developmental context of the problem (*consistent with core of psychodynamic, developmental, relational)

2/326-329 Notes counterintuitive pattern that client was v. comfortable discussion "sensitive" subjects in there, v. uncomfortable discussing mundane topics in daily life (*Consistent with psychodynamic)

2/320-322 Believes there's no such thing as a [totally] happy childhood/family (*consistent with psychodynamic)

2/319-320 Trying "anything I can think of" to "get behind the iron curtain" of memories from childhood (*consistent with psychodynamic)

2/312-317 When client reports "not knowing" or "not remembering" certain past details about life, the intervention is to "engage client around the not-knowing" itself

2/360-361 Notices escape pattern client uses to avoid anxious situations at work and at home (*consistent with relational/psychodynamic)

2/419-443 Uses ability to connect, and awareness of how she's responding to client to question other clinical interpretations of the presenting problems and concerns (own anxieties/internal cues used to make decisions) (*Consistent with orientation, very relational way to use energy in the room therapeutically)

2/p.1&p.2 Addresses consistency with importance of relationship for clinician, and core of relational orientation

2/617-621 Importance of trusting the process and therapeutic relationship (*part of core psychodynamic/Eclectic orientation)

1/153-155 Past and present are parallel tracks you refer back to in therapy

1/144-146 Having historical and current perspectives on problem are both equally important

1/139-146 Approaches clients' problems from 2 sides: How problem developed historically; how current life is affected

1/126-127 Strong developmental perspective in work

1/111-115 Approach has become more existential over time

1/186-190 Considers and uses the technique of working with transference

1/536-540 Core theory of orientation (*using core)

1/536-543 Consistent: clients engage in repetitive relationship patterns related to early relationships

1/513-526 Consistent across cases in existential issues related to human condition (*using core)

2/371-384 Two-part approach with interventions with social phobia: 1) education and behavioral strategies for anxiety management; distress tolerance 2) Relationship/interpersonal strategies using therapy relationship to experiment with new skills

A14 Views about length of treatment

2/60-63 Believes in a spiral model of clients returning to similar issues over and over at different levels through life

2/38-42 Rarely ends therapy. Clients often return for booster sessions.

1/265-267 Feels more free and effective with clients with a longer-standing relationship

3/137 Limited sessions with clients can lead to symptom reduction sessions and not therapy

3/137-138 Perceives self as outlier due to longer treatment time than evidenced-based therapy

suggests

3/147-150 18-24 months of consistent therapy bring clients to a different base level (coders note:*had strong reaction to this)

B3 Description of won theoretical orientation from Pp [core?]

-How parts work/fit together

-How evolved over time

-What approaches/parts make it up; what it entails

1/135-136 Explaining multiple theoretical influences

1/576-577 One important principle (from Jung) is the dialectic

1/569-576 Example of common theme therapist has seen in clients: dichotomous thinking

1/335-359 Relational/transference

1/553-555 A main intervention: exploring alternatives to the client's current themes and patterns

1/545-547 Free expression early in therapy allows themes to emerge from the client

1/p.17; 592-594; 586-587 A lot of relational aspects of this treatment; also brining in cognitive interventions

1/549-550 Therapist's role is to identify the themes client returns to again and again

1/551-557 Identifying themes in client's stuck points could be cognitive or emotional

1/147-154 Although CBT techniques don't "come naturally," is open to using if helpful to a client

1/139 "Existential over-lay" [thinks of theoretical orientation as having overlapping layers??]

1/135-142 Lists components of theoretical orientation: client-centered, psychoanalytic, and existential

1/135 Theoretical orientation has evolved over time

C2 Has a core theory into which she integrates everything else [goes against Integrative stereotypes]

2/277-278 Interpersonal or Integrative orientation is seen as the basis of Integrative orientation

2/(**shows full understanding of client's story, deep understanding of client's specific family, culture, goals --maybe consistent with narrative approach, or a general competency thing??)

1/88 "It's just kind of pillars to the treatment"

1/418-419, 421-423, 427-436 Little variation in conceptualization

1/670-671 Importance of being grounded in something, not flying by seat of pants

2/417-418 Story in treatment just like in clients' lives. Therapist checking in to see if technique and the event match the affect (*consistent with narrative orientation)

2/57-58 Overall umbrella for treatment was multicultural understanding

3/167-172 Termination differs depending upon the client

2/50-61 Core theory is foundation of treatment (*consistent)

3/152-190 Termination is an opportunity for intervention, and is also tailored to clients needs (*consistent with client-driven core ideation).

3/207-210 Prefers termination that is more formal (discuss and process end of treatment (*related to core)

2/313 Noting importance of talking about a topic day in and day out as a cue to focus on it differently (*client-driven)

3/214-215 Unique relationship

1/141-158 When assesses, assesses it from the client's experience of it (prioritizing what the need at the moment and what's pressing)

1/141-146, 163-168 Client-based. What client needs, understanding client's world, meeting client where they're at

3/172-174, 180-182 (*consistent with core theory, example of how relational core is consistent throughout process of therapy)

C3 General treatment approach level: relational stance/beliefs/worldview

2/224-225 Stay curious about client

1/208-212 Believes therapy really happens outside the treatment room, giving client something to reflect on

2/441-444 Working within client's cultural lens/worldview

1/400-406 Educating clients about concern

2/191-194 Therapist curious about client's cultural context related to concern

3/72-73 Treatment selection should take the whole person into consideration

3/482-487 Therapist careful not to impose own values onto client

1/448-450 Understanding client context/needs

1/667-679 Being present with your clients and not being in your head

1/664-665 No right approach for treatment, always, "it depends"

2/643-672 Understanding client within their cultural context

1/222-223 Thinks about own assumptions and counter-transference issues

1/212-216 Client has agency in treatment, therapist is the guide

2/614-615, 617-618 Tries to tell clients a rationale for interventions, which was helpful in this case

2/147-150 Relying on client resources/empowering (*fits with feminist, empowering, description from previous interviews)

1/90-92, 126-129, 141-146 Client-driven approach

2/624-630 Giving rationale to clients allows them to take agency

1/289-292 Educating clients about process of change

C19 Person of therapist level: ways who she is/what she values as a person is consistent with core and Integrative orientation (e.g. humor)

1/48-54 Multidimensional clinical experience- likes wearing different hats (different roles in practice)

1/61 Refers to prior info on background as "my story," "my journey being here." (*consistent with narrative approach. Ways who she is, what is valued to her shows up in clinical work)

2/633-641 Felt she grew a lot from case, including learning about culturally normative grieving and suicide, and ways culture, religion, and gender intersect for client (*consistent with her core approach/egalitarian)

1/177 Aware of how own cultural background (accent) impacts way she is seen by clients

1/156-157 Self-awareness of own views of psych problems/own perspective as well as client's view of what they need

2/388 Use of humor to develop rapport

2/471-475 Willingness to joke/show own personality, even in context of rapport with writer/interviewer

D4 Core/worldview, philosophical approach to therapy style [collaborative, reducing power differential, client directed, client-centered]

3/568-577 Very collaborative approach, reducing power differential

1/460-463 Important to understand client and instill hope

2/48-49 Mentions client's strengths, bright, good sense of humor

2/166-168 Assigns homework that is not overwhelming for client; matches task to client's functioning level

2/163-164 Collaboration to come up with what the first step will be; engage client to be less withdrawn

2/250-253 Treatment approach relies on asking the right questions, believes in power of self-discovery and doesn't want to give client the answers

2/231-233 Finding meaning in life is critical to client's survival (flexibility in treatment selection based on client's needs??) (coder's question: *Is this what you would've done with all depressed clients, or was it specific to how this client was presenting, and that that's what she seemed to need?)

2/329-334 Believes there's a strong connection between mind and body; anxiety and depression impact physical movements, so observe these in session

2/361-368 Transparency with reasons for note-taking; content of notes; facilitates equality

1/724-729 Internalization of therapy/therapist ("My voice goes with you" quote)

1/573 Nurturing self-discovery process in clients in important approach to therapy

1/p.20 Seems to be another example of "my foundation is relational but I'm not saying it"--talks about things like repairing relationships, collaborating, instilling hope, building trust

1/277-285 Provides psycho-education about therapy to clients; invites them to discuss their own ideas about therapy, this contributes to client comfort with the process

1/578-587 CBT too inflexible and the goal of therapy is to get at the right question to elicit emotions, memory or thoughts, you hit a nerve

1/129-130; 132-133, 143-144 Clients are more cautious during initial therapy and will be more open as therapy progresses

1/484 Builds on clients' strengths

1/558-560 Core notion in conceptualization of cases is "balance" in life, and what may be out of balance for them

1/508-528 Example of collaborative approach; being responsive to client input

1/394-396 Importance of emotion (as opposed to cognition or relational aspects of material)

1/703-706 Worldview as therapist: People adopt patterns of behavior based on what "nature" (life) gives them, some are dysfunctional and repetitive, but new patterns can be learned

1/603-613 (*speaking client's language/down to earth)

3/204-205 Humility is a key part of success

3/431-439 Cautions about not being over-confident about what doing as a therapist

3/207 Self-awareness of own limits, frailties, and strengths is important

3/563-570 There's no protocol for therapy. Other forms of healing (massage/acupuncture) have more structure to the treatment plan

3/255-259 Being with patient in therapy room is "a very complicated information processing task" → includes perceptual field of listening, watching, picking up clues, information, history, and current happenings

3/351-353 Transparency with clients about what information he has about them already (before first session)

3/* Style seems to be very egalitarian, sharing of power, almost like a feminist approach, almost like equals collaborating

3/392 Therapists are healers that represent hope for people

3/p.17-18 Examples of fostering collaborative relationship; each person (therapist and client) bring something important to the task

Note: From Pp D's Email: Overall comment: "There are multiple and diverse influences on my therapeutic approach and I'm not sure that my overall approach falls neatly into any of the four 'modes' of psychotherapy integration espoused by some authors, namely technical eclecticism, common factors, theoretical integration, or assimilative integration."

Broad theories or models he draws on: Interpersonal, Behavioral medicine/health psych, Mindfulness, Object Relations, Cognitive theorists/practitioners, ACT, motivational interviewing, and Victor Frankl for existential/meaning-making, Michael White and aspects of Narrative, also some additional, but less central, including Jay Haley, Albert Ellis, Leslie Greenberg. "I suspect that this may not make your task easy in trying to characterize the theoretical underpinnings of my approach!!"

List of people who have influenced his approach: Harry Stack Sullivan, Gerald Klerman & colleagues (IPT), Jeremy Safran & Zindal Segal→Jon Kabat-Zinn, Thich Nhat Hanh, Irvin Yalom, N. Gregory Hamilton, Michael Mahoney, Aaron Beck, Michael Hoyt, Lorna Benjamin, Stephen Hayes, Miller & Rollnick, Michael White, Viktor Frankl, Leston Havens, Joseph Wolpe, Jay Haley, Albert Ellis, Leslie Greenberg, "and the list goes on."

"…suffice it to say that fundamentally my approach is interpersonal (primary focus on relationship with self and others) examining traumas, fears, regrets, betrayals, etc., with an eye towards finding meaning and purpose in life, developing plans and courage to undertake needed changes in one's life, and effectively navigate the ups, down, and vicissitudes of life."

"I should also note that much of the time I focus more on emotions/feelings than on cognitions but I am also mindful of the interplay of thoughts and feelings in how life is experienced and interpreted. I also pay close attention to anxiety in its many manifestation…"

"So, as an eclectic/Integrative therapist, my task is to marshal all my knowledge and experience in service of the general goals listed here as well as the specific goals articulated by the patient. Goals evolve as you know, so I try to be flexible, creative, responsive, and empathic as I work with each patient."

-Note: What seems to tie together the interpersonal/emotion-focused, insight ones and the CBT, behavioral, mind/body ones is "In my approach, I also emphasize the importance of translating insight and understanding into action steps that promote positive change."

D17 Aspects of therapist as a person that relate to I/E orientation or treatment selection approach

2/460-461 Therapist believed client helped him be a better therapist, thanked client for that

1/129-130 Clinician disclosed in interview they've been in therapy before

1/404-439 Believes own personal history/experiences led to capacity for empathy (i.e. father modeled empathy, own experiences as a client)

1/380-389, 404-405 Therapist brings to therapy strength of empathy, which is foundation of his understanding, which is first step to intervening, and also, therapist must feel empathy for therapy/treatment to be effective

1/p.12-13 Discusses personal experiences with therapy. By him sharing this with me, it's in line with transparency, empathy, openness, quality of being empathic, knowing you've been 'on the other side of the couch'. Speaks to his character, how he is with clients. Humanness, or humility towards approach to therapy

3/225-229 Therapist transparent about his own struggles with mental health

3/181-193 To be an effective therapist, one needs to be smart, and have natural emotional attunement in order to be genuine "can't teach someone to be emotionally attuned".

3/59-62 Motivated for clinical work so that he can help people

E3 Core, underlying approach to therapy; Philosophy; What is consistent across clients [What is integrated into?]

3/93-94 Underlying philosophy of "doing what is best for the client in the moment" guides intervention (*flexibility, person-centered)

3/296-299 Thinks of "feminist lens" as multicultural lens and philosophies or theories more than empirical interventions

2/140-143 Integrates CBT components into therapy

1/218-220 Really thoughtful about everything I say, but still make therapeutic errors at times

2/155-156 Worked on eating disorder in a "clear cut cognitive behavioral manner"

2/500 Always proposes interventions before doing them

2/305-309 Incorporates understanding of both partners' family values and functioning, in conceptualization

2/155-157 Educates client about approach, shares conceptualization

1/168-174 Believes clients want an active therapist and clients want direction

3/294-296 Certain disorders need specific approaches (i.e. CBT with anxiety)

1/150-153 Therapist engages with clients differently "one size does not fit all" (*client-driven flexibility)

1/146-148 Likes that she chances approaches based on what client brings in (*client-centered)

1/537 Common thread in treatment: Always uses CBT in some capacity

1/255-256 Understanding what triggers and maintains symptoms is important for long-lasting treatment benefit (*brief vs. long-term)

1/701-708 Seems to take a contextual approach to understanding client history

1/663-665 Uses power in a therapeutic way

1/626-633 Regarding alliance, conveys openness to client feedback about what's working or not in therapy

1/577-581 Approach is a combination of CBT and psychodynamic

1/271-275 Gives client psychoeducation about what has been shown to be helpful re: treatment, then respects their choices (*flexibility?)

3/298-302 Uses feminist and multicultural lens to understand how the client views/makes sense of the world

II. 1. <u>Change: what produces it</u>

A8 Change, and what produces it

1/196-207 Uses interpersonal process and observation of non-verbals as avenues for change

1/370 Feelings are more fertile ground for change than thoughts

B16 Change and what creates it in psychotherapy

1/215-229 An important part of therapy is hearing self in a different way, as reflected by the therapist. (*Mechanism of how relationship can lead to change)

D11 Change and what leads to it

1/82-85 Interested in mechanism of change and immersed self in literature

1/613-618 Trusting relationship, empathy is key, and asking right questions helps someone evaluate their lives in a therapeutic way

3/360-361 Trust in therapeutic relationship is fundamental for effective change

<u>II.2. FLEX: I/E treatment selection is about flexibility in the service of tailoring treatment to each particular client's needs</u>

A6 Treatment selection is fluid/flexible (and the boundaries/structure of therapy allow for this)

3/224-228 Components of therapy are ambiguous, hard to differentiate or lable, but the overall structure of therapy is well-defined

2/112-113 Structure from training provides freedom to be more fluid, so you can abandon structure (*training's specific impact on current practice)

2/312-317 Takes time with client, moves at client's pace (flexibility)

2/410-417 Response to client worries about un-recalled abuse history was to downplay importance of need to remember everything (*flexible with interventions)

2/554-563 Flexibility with treatment options and areas to explore--dreams

??2/73-75 Defining treatment selection process feels like trying to put a taxonomy on something fluid

3/74-75 Treatment selection is fluid

3/115-116 Treatment selection is fluid and individualized

3/307-310 Not being rigid; flexibility

C1 Fluidity and flexibility are hallmarks of Integrative approach [client is the 'constant' therapist moves to meet them, then help them move]

2/249-251 Flexibility to shifting therapeutic focus when needed

3/130-137 Believes there is a lot of overlap with theories, wonders how other clinicians work with just one theory (*flexibility, not understanding how others could be rigid)

1/361-365, 317 Experimenting with different approaches to see what works

1/358-359 Creativity with intervention

1/419, 438-443, 456-469 Flexibility with treatment

1/511-521 Culturally sanctioned or informed flexibility with clients (freedom because of international piece)

2/583-587 Flexibility with regard to new challenges that arise for client

3/230 No specific rules for termination (*flexibility)

D19 Importance of flexibility [links to complexity]

1/167-171 "With complex mix of history, symptoms, and goals, eclectic/Integrative gives greatest flexibility to use all therapist's knowledge and experience to help"

1/232-236 Flexibility with questions during assessment, from the beginning there is flexibility to get to the heart of distress

1/332-334 Flexibility with treatment planning as client discloses more (*parallel to developmental path--early in career, more structure/formality, that decreases significantly over time/experience)

1/694 Knows what he can get away with in session

1/495-497 People are complex, and need flexibility of approaches

1/481-482 Collaborative approach, flexible in degree of directiveness, "if the situation calls for it"

3/374-379 Rigidity in applying theories doesn't do justice to the complexity of people

1/144-145, 170-173 Integrative/Eclectic = flexibility

3/374 Practicing therapy over time is an ongoing experiment where you gather data

3/439-451 People are complex and need flexibility

3/505-509 Rigidity in treatment, or excessively structured treatment plans don't allow for flexibility with client

3/455-460 Individual treatment plans for clients/tailoring treatment to their needs/flexibility

1/171-172 One narrow therapeutic model is not flexible enough

3/p. 20 Seems like (example of client who was closeted); one reason flexibility is important is that without that, you might miss a very important part of the client's problem; examples of consequences of what can go wrong if you're not flexible

3/642-647 Therapy can be oversimplified, and therapists need flexibility; "not like Beck said it was!" (*conflating flexibility with complication??)

E18 Importance of flexibility

2/445-452 Saw client at different frequencies over course of treatment, less often later on

2/216-232 As client's concerns shift, interventions, approach shift as well (*flexibility? lack of boundaries/organization?)

1/137-142 Example of interventions used based on a narcissistic style: not competing with client (*flexibility/tailored interventions)

1/314-319 Empathy is not going to work with all clients (*flexibility)

1/303-312 Some clients benefit or want more CBT, some do better with supportive psychotherapy (*flexibility)

1/433-443 Worked with a psychodynamic supervisor who didn't originally recognize her CBT skills. Saw them as "nascent" because they were so different. (*Flexibility, natural inclination towards integration. Pieces of what this person can teach me is integrated)

3/328-337 As a supervisor, does encourage supervisees to use CBT and to consider personality dynamics together (*teaches flexibility to supervisees)

3/262-266 Those trained in a particular approach, or working with a specific disorder may lack ability to work with other types of cases or do basic things (like intakes) (*flexibility, the other side of the coin)

3/61-67 Client receptiveness to interventions in the beginning influence whether other interventions are used later on in therapy. (*flexibility-- if one approach isn't working, reconsider how to sell it to the client, or reconsider using it)

II.2.a. FLEX: Impasses and re-selecting a new treatment- clues/cues/timing

A12 How treatment selection works related to impasses in therapy for I/E therapist

Note:***Positives of Eclectic approach is having a back-up plan if nothing is working. At impasse, trigger to play with more tools, to be more flexible

2/604-608 Flexibility with trying new techniques based on non-movement with client (coder note: *seems to be driven by clinician's anxiety, not client-focused, feels haphazard)

2/Explores treatment options when movement (observable) is not occurring in therapy

C18 Knowing you're on the right track with treatment selection [client directed/centered?]

2/356-357 Knew she was on track with client by looking at outcome measures

2/448-462 Using client's narrative and culture to guide gauging milestones

2/437-438 Notes that mismatches in affect and event point to something bigger that immediate concern

2/215-220 Stay curious about client, looked to client's lack of improvement as cue to be curious

abut unknowns

2/256-257 Looking for change within first 2-3 sessions; draws on past experience to judge how long intervention should take to work

1/270-271 Consequences of choosing "wrong" intervention at wrong time (i.e. push change too fast) can be premature termination

2/189-191 Noted client was not getting better after acute crisis phase

2/365-369, 372-379 Checking-in (directly asking client about treatment progress)

D20 Signs for needing to change/re-select a new treatment in therapy

1/639-646 Anxiety is important to pay attention to; it can be healthy, but can also be a signal to take action in directing therapy

3/524-526 Therapists can tell when things are getting worse for client, and needs emotional attunement to provide support for the client

3/405-416 Discusses with client when he sense they don't "click"

3/297-302 Sometimes, if something is not clicking early in therapy, wonder if missed crucial information, either due to won assessment or lack of sufficient client trust to disclose information

3/524-526 Signs for needing to change approach in therapy are 1)experience/instinct, 2)client resistance 3)client getting worse

3/511-522 Each session, learn more information about client, and trying to facilitate change. Over time, new information may indicate that the first approach is not working, and you need to shift

E19 How do you know you're doing the right thing/have selected the appropriate treatment -What to do at impasses

1/257-259 Does not belabor CB strategies if client is skeptical/not interested

3/60-61 Pays attention to how people respond to interventions in first few sessions

1/499-507 Now, confident in approaches used because clients give feedback that they're doing/feeling better

1/355 Frequently refers to initial treatment goals, especially if progress slows in treatment (*what does at impasses)

II.2.b. FLEX: Treatment selection as a "balancing," titrating amounts of x between poles

A11 Balance: dialectics of different treatment aspects in treatment selection

3/45 Balance of technical and relational during treatment selection depends on comfort or anxiety of therapist

3/20-26 Affect vs. cognitive; abstract vs. concrete

3/204-206 Therapy is a dual process of cognitive and relational; Therapy is guided by a sensory process and not a cognitive one

3/198-200 Difficult to discuss the different between intuition and technical/scientific aspects of doing therapy

2/89-95 Balance of intuition/relationship and technical clinically-focused diagnostic thinking

3/28-30 Hard to balance the closeness and empathic with distance and objective (*participant observer?)

C23 Treatment selection as a balance among different (competing?) goals/elements/options

3/146 [Therapy] is an art and a science at the same time

1/525-529 Balancing out of the box multicultural approaches with appropriate boundaries and being intentional with interventions

2/494-497 Balancing helping client increase her flexibility without breaking her values
2/201-209 Example of balancing supportive interventions with change interventions
1/121-127, 126-129 Balances change strategies with clients values/culture and preferences (*client-driven flexibility)

D15 Treatment selection as balance among different elements [including big one: Therapy as Art v. Science]

3/311-316 Walk like between allying anxiety too much and not enough
1/478-487 Understanding, emphasis on relationship, but not "touchy feely", also problem-focused, finding solutions
3/263-271 Challenges with testing subjectivity, however the subjective component of therapy is very important to the process of therapy
3/688-689 Therapist stance: not be over-or under-emotionally involved
3/471-477 The mystery of treatment selection involves balancing how therapists monitor feelings and monitor thoughts
3/848-855 Therapy is both an art and a science, it's hard to know when someone becomes an effective therapist

II.3. FLEX: Being collaborative/client-centered, client-directed, client's role in treatment selection

B8 Importance of being individualized and client-driven

1/407 Starts where client starts
1/93-94 Meets clients where they are
1/389-397 Client-driven, meeting them where they are at
1/184-189; 191-194 Client-driven, specifically tailored to clients' needs, no template for doing therapy
1/160-162 Client-driven in which threads to accentuate
1/107-122 People are unique so need client-driven work
1/p.14 Seems to strongly suggest flexibility and client-driven approach
1/147-154 Can meet client where they're at, even with not varying theory/orientation
1/103 Individualized and client-driven

B9 The structure of therapy comes from client themes

1/539 The structure of therapy emerges from the themes in the client's material
1/545-555 Client-driven therapy--themes that emerge, no pre-determined structure from therapist
1/604-607 Client's themes are the unifying structure (is this what is used for conceptualization/treatment selection?)

C4 Collaboration, techniques to facilitate collaboration [client's role in treatment selection]

1/203-207 Client-driven, further factors that influence treatment selection
1/361-365 Client role of saying which techniques are used in therapy (*client driven, based on trying to build it equality, flexibility with treatment)
2/517-519, 521-529 Working within client's spiritual beliefs, understanding problem through client's cultural lens
1/173-174 Educates client how to be a client
1/329-336 She's educating the client how to be a client working w/ Integrative therapist. i.e. client has to be flexible, therapist models flexibility in change process (*universal-setting client up in therapists' change paradigm)

1/276-278 Understanding what change means to the client
1/448-469 Importance of negotiating focus of sessions with client (e.g. when client is avoiding)
2/605-610 Cooperates with client for treatment planning
2/200-201 Collaboration of treatment is important (one way is to "check-in") checking in facilitates collaboration
2/359-351(?) Collaborating and working together to make meaning
2/25-30 Treatment approach is collaborative (*client's role in treatment selection)
3/218-230 (*consistency with core theory and client-directedness/focus on collaboration)
C24 Part of treatment selection is prioritizing what client issues to work on
2/36-40 Attends to crisis first
2/103-105 Deal with immediate stress and crisis first
2/104-105 Therapist's first thoughts about treatment focus are based on client symptoms
2/69-73 Crisis comes first

II.4. FLEX: What potential treatments are integrated: What range of things are therapists deciding among/ Technical/Intervention Level
A19 Treatment selection as Intervention, Technique, Technical Approach Selection
1/448-455 Some approaches that therapist uses are more comfortable for some clients than others, so does consider match in that sense (i.e. with mindfulness interventions)
C15 Technique level treatment selection: What treatment tools are in the bag, and when to use them
2/315-318 Using client needs to guide treatment at technique level
2/308-310 (*cues to do certain interventions)
2/341-347 Aware of big picture in terms of potentially contradictory coping styles for client
1/348-352 Example of how she would interweave process comments into flow of change process (*you need a lot of tools in your belt, wide range of interventions)
1/367-395 Doesn't provide answers for clients
1/280-285 Example of how to ask what would change look like to client
1/418-419 Much variation in interventions
2/139-140 Open to client's spiritual beliefs as a coping skill
2/276-279 Treatment approach fits with client's clinical needs even if outside of traditional approach (*flexibility/client driven/needing lots of tools)
2/127-134 Acknowledging real world constraints in client' s life/working with system
3/600-602 Using psycho-education as a strategy to get client buy-in to treatment
2/278-279 "borrowing" another treatment approach because I know it works well with a particular problem
2/320-321 Looks to previous knowledge of what specific techniques can be helpful in general
2/120-123 Understanding family and cultural influences
2/325-334 Example of using interpersonal process comments
1/228 Therapist has multiple treatment tools/treatment options
D12 Examples of interventions used: What is integrated :
-Techniques
-Things the therapist does
-These are tied to worldview, philosophy, theoretical orientations, training
2/207-217 Treatment selection included making meaning of life/reason to live (*how did this

happen? what did it look like?)

2/172-174 Initial plan/goal was for client to walk every other day

2/166-168 Collaboration with client to come up with action plan to make therapy less overwhelming

2/181-182 Worked with client to identify sources of social support

2/174-181 Identified depressed behavior pattern with client, and examined practical ways to break it pattern

2/141-146 Part of treatment for severe anxiety or depression is remoralization; reminding clients of strengths and resources they have

2/123-130 Therapist noted/acknowledged real environmental/outside barriers to client's goals (e.g. ex-partner's behavior)

2/127-128 Client shared letters with therapist; therapist had phone contact with ex-partner [use of outside information to inform therapy]

2/240-256 Noted strength of not using drugs/alcohol as a way of coping

2/121-123 Noted client's strengths/what was most important to client

2/222-227 When client directly asked why she should want to live, therapist did 2 interventions: one, collaborative/matter of fact inviting client to examine that, brainstorm, problem-solve, and two, cheerleading, reminding of strengths

2/209-215 Acknowledging/empathizing with life events of client, and impact on client's sense of self

2/310-313 What does in therapy: Asks right questions, observes non-verbals

1/710-714 Encourages discovery of, and trial of new patterns of behavior and thinking

1/313-326 Attends to non-verbals and provides feedback as part of intervention

1/651-671 The client's symptoms, narrative, history, etc., are clients to their problems, and therapists are like detectives to ask the right questions. Probes until client gives some sort of affective reaction/causes some internal shift (probably non-verbal); also foster's client's own self-detective skills

1/603-610 Interpersonal process is introduced in non-threatening, down-to-earth way (i.e. "time out on the field"); this benefits building trust in the relationship

1/592-603 Elicits feedback from clients regularly

1/673-674 Sometimes hit and miss, trial and error when asking questions

1/568-572 Helps client connect life circumstances and own behavior to distress and symptoms they're experiencing

1/582-592 "Asking the right question" to encourage deep reflection is another tool frequently used

1/530-556 Examples of "staying in balance"; some tools in tool bag are mindfulness, breathing and relaxation exercises, encouraging self-care, and walking

1/678 Uses a lot of humor in therapy; this helps clients gain perspective

1/689-694 Uses paradoxical techniques

3/555-561 Taking time-outs to process when you recognize they had a reaction to an intervention (time-out on the field)

3/248-261 Therapist doesn't focus on dysfunctional thought patterns; attends to client's dysfunction as a whole, and has to be attuned to pick up a variety of cues within the perceptual field

3/317-335 Provides psychoeducation to clients, carefully discusses informed consent, etc.

3/418-423 Provides psychoeducation to clients about the process of therapy

3/579-583 Provides psychoeducation about what therapists and clients bring to therapy, such as expectations of the client, and modeling how to be in therapy

E9 What is integrated; Techniques/interventions used; tools in toolbox; includes interpersonal/relational stances as choices made

2/605-617 Considered/tried referral to couples therapy, but couple was not interested

2/516-537 Motivation interviewing for ambivalence

2/356-357 Also used psychodynamic, relational, interpersonal interventions

2/346-353 The PTSD treatment was like a separate mini-therapy within the therapy-- a few sessions, then returning to original goals/problems

2/246-251 Feminist approach integrated into work w/ eating disorders due to contextual factors such as working in a setting that was very appearance-focused (*flexibility)

2/234-237 Used feminist perspective with eating disorder perspective with eating disorder symptoms by exploring client's context and messages about weight and size

2/223-226 Linked symptoms with life events

2/182-183 Vocational counseling re: questioning career

2/185-187 Feminist unclear, because client wanted to be in math and sciences?

1/56-57 Indentifies strengths for resilience

1/50-52 Uses cognitive behavioral interventions for quick decrease of distress

1/76-80 Uses many techniques such as gestalt, mindfulness-based techniques, and here and now processing

1/82-84 Trained in DBT which informs practice, especially around emotion regulation issues/distress tolerance

1/203-209 Self-disclosure to build interpersonal connection

1/180-181 How much therapist bring self into room is depending on client (this is another continuum of behavior) (*flexibility)

1/157-166 One parameter that changes is how active therapist is (but never ranging down to the point of being passive) gives example of a passive-dependent client

1/321-322 Asks what clients have tried in the past that helped in order to suggest a direction for treatment now (*flexible, collaborative)

1/306-311 Often provides supportive psychotherapy/Rogerian techniques. Empathy and validation go a long way: "Talk therapy? Like the talking cure? It really works."

1/300-306 Most clients are interested in CBT, some even ask for it by name

1/653-676 Integrates feminist approach into work

1/682-683 Always integrates feminist and multicultural perspective

1/609-616 Explicitly describes to clients how they can use insight to make changes in current life

1/259-263 Uses self-disclosure as part of installation of hope, and installation of confidence in therapist expertise

1/237-239 Feels comfortable/familiar with "most major movements since modern psychology" and utilizes them

III. THERAPEUTIC RELATIONSHIP IS INEXTRICABLY LINKED W/ THE TREATMENT SELECTION PROCESS

III. 1. Importance of Therapeutic Relationship

A2 Importance of therapeutic relationship
3/402-404 You can't let your conceptualizations carry everything, needs to be in addition to relationship
3/125-129 More effective when knows client well over long time period, because can begin to predict their tendencies
2/245-250 Compassion for client's discomfort in first session of therapy (*relationship building)
3/129-130 No shortcut to getting to know the client well
2/p.8 and throughout: [meta: from coders: Took a long time to get to the story, lots of qualifying…maybe indicates great respect for client, great care over client confidentiality--related to valuing of relationship]
2/50-53 Therapeutic relationships that end are the ones that never fully developed
2/40-53 Therapeutic relationships never end
1/408-418 Therapist authenticity and unique directness of therapy relationship are agents of change
2/all p.5 Focuses on clinician's value of relationship within psychotherapy
2/118-121 Relationship is active ingredient in psychotherapy
1/196-202 Client-therapist relationship is important part of therapy
1/236-237 Power and effectiveness of treatment is the relationship, human condition
2/704-707 Shift in treatment seemed to reflect a shift in client-therapist relationship. Stronger relationship got, things shifted and began to click more in therapy (*Consistent with relational approach)

B10 Importance of therapeutic relationship
1/239-240 Building trust and rapport is not technique-based
1/316-323 Therapist is attuned to therapeutic climate or atmosphere
1/341-342 Creating a therapeutic environment where client can express themselves is prerequisite for treatment
1/246-251 Building relationship is pre-requisite before any technique will be effective
1/242-246 Relationship is fundamental to work with clients, at core
1/242-246 Trust is a gift (transparency, respect, no assumptions that they will open up…trust must be earned)
1/242-246 Building a relationship includes not taking trust for granted
1/305-310 Foundation of therapy is whether there are grounds for a common understanding
1/169-173 The relationship is most important in therapy--more than theoretical approach
1/408-418 Not directive, collaborative, sharing of power
1/502-504; 510-511 Self-disclosure; transparency important

C12 Therapeutic relationship as change factor/core approach to treatment
1/100-105, 116-124 Components that lead to therapeutic change: relationship (*ways change happens in relation to interventions' mechanisms)
2/25-30 Developing relationship is important to treatment approach
1/427-436 Therapeutic relationship used in a therapeutic way is constant (*relational approach part of core)
2/373 Sensitive to ways culture impacts their relationship
2/25-30 Change occurs or can be created if therapeutic relationship is there/necessary for change
1/95-98, 100-105 Therapeutic relationship (*foundation of orientation. "grounds me."
1/254-255 Relationship building

2/25-30 Relationship/alliance building comes first in treatment approach

C25 Therapist's level of comfort/discomfort, informs treatment selection [treatment factors]

2/136-137 How therapist's own feelings/empathy guided treatment selection

2/553-557 Awareness of own counter-transference

1/531-538, 535-544 More comfort in providing therapy leads to more flexibility with treatment approach (ex. of CBT comfortable at first)

D2 Therapeutic relationship: Empathy and importance of trusting treatment relationship
-ways therapist facilitates this
-what are important aspects of building this

1/443-446 "Getting it" involves an emotional connection; clients want to be understood

1/696-698 Repairs relationships with clients when conflicts arise

13510-513 Believes therapy relationship, with its firm boundaries, is "for the duration"

2/401-406 Turning point in therapy was directly confronting client about withholding key information, and processing client's motivations, and the implications for the therapy relationship

1/439-448 Empathy is the basis for connection and understanding in therapy; empathy is fundamental

2/303-308 Seems to suggest the importance of relationship; not explicitly said

1/122-133 Importance of trust and rapport material that clients will share

1/249-255 Compassion for anxiety/discomfort of initial session for client

1/448-454 Alliance and rapport are based on client's belief that: therapist understands their suffering; therapist has knowledge, expertise, and training to support client's hope for positive change

E8 Relationship itself as intervention

1/59-64 Therapeutic relationship important for change is influenced by humanistic and psychodynamic theories to provide a mirror for client, and positive regard

1/61-62 Lists specific ways therapy relationship can help lead to change: It's a mirror for client, Experience of positive regard, enables use of transference/countertransference

E16 Interaction of relationship/alliance with treatment selected, intervention/technique used

1/279-287 Uses Psychodynamic approach; attends to relationship and uses that for teaching interventions (*flexibility?)

3/103-107 Approach to treatment/intervention decision-making changes as the connection/alliance increases

3/107-109 Once alliance is well established, clinician responds to emotions, and selects interventions based on that

E20 Therapeutic relationship and treatment selection: How they interact

1/608-616 Relies on client characteristics for treatment selection (*client-driven approach)

1/604-608 Determines if client is psychologically minded enough and non-defensive enough to focus on insight regarding their relational patterns (*client-driven)

1/279-283 Uses dynamic between client and therapist to make decisions about how/when to introduce and tech techniques and follow-up with them

3/54-55 Client's personality influences the acceptance of treatment selection

3/52-55 Understanding client personality helps predict how they will respond to treatment

suggestions, where areas of resistance will be

Note: it also seems to make sense to subsume the Merged Finding of "treatment selection as relationship selection under III. 1. So:

A1 Treatment selection as Relationship Selection process: interpersonal stance, interpersonal behavior choices

2/25-27 Related to flow with client not conscious choices about technique

1/213-215 Deeper connections with clients will lead to an intuitive understanding of the therapeutic process

1/361-161 Choosing what to focus on is more clear with knowledge of client's narrative

1/309-318 Treatment selection includes moment-to-moment decisions (i.e. "do I follow up on that emotion or do I let you sit with it…?")

1/365-372 Choice of what to follow up on guided by: Knowledge of overall narrative; what is client's emotion

1/447 Matching goes on between people (therapist and client) more so than between client and a chosen theoretical approach

1/260-265 Makes conscious decisions around confrontation vs. support; thought shifting vs. attending to affect

1/358-360 Steers interactions in therapy by choosing which aspects of client's material to pay attention to

1/210-212 Therapist uses where to go next as barometer of relationship

3/157-159 Associates "treatment selection" with "positioning" self as a therapist

3/95-100 Treatment selection is not about the technical interventions for specific diagnosis

3/94 Treatment selection is about where to position yourself in relation to the patient (*interpersonal)

1/647-673 Other variables/clinical decisions may include interpersonal issues such as: amount of physical touch, whether to allow after-hours phone contact, level of formality, rigidity of boundaries

3/32-33 Moves between "close" and "distant" stances at different times in the therapy hour

1/641-645 Varies amount of disclosure for different clients' needs: if they will find it useful

1/466-470 Rarely, client and therapist are not viable match

B11 Treatment selection as Relationship Selection: "An interpersonal selection process" [vs. matching client to "treatments" or "interventions"]

1/370-373 Expresses what he doesn't do--doesn't explicitly match client to approach

1/367-371 Notes that his response to interviewer's question about treatment selection did not mention treatments

1/303-330 Treatment selection starts with the client--"an interpersonal selection process"

III.2. Treatment Selection as Mysterious, Intuitive, Instinctual, "natural" (lived experience?) [HOW make treatment selection decisions? by listening to intuition, instinct, experience]

A4 Intentionality, knowing own motivations behind interventions

??1/407-411 Clinical intuition is most powerful agent of change

3/299-303 Novice therapists should wait to intervene until they know what their motivation is

3/p.6 Intentionality in the moment to moment aspects of therapy is also balanced with the intentionality that she calls ex post facto. Two kinds of intentionality going on.

A16 Mystery/"intuition" in treatment selection process
1/258-261 Moment to moment decisions about interventions are not cognitively-driven, but intuitive
1/260-265 Therapeutic process is intuitive, empathy-driven, relationship-driven
1/320-321 Over the years, learning to trust clinical instincts
1/348-351 Sometimes feels as if she has a mysterious, intuitive sense of what the client is talking about
1/320-321 Trusts own thoughts about what is relevant to the therapy
B17 Intuition, spontaneity, aspects of treatment selection other than conscious, moment-to-moment decision-making process
1/179 Experiences doing therapy as spontaneous
C5 Mysterious aspects/unknowns of treatment selection/"intuitive" parts
3/141-144 Mystery to the process of how therapy is conducted
3/47-51 Thought of initial triage decisions as "coming naturally"
1/409 "intuition?"
3/116-118 Unsure how other therapists engage in treatment selection (mystery)
D3 Mysterious parts of therapy
1/320 Treatment selection process is mysterious
3/492-493 Mystery of treatment selection involves reaction to clients or the degree to which they are likeable; unlikeable clients are harder to work with and therapists don't always know why they don't like a client
3/471-488 Mysterious parts of therapy are emotional parts/countertransference, reactions to clients
D10 Lived experience: what it is like for Pp to be doing I/E therapy
2/93-94 Therapist felt he was "in for the ride of my life" with client's complexity
1/642-646 More comfortable with practice style now; more efficiently gets to the heart of the matter (*increase in comfort level over time)
E4 "Instinct"- challenge of describing decision-making process
2/545 Interventions are instinctual, and not conscious "I just do it"
1/133-135 Comment that there are probably many personality dependent interventions she uses, but they're not immediately conscious to list
1/333-334 No conscious, formal process by which her decisions are made, but may likely be am implicit process that could be deduced if we were to watch videos from her sessions
3/98-101 Decision-making is difficult to describe as a heuristic or algorithm but could probably be derived from viewing session recordings

IV. THERAPISTS ARE NOT DOING 'EVIDENCE-BASED EVTs'

IV.1. Not doing EVTs/View of Research Lit
A21 Role of knowing/keeping up with research in treatment selection
2/139-167 Mentions research indicating "real" relationship is more important to clients that to clinicians
1/397-405 Aware of process research indicating that effectiveness most correlates with client, therapist, and relationship values (coder note* legitimizing what she does/impression management?...)

1/407-408 Knowledge of research on psychotherapy effectiveness increases confidence/freedom as therapist

A22 Treatment selection and the medical model

1/231-233 Medical approach doesn't fit psychotherapy, there isn't anything therapeutic about diagnosis

1/235 Field of psychology gets "caught up" in having a medical identity (*maybe related to legitimacy of eclectic)

1/238-239 Sees medical model as a way of separating from clients

2/54-55 Mental illness is not illness, it's life, and there is no cure

3/112-114 Goals in therapy are fluid, harder to define than in medicine

3/165-169 "Treatment selection" is inaccurate because therapy is not medical

3/395-396 Therapy is not a medical procedure, the most powerful tool is how you use yourself as the therapist

B4 Overall view of therapy

1/486 "It's complicated."

1/223-226 Therapy is going on all the time--friendships and outside things are therapeutic. Not just confined to the formal structure of therapy.

1/171-172 Therapy is an art more than a science.

C21 Relation of integration to ESTs: Pressure towards them/Role in own practice/ role of research lit to own practice [conflicted about ESTs]

3/128-139 Pressure to do ESTs

3/118-119 Feels there is pressure on doing empirically supported treatment (*related to earlier aspects of 'throwing in' references to research literature when they seemed out of context with rest of her approach?]

1/440-442 Again notes use of evidence-based interventions, especially for anxiety and panic

3/119-123 Notes non-manualized treatments are more difficult to research, thus harder to validate empirically

3/116-124 Hard to fit various theories into a researchable study

1/137-139 There is a role for evidence-based treatments and research literature in her treatment selection approach (coders note:*inconsistency??)

D13 Views about/role of empirically validated treatments [conflicted]

1/104-106 Patients believe CBT doesn't get to the heart of the issue

1/87-96 CBT is safe and researchable

1/291-292 More discussion about medical models, ESTs and how the filed of psychology has shifted to this (*assumptions about meaning of evidence-based practice for eclectics?)

1/291-309 Does not agree with evidence-based therapy that leads to CBT being required by some insurance companies for all depression diagnoses

1/343-348 Believes faculty/supervisors taught CBT with 'a gleam in their eye' indicating this was not what therapists really do in practice (*perceived distance between what is taught/prescribed for therapists to do, and what is actually done in practice)

3/101-106 Difficult to adhere to evidence-based treatment when clients are complex (*conflict with EVP)

3/141-145 EBT can be too prescriptive and not allow flexibility to roll with what a person needs

3/90-92 Has kept up with literature and "thorny" issues around evidence-based practice

3/284-290 Insurance companies prefer EVTs

3/p. 4 (*** Seems to be a link with treatment selection and EVPs in all interviews--also legitimacy of their approach (eclectic/integrative) comes up in that discussion)

3/753-760 Training programs want student to be training in empirically validated treatments

3/94-106 Feels conflict around evidence-based practice: on one hand, believes EVP is important, and is an advance, is heavily influenced by faculty under clinical scientist model of training, believes in science on one hand, practice on the other hand. Real-world experience with complex individuals makes it very difficult to adhere strictly to EVP guidelines (*conflicted around evidence-based practice)

D14 View of psychotherapy research and relation to practice

3/87-88 Academic environment keeps therapists up to speed with scientific literature

3/31-33 Difficult to do psychotherapy research because can't control subject variables

E10 View of Empirically Supported Treatments

2/94-96 Empirically supported treatment: digging it on the down-low. (*dig at empirically-supported/short-term therapy-- associated conflating them with each other) (*Is treatment selection based on the treatment model? Brief vs. longer term? Certain biases)

1/477-482 Tension between providing what may be useful for client and providing empirically supported treatment (*tension)

1/477-479 Despite solid training and good clinical intuition, felt hesitant about 'going with' what she thought was the right intervention at the time, if it was not an EST

1/543-545 There's empirical support for using CBT with eating disorders, but using it as a rigid, manualized approach can backfire

1/267-269 Would be remiss in not using cognitive and behavioral strategies because there is empirical support for them

3/286-294 There are empirically supported relationships as well as treatments; focus on relationship is not counter to empirically supported treatment

E15 Role of research literature in own treatment selection process

3/282-284 Research literature plays a big role in what treatments are selected

3/286-288 Some therapies do not lend themselves well to research

IV.2. Feeling un-valued/looked down on as an I/E therapist

B14b Perceptions of others' views of "I/E" and own perceptions of I/E [Edited version-- some segments from the original passengers of B14 are left up in B14 in "Identity as an I/E practitioner"]

1/135 Term Eclectic is a dirty word. Perceives that for others, Eclectic has a negative connotation

1/156-158 Eclectic approaches are associated with not conceptualizing or not knowing what you're doing as a clinician

client and his/her set of concerns (flexibility, client-driven approach)

1/659-660 Regarding evidence-based practice, feels there is pressure put on therapists from outside sources to be more precise [with measurement of outcomes/interventions] than is possible

1/373-380 Eclectic can sound thoughtless, but that is based on an assumption that thoughtfulness in conceptualization requires thinking in terms of diagnostic categories of approach to therapy

D8b Perceptions of how I/E practitioners & approaches are viewed [split up on 6/2/12]

1/112 Secrecy around acknowledging Integrative style

1/108-118 Heard from supervisors and colleagues that while they rarely adhere to one exclusive

theoretical orientation, they seemed reluctant to overtly identify as Eclectic or Integrative
1/177-178, 180-182 Focus on evidence-based practice in 1990s led therapists to be reluctant to say if they did something else
1/315-318 Clinicians need to be under the rug with their approach because of insurance
3/284-290 Doesn't talk about Integrative approach freely with others because it is looked down upon
3/166-171 Glad for research on Integrative/Eclectic therapists because feels he/they are marginalized for not practicing EVTs
3/759-762 Therapists who admit they are Eclectic and Integrative are mavericks
3/p.24-25 Example of how Integrative/Eclectic people could be marginalized/not integrated into professional world. Eclectic Integrative people don't fit into APA because it is evidence-based; thus feel marginalized

E7b Perceptions of the views others have of acceptability of I/E orientation, and view
1/513-516 Concern over not using approved ESTs in VA was that she would be challenged [in contrast to not using non-ESTs because of concerns other techniques wouldn't work}
1/479-487 Example of struggle with EST guidelines: Was concerned about using empty chair technique with a client, until colleague reframed it as exposure of client to his thoughts and feelings related to person in chair (as exposure is an EST, this made the intervention "ok".)
1/568-574 Thought people would associate "Eclectic with not knowing what or why you are doing something (*perception of "eclectic" as negative ***assumption that term Eclectic needs to be qualified)
3/250-256 Although it was more acceptable to be Eclectic in private practice, still didn't use that word explicitly. Eclectic orientation was only implied by colleagues' case descriptions. (*view of the perception others have of Eclectic orientation)

V. THERAPISTS DESCRIBED CONCRETE, SPECIFIC THINGS THEY BASE TREATMENT SELECTION ON

V.1. Treatment Decisions made based on thoughts about TIMING of Interventions
B5 Timing of interventions as important treatment selection component
1/201 Time-pacing client-driven, respect for client-timing, importance of what the client doesn't share
1/196-197 Timing is important to therapy, timing of intervention and pace of therapy
D7 Treatment selection as timing of interventions
1/122-125 Treatment planning and conceptualization changes the longer you're seeing a client
3/539-549 Therapist needs to be attuned to client progress (the client will make mistakes, will feel discouraged, and will also make gains) and so therapists need to challenge at the appropriate time, and back off at times, clinical errors can occur when something is brought up before the client is ready for it
E11 Timing/when to do different aspects of treatment selection
-When does treatment selection happen?
-"In the moment"
2/469 Focus on most distressing symptom first
2/274-283 Exploring family dynamics in treatment was initiated based on client's situation:

dealing with triggers during visits with parents (*client-centered?)

2/142-151 Began to address eating disorder symptoms with cognitive behavioral interventions, including client record keeping about behaviors, triggers, and related thoughts and feelings

2/120-122 First few session orient treatment to therapy, feel comfortable working with therapist and establishing relationship

2/117-118 Initial interventions= humanistic, validation, support, and normalization

1/362-365-368 With longer-term clients, it's different: revisit old goals less frequently because relationship is so well-established, both know what they are supposed to be doing

1/357-363 Uses recall of previous sessions to reintroduce issues that haven't been addressed-- once clients' initial goals seem to be going well (*timing?)

1/550-554 When treatment selection is introduced to client is important. e.g. with eating disorders, she always uses CBT, but the biggest decision is WHEN to introduce CBT (*timing)

3/97 Decision-making done on the fly, based on what feels right for the clinician regarding the client

3/86-87 Meta-level of therapy involves choices made moment-to-moment--what direction to go with the client

3/76-81 Be in the moment with the client

3/76 Is sorting through client's reactions to interventions, and implications for personality in the moment

3/179-215 Approach to treatment changed over different work settings and different presenting problems (Axis I vs. Axis II)

V.2. A Variable: Formal DIAGNOSIS

A5 View/role of diagnosis in treatment selection

3/57-59 When therapist confidence in own process drops, more likely to refer back to diagnosis, symptom checking, and more technical aspects of treatment selection thought process

2/344-346 Client resonated with diagnosis given (*recognition of client's view of diagnosis)

2/335-338 Gave client diagnosis to comply with insurance requirements

2/340-342 Collaborative/empowering clients via showing them diagnosis and discussing why/client's reactions

2/348-353 Flexibility and creativity with diagnosis due to insurance limitations

2/297 By third session, made a diagnosis (social phobia)

3/15-16 The better you know someone, the harder it is to diagnose them

2/104-106 Agrees with Yalom quote that "there's nothing therapeutic about diagnosis"

3/20-22 Aware that clients have complexities and contradictions and diagnostic hard to capture individual experience

2/371-376 First step of assessment is understanding, accepting, and knowing diagnoses, second step is coming up with simple strategies of diagnosis

2/348-358 Changes diagnosis to panic disorder because: insurance, panic symptoms becoming more prominent at client's job

2/106-110 Uses Yalom quote to illustrate that focusing on formal assessment and diagnosis is important early on in therapy, but is used less as gets to know client better

B7 View/role of diagnosis in treatment selection

1/110-111 When meeting clients first time, not focused on giving a diagnosis

1/86-87 Meets clients on individual basis rather than seeing diagnostic categories

1/105-107 Flexibility with understanding client concerns and not abusing diagnostic label-- respectful

1/117-118 Sees usefulness of diagnoses in education and broader contexts

C14 Role of diagnosis/presenting concerns and impact on chosen approach [assessment]

1/239-243 Begins with standard assessment, important

2/577 But approach does differ based on presenting concern

1/250-259 Helpful to come up with a solid diagnosis, because it's a jumping-off point for treatment (*universal?)

3/37-46 Considers the appropriateness of treatment based on diagnosis

2/80-85 Assess symptoms for diagnosis, diagnosis

1/187-193 Decision-making for clinical process (*describes intake process, importance of assessment of many areas/client variables) (*note: universal process of all approaches for intake)

1/245-250 Integration of orientation in how she understands and communicates the problem to the client, in addition to how she understands the diagnosis herself (*orientation influences how you describe the diagnosis to the client)

1/221 Assessment of client is ongoing in therapy

D5 View of diagnosis

1/154-165 Diagnoses are not precise, but are necessary for insurance reimbursement

E5 Role of diagnostic characteristics in treatment selection

1/374-382 Some diagnoses need longer treatment (e.g. eating disorders or individuals with long-standing issues)

1/246-247 Uses CBT for anxiety disorders because it is "clearly effective"

2/143-144 Eating disorder might require more CBT approach

2/143-144 Clinician needed to assess how severe eating disorder was before choosing intervention (*severity of diagnosis influences approach used)

V.3. Decisions early in therapy; Related to ASSESSMENT, includes client variables

A9 Treatment selection as related to early therapy/assessment process [timeline?]

1/289-292 Less active; asks more questions at beginning of therapy

1/309 "This whole treatment selection process is from the first minute"

??2/257-263 Building trust, transparency; collaborative style; not expecting or assuming full client trust initially

2/247-255 Approach to first session is active, collecting information & engaging client

2/330-331 Holistic assessment of current outside functioning as well as exploration of past-current jobs

2/67-80 Got rigorous training in psychiatric interviewing on internship at inpatient site. Still does essentially psychiatric interviews at first session.

2/p. 12 The clinician's process of assessment--everything has care and respect, but not clear on factors involved or decision tree

2/82-87 Global assessment of client at intake helps therapist choose/helps to direct focus of treatment

1/80-81 Clients enter therapy not knowing exactly what is wrong diagnostically, so therapist starts with exploration

1/77-79 A client's initial presenting concern is often not their main concern

1/295-261 During first few weeks of therapy, looks for "common cascades" [themes] related to

client anxiety

1/292-293 Early in treatment, therapist's goal is to map out where client has anxiety

1/91-94 Thinks about "quadrants" of presenting problem areas, i.e. mood, thinking, relationships, etc.

B6 Initial session/Assessment

1/425-438 Sometimes the initially-mentioned presenting concern is the client's whole reason for seeking therapy, and sometimes not

1/438-440 There are always surprises in people's stories, so therapists should avoid assumptions/constructing a story before it unfolds

1/233-234 No pre-set approach to the first session

1/235-237 Asking, "why here now" is often a starting point

1/408-418 First session focuses on fostering equality and freedom of expression in relationship with therapist

C11 First treatment selection decision: who the therapist will be; client-directed triage [Related to time-line of treatment selection]

3/36-38 Treatment decisions can include the triage phase, as noted in academic definition

3/47-51 Determines if client is appropriate for agency and therapist assignment

2/579-583 Process of therapy: assess problem, develop relationship, then allow client to lead

3/51-55 Considers client's energy and if there is a preference for type of therapist (i.e. age or gender) (*client-directed triage)

3/53-55 Make sense that treatment starts the moment client arrives at agency seeking help

3/59-63 Matching needs/preference for therapist is part of treatment selection

3/59-63 Matching is a two step process, first matching to therapist then matching to treatment

1/70 Certain clinical issues that work well with her orientation

3/37-38 Thinks about treatment selection prior to client entering the system

C22 When select termination as an important intervention

3/194-198 If client reports feeling better, and has little to discuss in therapy, then termination may be initiated

3/152-155 Termination is not discussed very often

D1 Initial/early aspects of treatment selection/assessment

3/40-45 Gather thorough history of client to understand life story

3/23-30 Obtained clinical notes for this client and gathered prior therapy experience for client - maybe part of treatment selection process?

3/57-59 During treatment selection process, the first session may be informative as a way to understand client's life history and make interpersonal connections

3/56-59 Selection process involves formal intake questionnaire

1/238-251 Streamlines the technical aspects of intake because the client has a story to tell and wants to get to what is troubling him/her emotionally, relationally, academically, and so forth

1/138-141 Need to stay open-minded when initially working with clients, because the heart of issues may not come until the middle or later in the relationship

1/224-230 Assessment structure includes intake questionnaire and using open-ended questions

1/217-224 Different clinical settings/populations call for different assessment styles (more or less structured/formal)

1/208-211 Treatment selection depends heavily on on-going assessment: rule in or rule out, open questions like a qualitative researcher

3/335-340 Assessment of client begins in the waiting room (e.g. how they handle administrative tasks of beginning therapy)

3/355-360 Beginning of therapy is a process--like a dance, involving gathering information, and also building trust in the relationship

3/344-353 Almost always knows something about client before first session, from the physician who referred them to his clinic

3/308-312 During first moments of session, tries to communicate that the therapist is "there" for the client (e.g. reassuring words, hand shake, good eye contact)

3/389 Therapy begins in the first few seconds

D21 Cues/presence of variables that indicate selection of certain treatments or approaches

2/47-52 Client's level of insight may shape the treatment selection process

2/112-115 Treatment selection approach depends on severity; safety first for clients who are suicidal

2/103-107 When client has severe symptoms, therapy focuses on basic functioning (i.e. eating, hygiene, sleeping) (*universal? some continuum among specific/Eclectic *behavioral activation techniques)

2/103-107 Treatment selection depends on severity of mental health, higher level therapeutic work won't be useful for someone who is decompensated emotionally

2/156 Treatment focus on day to day functioning when symptoms are severe

2/135-136 Focus on keeping client alive when risk of suicide

2/284-287 During risky times and in response to legal issues, therapist consulted with supervisors and colleagues

2/255-263 Therapist attuned to life crisis and existential struggles, and used that to know how to proceed in treatment

E12 Client=centered assessment: Identifying cues from/about client that would guide treatment selection variables

OR

[First session/Early in Treatment]

2/61 Initially thought client was not psychologically minded (*assessment of client characteristics: psychological mindedness)

2/590-601 Client distress level also a factor in which interventions are used. For more distress, allowed for longer period of validation, focused more on understanding of client's struggles versus immediately moving to work on changing them

2/359-375 When relationship is solid, clinician can be more blunt with client

2/324-337 As concerns of the client shifts, the focus of treatment interventions shifts as well

2/159-162 Client's psychological mindedness will influence intervention. Flexibility in choice of interventions, low psych mindedness leads to more psychoeducational intervention

2/145-146 Assessment of symptoms from client's perspective (i.e. what is a binge from the client's perspective)

2/130-133 Some clients respond well to validation or not, depending on personality

2/123-128 Assessed client's social support as low, which even increased the importance of therapeutic relationship

1/54-57 If clients willing to do more work, can do deeper into more long standing cognitive, behavioral, and relational patterns that influence distress

1/114-119 Informal assessment (clinical assessment) of personality style from very beginning

→to inform therapy

102-108 Attends to personality spectrum to inform how to intervene with clients

1/193-209 Examples of thought process/variables that would indicate if self-disclosure is therapeutic/list of motivations for self-disclosure

1/198-200 Careful with self-disclosure for clients who pull for it

1/186-187 Before self-disclosing, always thinking, "is it useful for the client." Always about the client

1/144-146 Client personality style, transference, counter-transference, and alliance determine technique/how to interact with client

1/337-343 First session there is an extensive intake, then based on goals in second session, develops treatment plan

1/335 Does have specific approach for new cases

3/57-60 Counter-transference is a part, but not the most important part of personality assessment

V.4. A Variable: TREATMENT GOALS

C20 Relationship between treatment goals and techniques [does have a set goal, but path to reach that goal is flexible]

1/15, 38 Decision-making re: clinical focus- what a person doesn't like

2/36-42 Choosing techniques/approach from multiple areas is based on treatment goals

2/264-271 Techniques fit goal and conceptualization of clinical problem (*various techniques that are being used are very intentional and complementary to her conceptualization, using core approaches. Always seems to fit).

2/339-340 [maybe implicit?] Goal of helping client be more accepting and compassionate to self

2/585-586 Does have a destination and overarching goal, but cannot predict everything along the way to goal

1/285-287 Notes some client goals are not feasible (like zero anxiety)

3/210-212 Goal for clients is not to need treatment anymore!

2/500-509 Notes not always knowing exactly how to accomplish goal of increasing client's flexibility with imposing own values

D16 Treatment goals/purpose of therapy

3/634-640 Purpose of therapy is to help people recognize and change dysfunctional patterns, be more interpersonally effective, and increase positive affect

2/183-188 Therapist and client agreed on expectations: client would probably never be 100% free of depression all the time

2/429 Last 2 years of therapy, client underwent significant transformation, including new relationships, new connections, spirituality

1/485-488 One goal of therapy is positive risk taking: one mechanism of behavior change

3/634-640 Purpose of therapy is to help people get past their neuroses and become more effective

1/366-378 Goals in therapy shift due to "life happening" i.e. crises

E13 Goals and their relation to treatment selection

1/352 Goals can be explicitly interpersonal or psychodynamic

2/460-461 When client comes in, the first goal is to decrease distress

2/469-478 Brief vs. long treatment, symptom reduction vs. insight, and what approach is used

2/462-467 Initial goal-driven interventions is to decrease distress: accomplished with CBT to reduce symptoms, and Rogerian/humanistic approach to instill hope and provide support

V.5. Distant Variables: LARGER INFLUCENCES on treatment selection: Social, cultural, professional, contextual, etc.

C8 Treatment selection as impacted by larger systems, institutions, culture [treatment selection decisions not made in a vacuum]. (Maybe triage and therapist matching would go here??]

1/571-642 Agency-specific procedures

3/63-66 Agency challenges with therapists having autonomous say in treatment selection

3/39-43 Brief treatment model not appropriate for certain clients, may select them out

1/427-4f30 Example of how agency's brief treatment model affects treatment selection

E21 Larger Developmental, social, cultural, professional influences on treatment selection (i.e. Influence of practice setting/agency on treatment selection)

1/121-125 Formal personality assessment more difficult to do because one doesn't own the testing material, can do in a larger private practice

1/520-526 Part of being early career psychologist is proving yourself as competent/good

1/497-500 Less pressure to "prove self" with regards to techniques used, once out of an academic setting (*practice setting influencing treatment selection)

VI. THERAPISTS AT TIMES SURPRISED THEMSELVES WHEN TALKING ABOUT THEIR TREATMENT SELECTION PROCESSES

VI.1. Meta-process/what it's like to participate

A15 Process/Meta aspects: What like to participate in IVs, reflections from coders

3/447-452 It's worthwhile to try to articulate ambiguous concepts of how to do therapy

2/172-217 Therapist's concerns about client anonymity discussed with interviewer before case example

2/63-65 In reading treatment notes for the example case, was struck by how technical they are

3/219-220 Articulating own process in therapy is difficult because part of the process itself [of therapy] is non-verbal (e.g. visual, empathic)

3/91-92 In interview, is self-conscious of "how this will all sound" (*anxiety around sharing work)

2/21-23 Process of articulating process used in therapy is useful

2/168-169 Interview process led therapist to reinvest in idea that both technique and relationship are necessary/important

1/171-177 (coders comment: *name dropping in IV: maybe issue of insecurity re: being eclectic??)

2/142-148 (coders comment: *sounds very academic--part of identity or impression management?)

2/93-94; 126-128 Felt surprised by own realization that approach includes technical/diagnostic-based elements (*self-awareness of clinical decision-making process)

3/465-484 Compared interview process and miscommunications to therapy process and parallel of potential miscommunication

3/436-441 Therapists can deconstruct what they are doing with a client via video, after the fact, but cannot (and should not) be explicitly making those decisions in the moment

A18 Resistance to talking about treatment selection (??)
3/65-66 Unsure what treatment selection is
(line numbers?) Treatment selection is something that can't be explained to outsiders, and that describing the treatment selection process doesn't help the process of therapy- futile
B15 Meta: Process Reactions to participation in IVs
1/177 Not apt to "conceptualize own conceptualization process"
C10 Views of term/concept "treatment selection" and Meta: reactions/comments about thinking about treatment selection/participation in IVs
3/70 Term treatment selection sounds medical, dry, and isolating
3/46-47 Meaning of term treatment selection focus on which interventions therapist would use
3/72-73 Thinks term treatment selection implies not taking the entire client into consideration
3/80-82 Treatment selection sounds too finite or rigid, takes out personal choice
3/33-35 Agrees with scholarly definition of treatment selection
3/88-90 "Appropriateness of treatment" is used more than term "treatment selection"
3/142-144 Hard to dissect what is going on in therapy in the moment
3/84-86 Not familiar with term "treatment selection" from training
3/100-102 Reflecting on own approach to clients can increase rigor in practice
3/80 Term treatment selection does not encompass fluidity of interventions
3/100 Saw participation as opportunity to reflect on own style

*** PUT IN INDIVIDUAL CASE ANLYSES FOR EACH Pp:***
Therapist's own descriptions of their treatment selection process/how pieces fit together [Maybe break up into other categories based on content]
C6 Therapist's own overall description of how different aspects of the treatment selection process work together to create her approach
1/90-92 Commonalities to approaches used, don't use one more than another
1/79-81 Good fit with techniques, approach, and conceptualization based on client needs
1/259-271 Discusses role of stages of change in choosing interventions, understanding that with client
1/227-228 Treatment selection process itself is ongoing (*matches idea of flexibility, meeting client where they are)
1/70-77, 68-70 Also a fluidity between approaches used; theoretical orientation continues to evolve, incorporate additional components (*combo of stability and flexibility)
1/546-550 The more tools you have, the more flexible you can be with your treatment, and matching it to your client's needs
1/333-336 Example of therapist having high consistency with feminist approach and empowerment, and client agency, as well as collaboration (*How different components of approach come together)
1/367-395 Example of using two core approaches to be with a client, what actions she takes or doesn't take (i.e. relational) (*How theory/orientation trickles down to moment-to-moment interactions in a session)
2/44-48 Draws on core theory to understand client's needs, then uses other techniques to achieve treatment goals (*consistent with own description in first interview)
D9 Pp's own description of how components of treatment selection process fit together
-What he does

-Understanding/view of what treatment selection is, more generally
2/101 No limits on types of interventions when the relationship alliance is strong
2/56-68 During history gathering, therapist determines complexity of case for treatment selection
2/256-258 Underlying hypothesis for therapy→if client could connect to meaning of life→would raise the whole level of things [allow for better coping in many contexts]
1/145-153 Narrowly focused problems call for less-deep, more behavioral therapy; more complex cases call for more multi-strategy interventions (*complex individuals→multi-strategy intervention)
2/336-349 Non-verbals are not only an information channel, but part of therapy as opportunity for therapist to combine current observations with knowledge of client's history to ask a good, thought-provoking question
1/272-275 *Question about order of operations: is there some sort of pre-formulation that's going on? Maybe like a parallel process going on--not linear. As talking they're formulating and thinking and it's free to change online as new info comes in, and Treatment selection begins in first session with formulation of case, thinking about possible treatment options
1/287-289 "Clients won't get a standard medical model with me"
1/254-256 Connection with client and putting them at ease→allows open communication of the problem→allows for obtaining information needed for treatment selection
1/360-365 Complex interplay of effective listening, putting information together, drawing on experience, intuition, and knowledge of treatment models and diagnoses
1/456-476 Rational/general goals for therapy as described to clients: Understand how got to this point of difficulty, gain courage to do things differently, make and evaluate changes
3/12-16 Believes treatment selection is a process and not something that can be defined
3/20-22 Treatment selection is not a recipe
3/259-263 Complicated information processing done in therapy is cognitive and emotional and subjective, brought from therapist's life experiences, intellect, and based on training
3/24-27 Treatment selection involves objective and subjective parts: 1)assessment→diagnosis which argues for a treatment selection (this part is objective). 2) knowing client well enough to know if a particular treatment you select (based on diagnosis) is a good fit or not (this part is subjective)
3/20-21 Treatment selection process is interplay of careful assessment and beginnings of therapeutic relationship
E6 Pp's own description of how components of treatment selection factors come together/interact [causally?]
2/157-161 Cognitive behavioral interventions contributed to client insight about emotions as triggers for behavior
1/p.3 Training informs what tool bag consists of, then client characteristics lead to what she chooses
1/91-97 Training in personality informs how interventions are utilized within a session, particularly in selecting what should be held off for future session, pays attention to what client can hear in the moment
1/337-350 Treatment process is: Thorough intake, gives client impressions and recommendations, At first session: treatment plan/articulate goals, Goals are typically some combination of : 1. Symptom-reduction-based goals to be addressed with CBT, 2. Longer-term goals needing interpersonal work (i.e. "to process grief related to loss," or "to understand how

early family dynamics are impacting friendships now"

1/328-329 Relies on theoretical orientation for treatment selection, but not formal schema for doing treatment

1/283-290 Listening for important relationship information does double duty: short term to solicit support for using new CBT techniques and long-term in psychodynamic conceptualization, and later therapy focus (i.e. how are relationships working/impacting anxiety and depression?)

1/560-562 Always uses a combination of psychodynamic/interpersonal and CBT, but timing of CBT is biggest part of 'selection' (*timing/relational/interpersonal base?)

1/587-588 Approach is integrated and does not use CBT for one client and psychodynamic for another client

1/591-599 Does not conceptualize in simple behavioral terms

1/556-558 Decision of when to begin CBT techniques is based on how receptive client will be. Client receptivity is judged/assessed based on their personality, symptom severity, and the therapeutic alliance

1/275-277 In early sessions, pays attention to client personality while teaching CB strategies (*How integrates)

1/249-257 Uses CBT strategies as initial ways to stabilize distress then will go deeper into understanding triggers

1/244-246 Interventions used based on combination of diagnosis and client personality (*flexibility/client-centered)

3/123-133 What is helpful for client is based on treatment plan, established goals, how the client is going about attaining those goals, and interventions used for a given client

3/83-87 Levels that influence intervention selection are 1. content 2. process 3. meta-level of differential diagnosis and hypothesis testing

Miscellaneous for Participant E

3/42 Uses countertransference as an assessment tool

3/42-49 Assesses how client talks about other relationships as a way to understand how client will relate within the context of the therapeutic relationship (e.g. how they interact, how other people treat them).

3/28 Explores client's concerns if not open to treatment selected

3/28 When meets resistance, explores client's concerns

3/35-36 Not an error to introduce treatment selection [CBT?] too early--it is planting a seed if client is not open to it initially

3/24-26 Educates clients about advantages of interventions if clients are not receptive

3/18-29 Anxious about when to introduce CB strategies to clients

3/24-26 Suggests what would be helpful, but does interventions at client's pace (*flexibility)

3/17-18 Consistently assesses right time to start introducing CBT-based on client factors

3/18-19 Unsure of how clients will receive CBT interventions

1/492-495 Later, in private practice group, could balance being intellectually rigorous and knowing research, with less pressure to prove self with using only the "right" techniques [Move this to section on perceptions of how I/E is viewed by other people]