While attempting to develop a secular philosophy, Freud failed to escape the symbols and rituals of religion (Vitz, 1988). Denuded of their reliance on deity, these rituals and symbols were given a degree of scientific respectability by associating them with concepts of neurology, physiology, and physics. Likewise, Client Centered Therapy (Rogers, 1951), representing the first major departure from psychoanalytic symbolism, also incorporated religiouslike values. Coming from a forgiving, American Protestant tradition, Rogers incorporated concepts of "free will" and Christian acceptance into a view of personal change. With the general acceptance of client-centered assertions about the value of nonjudgmental attitudes and nonjudging acceptance, psychotherapy paradoxically has adopted the religious concepts that destine it to remain a value-laden procedure.

Corresponding with its implicit alliance with religious methods, it has always been an implicit clinical belief that treatment effectiveness can be enhanced by matching client and therapist for compatible backgrounds, attitudes, and belief systems. This process casts psychotherapy more into the mold of a social influence (i.e., benign persuasion) process than of a healing process. While the forces of persuasion are important processes in all mental health treatment, they are most directly observed in psychotherapy. It should be emphasized, nonetheless, that psychotherapy is not a distinct class of treatment. The specific applications of designated procedures, ranging from chemical agents to selective reinforcement, are not qualitatively different from the psychotherapy process, and they can be investigated as ingredients within the broader framework which that process implies. That broader process is one of persuading clients to change the attributions, attitudes, and even values that dictate treatment compliance, govern the nature of the doctor-client relationship, and result in client benefit. Understanding this relationship necessitates identifying the values that underlie the efforts of therapists to influence clients and exploring how and under

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what conditions these values facilitate or impede the effects of specific interventions.

Suggesting that psychotherapy is a process of social persuasion implies a certain degree of intent to exert influence. Certainly this intent is most directly observed in the cognitive change therapies that accept the explicit task of altering attitudes and beliefs. To the degree that any therapist intends the therapy process to create noncoerced changes in a client's feelings, insights, attitudes, viewpoints, or behaviors, however, all psychotherapies are based on interpersonal influence. Therapists have ideas about what constitutes emotionally healthy changes and these ideas influence treatment aims; he or she must rely on his or her own preferred values and beliefs to define what constitutes "healthy" changes. This fact implies that clients will be asked to accept, if not adopt, certain of the therapist's viewpoints.

Whether or not we can justify ethically the role of attitude conversion in psychotherapy, it is probable that attitude persuasion is best accomplished within the context of a collaborative, supportive, caring and respectful (i.e., compatible) relationship. Moreover, a compatible relationship is not accidental—it evolves from a complex interaction of the inherent dispositions contributed by the parties involved and therapeutic strategies that establish an environment that is conducive to change. In the final analysis, it may well be impossible to separate the so-called nonspecific qualities of the relationship and the procedures that the therapist uses (e.g., Rounsaville, Chevron, Prusoff, Elkin, Imber, Sotsky, & Watkins, 1987; Waterhouse & Strupp, 1984).

At least three separate but overlapping lines of research have addressed methods of enhancing therapeutic compatibility. These lines of investigation reflect the interplay among therapist, patient, and treatment variables in facilitating productive treatment matching. Some research, for example, has concentrated on discovering preexisting, personal qualities of clients and therapists (personal matching) that facilitate the development of a productive relationship; other research has attempted to enhance compatibility by educating clients in the nature and goals of treatment (client preparation), and thereby bringing their expectations into alignment with the demands of the treatment to be provided; the third type of research has concentrated on matching treatment interventions themselves to the nature of preexisting client characteristics (technical eclecticism).

Personal matching implies that the nature of compatibility is to be found in qualities of the client and therapist that interact independently of treatment technologies and professional theories. The subject matter of such investigations includes client-therapist personalities, values, attitudes, cognitive styles, and demographic characteristics. In contrast, the other two research approaches emphasize the importance of treatment rather than trait characteristics. Client preparation studies, for example, are based on an implicit assumption that treatment embodies a set of relatively immutable values that if acknowledged and adopted by the client will facilitate treatment gain. This form of client-therapy matching concentrates on altering clients' expectations of the length and frequency of treatment, and assumes the task of educating them in the roles that may be adopted by client and therapist. Its methods are devoted to alterations of clients to fit the parameters that are set by the treatment. Concomitantly, it gives little attention to modifications of the treatment or to variations among therapists who apply treatments.

The third area is one of still embryonic research and stands in contrast to the other areas of investigation by emphasizing the possibility that different treatment procedures may be more or less well suited to clients whose problems and personalities differ. Research of this latter type has focused on the selection of global treatment models (e.g., behavior therapy, cognitive therapy, insight therapy), the application of specific treatment procedures (i.e., interpretation, reflection, homework, etc.), and the assignment of therapists who favor either directive or nondirective approaches. The concepts studied fall within the purview of what Lazarus (1981) has called "technical eclecticism."

In this chapter we will consider these three types of research and their interrelationships. Because of the breadth of the topic of matching, a comprehensive review of current literature would far surpass the page limitations of this volume. Instead, we will summarize some conclusions from the most methodologically sound research currently available and illustrate these conclusions with references to more narrowly focused but exhaustive research reviews than our own.

**PERSONAL COMPATIBILITY**

It is now reasonably well established that patterns of similarity and difference at least partially dictate what constitutes an initially good thera-
pist-client match and go far to determine the degree to which an effective therapeutic alliance can be established. Whereas research on personal compatibility has addressed similarity of demographic variables, attitudes and values, prior experiences, and personality (Atkinson & Schein, 1986), the first two of these areas has been the most productive and promising (cf. Beutler, 1981; Beutler, Crago, & Arizmendi, 1986) and will be the areas emphasized here.

Demographic Similarity

One's gender, aspects of appearance relating to ethnicity, and features that index one's age are easily observed (Shapiro & Penrod, 1986) and are used by clients to make relatively accurate judgments of therapists' status (Berry & McArthur, 1986). Because they are so readily observed, the effect of client-therapist demographic similarities on treatment commitment and outcome have been extensively researched. Unfortunately, most of this research has dealt with analog populations of clients and/or therapists, quasitherapy environments, and criteria that are far removed from those used to judge result in clinical settings. As a result of such disparity among methods and populations, the results of research in this area are far from consistent. Nonetheless, if one considers only the most clinically relevant studies, some tentative conclusions do emerge. Namely, demographic similarity between client and therapist (a) facilitates positive perceptions of the relationship in the beginning stages of treatment; (b) enhances commitment to remaining in treatment, especially among disenfranchised groups; and (c) sometimes accelerates the amount of improvement experienced by those who complete a course of treatment.

More specifically, both age (Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983), ethnic (Jones, 1978), gender (Blase, 1979; Jones, Krupnick, & Kerig, 1987), and socioeconomic background (Carkhuff & Pierce, 1967) similarity have been associated with positive client perceptions of the treatment relationship. Of the various demographic dimensions studied, gender similarity and ethnic similarity appear to be the most strongly preferred by clients, and similarity in these domains generally enhances clients' perceptions of their therapist's understanding and empathy, increases clients' liking for their therapists, and results in the relationship being judged to be more helpful than when such similarity is lacking. Ethnic similarity between client and therapist is especially preferred by black clients, and in this group such similarity is associated with an enhanced commitment to remain in treatment. Conversely, ethnic dissimilarity may be associated with early dropout rates (Turner & Armstrong, 1981; Nelmeyer & Gonzales, 1983) and refusal to enter treatment after an initial evaluation (Abramowitz & Murray, 1983; Terrell & Terrell, 1984). It is notable, nonetheless, that the strength of this effect appears to be somewhat less among nonblack minorities than among blacks (Atkinson, 1983).

Overall, research on personal matching suggests that clients use relatively obvious similarities to establish a basis for trust and for assessing how likely they are to be understood. On the other hand, the relationship between similarity and treatment outcome is generally very small and probably not direct. For example, in spite of evidence both that ethnic similarity is preferred among black clients and that female therapists are more likely than their male counterparts to facilitate therapeutic change generally, these effects are quite modest compared with other contributors to outcome (e.g. Jones et al., 1987; Merluzzi, Merluzzi, & Kaul, 1977; Proctor & Rosen, 1981). Even more important, it appears to be the androgyny and flexibility of attitudes that one holds toward ethnic and sexual roles rather than gender or ethnicity per se that most likely account for even these modest effects. In gender-matching studies, in particular, the flexibility and acceptance of diversity that is embodied in androgynous and traditional female roles appear to contribute to client satisfaction and growth whether they are present in male or female therapists (Atkinson & Schein, 1986; Beutler, Crago, et al., 1986; Blier, Atkinson, & Geer, 1987).

Personal Beliefs

Personal beliefs represent the cognitive elements that both underwrite one's personal strivings and that derive from one's background. While the weight of evidence persuasively underlines that treatment outcome is related linearly to the degree to which clients acquire the global beliefs and values of their particular therapist (Beutler, 1981; Beutler, Crago, et al., 1986; Hamblin, Beutler, Scogin, & Corbishley, 1988), improvement is only enhanced by a complex pattern of similarity and dissimilarity between client and therapist belief and value systems (e.g., Beutler,
Jobe, & Elkins, 1974; Cheloha, 1986). Indeed, the specific beliefs that contribute to this value-conversion process remain open to question (Tjelvæt, 1986).

The most consistent evidence available suggests that treatment outcome is enhanced when clients and therapists place similar value on such attributes as wisdom, honesty, intellectual pursuits, and knowledge. At the same time, the degree of difference that exists between client's and therapist's valuing of such qualities as a sense of personal safety (Beutler, Pollack, & Jobe, 1978), interpersonal treatment goals (Charone, 1981), social status and friendships (Arizmendi, Beutler, Shanfield, Crago, & Hagaman, 1985; Beutler, Arizmendi, Crago, Shanfield, & Hagaman, 1983; Beutler et al., 1974) facilitates improvement.

The mere observation that converging beliefs and values are associated with improvement may be enough to justify efforts directly to persuade clients to adopt therapists' value stances. However, most therapists are trained in the tradition of free will and self-selection and have difficulty morally or ethically justifying such a position. Some comfort may be found in the observations that therapists' values are more similar to those of their clients than they are different (Beutler et al., 1978), and that religious attitudes, those on which clients and therapists are most likely to differ (Bergin, 1980), are seldom listed among those that either change during treatment or contribute to improvement (Chesner & Baumeister, 1985; Houts & Graham, 1986; Lewis, 1983; Hill, Howard, & Orłinsky, 1970). Even more important, evidence suggests that it is the acceptability to the therapist of the client's viewpoint (Beutler et al., 1974) and the therapist's ability to communicate within the client's value framework (Probst, 1980; Probst, Ostrom, & Watkins, 1984) more than the particular values held by the therapist that contribute to client improvement. If they are sufficiently accepting of the client's religious values, even nonreligious therapists and therapists representing a very different religious orientation from the client can communicate within the client's value system and effect improvement without threatening the client's valued beliefs (Beutler, Crago, et al., 1986; Chesner & Baumeister, 1985).

Aside from client-matching, there appear to be some values that generally distinguish more and less effective therapists. Lafferty, Beutler, and Crago (1989) suggested that therapists who value intellectual pursuits and hard work tend to be more effective than those who place relatively more value on social and economic status. It is interesting to note, however, that these productive values may be more characteristic of academic teachers than they are of therapy practitioners (Conway, 1988).

**TREATMENT PREPARATION**

Client role induction allows some opportunity to compensate for the limitations on therapist-client compatibility imposed by the self-selection of client and therapist. Most investigations of role induction, though varying in method, objectives, and client sample, have suggested that pretreatment preparation enhances the persuasive potency of the therapist (cf. Beutler, Crago, et al., 1986; Mayerson, 1984; Orłinsky & Howard, 1986; Parloff, Waskow, & Wolfe, 1978). These studies suggest that role induction improves treatment retention rates (LaTorre, 1977; Wilson, 1985), facilitates positive perceptions of the treatment process (Jacobs, Trick, & Withersty, 1976; Yalom, Houts, Newell, & Rank, 1967; Zwick & Attkisson, 1985), promotes treatment compliance (Meichenbaum & Turk, 1987), and enhances psychotherapy outcomes (Childress & Gillis, 1977; Strupp & Bloxom, 1973; Zwick & Attkisson, 1985).

The procedures of role induction can be subclassified into three subtypes (Beutler & Clarkin, 1990): (a) instructional methods, (b) observational and participatory learning, and (c) treatment contracting.

**Instructional Methods**

Instructional methods of inducing role behaviors among clients consist of providing direct written or verbal information about the nature of therapy and of the roles expected of the client and therapist. In their simplest form, role-instruction methods explain what to expect and how to respond to the treatment. However, most role-induction interviews are somewhat more elaborate than this.

In one of the best known studies of instructional methods, Hoehn-Saric, Frank, Imber, Nash, Stone, and Battle (1964) constructed a pretreatment interview that specifically described the nature of individual psychotherapy, outlined what behaviors were expected of client and therapist, described the nature of such therapeutic phenomenon as resistance and transference, provided suggestions for recognizing and dealing with these issues when they arose, and specified the length of
time before improvement should be anticipated. When systematically compared with the treatment of clients who did not receive this pretraining, they found that the role-induction interview significantly enhanced the process and outcome of psychotherapy.

While there are some exceptions (e.g., Yalom et al., 1967), most of the current evidence indicates that instructional methods facilitate symptomatic change, encourage the adoption of role-appropriate attitudes, and promote the development of positive feelings about treatment (cf. Mayerson, 1984; Zwick & Attkisson, 1985). Other research suggests that direct instruction reduces nonproductive advice-seeking and enhances involvement in treatment (Turkar, 1979). Moreover, the procedures apply across client groups, impacting many who present special problems or who usually are considered to be poor risks for conventional psychotherapies, such as the poor and the uneducated (e.g., Heitler, 1976; Holliday, 1979).

Observational and Participatory Learning Methods

A second role-induction method of enhancing client-therapist compatibility consists of pretherapy modeling and/or practice. Truax and colleagues were among the first to report positive results with this procedure (Truax & Carkhuff, 1967; Truax & Wargo, 1969). Their induction procedure consisted of a 30-minute audio tape of representative therapy segments. The procedure was specifically aimed at facilitating group therapy process and modeled "good" and productive interchanges among group members.

In an effort to extend the procedure of Truax and his colleagues, Strupp and Bloxom (1973) employed a role-induction film to prepare clients of low socioeconomic status for conventional treatments. At the end of 12 treatment sessions, those clients who had been presented with film demonstrations before treatment reported more facilitative treatment relationships, exhibited more productive in-treatment behaviors, and experienced better treatment outcomes when contrasted with similar clients receiving a control film. A third group receiving a role-induction interview demonstrated similar effects to those observing the film. In other studies, role-induction films also have demonstrated a positive impact on dropout rates, even among clients with relatively severe psychopathology (Mayerson, 1984; Wilson, 1985).

In a variation of these procedures, Warren and Rice (1972) suggested the value of adding therapy practice sessions to observations in order to stabilize or reinforce effective treatment behaviors. In this procedure, clients met with someone other than their own therapist for approximately half an hour following every third or fourth session of time-limited psychotherapy. During these meetings, clients were encouraged to talk about problems that arose with therapy or with the therapist, and then instruction and information were provided to enhance the client's response to these problems. The authors demonstrated that this procedure reduced dropout rates among poor prognosis clients.

Contracting Methods

Whereas therapeutic contracting has been discussed widely in family systems theory (Madanes, 1981), gestalt/transactional analysis (Goulding & Goulding, 1979), and cognitive therapy (Beck, Rush, Shaw, & Emery, 1979), behavior therapists have been most active and explicit in defining its use. The specific techniques used include signed agreements (Alexander, Barton, Schiavo, & Parsons, 1976) and requiring the client to deposit money that will be returned if the predetermined goals are achieved (e.g., Pomerleau, 1979; Pomerleau & Pomerleau, 1984). These various contracting procedures can be viewed as components of several lockstepped but supraordinate phases (Kirschenbaum & Flaner, 1984): (a) initial decision-making, (b) the generation or modification of expectancies, (c) the identification of target objectives of change, (d) monitoring progress, (e) delivering consequences, and (f) programming generalizations.

The role of contingency contracting is currently receiving wide usage in marital therapy where it is employed to facilitate communication and the provision of mutual support (Azrin, Naster, & Jones, 1973; Emmelkamp, 1986). Contracting has been especially well received among those who attempt systematically to train couples in communication skills (Weiss, Hops, & Patterson, 1973).

The use of behavioral contracting extends beyond treatment preparation to the instigation of therapeutic change (Emmelkamp, 1986). Hence, much of the activity in treatment programs that uses behavioral contracting has centered around negotiation of the contract itself and, concomitantly, on the acts of assessing and reinforcing compliance.

The role of contracting as a procedure for
enhancing client compliance is best seen in studies of time-limited psychotherapy. One of the most surprising conclusions to come from this literature is the serendipitous finding that an explicit, preset time limit results in clients remaining in treatment longer than when no such explicit contract is present. While the usual treatment duration in outpatient settings varies from five to eight sessions (Butcher & Koss, 1978; Koss & Butcher, 1986), a sampling of literature (e.g., Sloane, Staples, Cristol, Yorkston, & Whipple, 1975; Elkin, 1986; Beutler, Scoggin, Kirkish, Schretlen, Corbishley, Hamblin, Meredith, Potter, Barnford, & Levenson, 1987) led Beutler and Clarkin (1990) to conclude that time-limited therapies may have a mean treatment duration closer to twice the length of open-ended treatment. Moreover, clients who are explicitly contracted to a given treatment duration become more quickly involved in the treatment process than their peers in open-ended treatment (Koss & Butcher, 1986). Clearly, what we have traditionally thought of as “short-term” treatments, by this standard, are not short term at all.

TECHNICAL ECLECTICISM

Clinical wisdom has always held that the persuasive power of psychotherapy is enhanced when there is some type of compatibility between the client and problem variables, on the one hand, and the specific treatment procedures selected on the other. The usual term referring to the matching of clients to treatment procedures is technical eclecticism. However, the term eclectic, at least as it has been applied to mental health treatment, has been overused and, at times, has been used as the equivalent of “muddle-headedness” (Norcross, 1986b). In contemporary literature, there are really several different types of eclecticism (see Norcross, 1986a; Norcross & Prochaska, 1988; Lazarus, 1981; Wolfe & Goldfried, 1988 for a discussion of these terms). Technical eclecticism maintains that integration among various treatment approaches should take place at the level of specific procedures rather than at the level of theory. That is, a technically eclectic clinician endeavors to select the best and most useful procedures for a given client from among those advocated by the hundreds of procedures available, irrespective of the theories from which these procedures derive. Some technical eclectic variations have developed specific guidelines to help the clinician determine the procedures to be selected. These approaches are collectively referenced by attaching the adjective “systematic” to the term eclectic (Norcross, 1986a; Beutler, 1983).

Systematic, technical eclecticism arose from the awareness of the inconsistency between therapists’ theoretical viewpoints and their in-therapy behavior. The foundation for this movement was in the joint observations that (a) therapists of equivalent experience but different theoretical positions behave quite similarly to one another (Fiedler, 1950; Sloane et al., 1975); and paradoxically, (b) there is great diversity in therapeutic behaviors and outcomes among therapists who are representative of any given theoretical orientation (e.g. Lieberman, Yalom, & Miles, 1973; Luborsky, Singer, & Luborsky, 1975). Collectively, the methodological and clinical concerns arising from these observations resulted in an effort to operationally define and standardize treatments (Luborsky & DeRubeis, 1984). “How to do it” manuals soon appeared for cognitive therapy (Beck et al., 1979), interpersonal psychotherapy (Klerman, Weissman, Rounsaville, & Chevron, 1984), psychoanalytic psychotherapy (Luborsky, 1984; Strupp & Binder, 1984), gestalt therapy (Daldrup, Beutler, Greenberg, & Engle, 1988), and various forms of group and family therapies (Jacobson & Margolin, 1979; Freeman, 1983; Sank & Shaffer, 1984).

Numerous studies have followed the lead of the National Institute of Mental Health Collaborative Study of Depression (Elkin, Parloff, Hadley, & Autry 1985) which was the first effort to test manual-driven psychotherapies. These studies have attempted to find the best type of treatment for clients who present with symptoms of both depression and psychogenic pain (e.g., Beutler, Daldrup, Engle, Guest, & Corbishley, 1988), generalized anxiety (e.g., Borkovec, et al., 1987), and age-associated depression (e.g. Thompson, Gallagher, & Breckenridge, 1987). As these initiatives have caught on, manuals have become increasingly more clinically oriented and less often geared only to specific research applications. With the advent of manuals that define what psychotherapists of various schools actually do, the degree of overlap and eclectic “borrowing” across therapies and populations has become apparent even to those who would like to maintain a pure view of theory and practice. Many researchers have come to believe that distinctions among theories is more artificial than real; others identify with the clinical impression that there are meaningful differences
among the effects that can be attributed to different procedures and client characteristics.

While various types or modes of psychotherapy are associated with distinctive therapeutic processes, only a few dimensions are necessary to describe most variations among psychotherapy orientational strategies (Sundland, 1977). Some of these differences reflect differing outcome goals, others reflect differences in mediating changes, and still others reflect differences in the specific techniques employed. Beutler and Clarkin (1990) have attempted to consolidate a number of eclectic models with current research to propose client variables that can efficaciously be matched with each of these dimensions. In the absence of prospective research, however, these proposals remain speculative at the present time, but are presented here as promising hypotheses.

Goals

To the degree that there are systematic differences among practitioners from different orientations, these differences generally are consistent with the theoretical frameworks to which therapists adhere (Brunink & Schroeder, 1979; Larson, 1980; Sloane et al., 1975; Sundland, 1977). Yet, there are nearly 400 different theoretical systems, and it is unlikely that all of these embody unique aspects of either theory or practice. The probability that there are a relatively few clusters of representative approaches and theories has sponsored several efforts to find dimensions of basic commonality and distinction.

The principal method used for reducing the number of theoretical systems into clinically meaningful groupings has been to seek the common philosophical positions and/or developmental roots. As one views these efforts to collapse the number of theoretical systems, two points become clear: (a) there is currently no consensually accepted set of dimensions that allows one to make rational distinctions among theoretical systems, and (b) the effort to find commonalities is hampered by the tendency to equate theories with therapeutic procedures and formats.

Different forms of treatment are designed to induce outcomes that range along a dimension of breadth. The variations in desired outcomes can be seen in two extreme types—altered symptoms and resolution of internal conflicts. This definition parallels various distinctions between "action" and "insight" (London, 1986) or "reality-oriented" and "insight-oriented" (Thorpe, 1987) therapies. The differences between these two categories are most obvious when the effects of broadly focused psychological therapies are compared with more narrowly focused somatic therapies (Christensen, Hadzi-Pavlovic, Andrews, & Mattick, 1987; DiMascio et al., 1979; Klerman, DiMascio, Weissman, Prusoff, & Paykel, 1974). Somatic therapies are designed to effect change in the symptoms that constitute the client's diagnosis. Behavioral and cognitive psychotherapies, in a similar fashion, are directed specifically at altering symptomatic presentations over the course of treatment.

In contrast, therapies such as interpersonal, experiential, and psychodynamic therapies place higher priority on changing patterns of coping than on changing symptoms per se. Though not ignoring the importance of symptomatic change, these theories add to the definition of improvement, alterations of internal and nonobservable characteristics. Indeed, to most clinicians of these latter persuasions, it is not unthinkable that some improved clients will continue to have symptoms at treatment's end.

The importance of defining a focal objective and following the plan that evolves from this focus is seen in the observation that the amount of focal concentration on the problem constituting this formulation (Strupp, 1980a, 1980b, 1981), as well as the degree of adherence to the structure and processes defined by the therapeutic plan, are related to client outcome (Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985; Rounsaville, O'Malley, Foley, & Weissman, 1988). In other words, consistent attention to the relationships and goals that constitute the focus of treatment may well be more important to treatment outcome than either the strength of the techniques employed or the accuracy of the theory from which these techniques were originally derived.

Corresponding with the two types of therapeutic outcome goals—symptomatic and conflictual—clients present problems that vary in complexity. Beutler and Clarkin (1990) proposed that an effective treatment assignment is one that matches the nature and complexity of the client's problems with the nature of the targeted objectives.

In addition to the breadth of goals targeted by different procedures, theoretical systems also differ in the types of mediating changes valued as a means to achieve these ends. These valued
changes range along a dimension of “depth” to complement the dimension of “breadth.”

Mediating Changes

Just as a treatment plan must accommodate variations in the ultimate goals of intervention, it also must recognize that these different goals will be met most efficaciously by following different paths. Conflicting goals entail a different set of intermediate steps and require a different level of intervention than symptomatic goals. That is, treatment selection must recognize that different paths must be followed to modify an overt behavior as opposed to raising a repressed memory or recognizing a dysfunctional thought. The therapist's formulation of the problem must be consistent not only with the type of problem to be addressed but with the client's preferred method of coping with problems. Concomitantly, the methods of intervention selected must be able variously to support, circumvent, or alter the client's coping style.

For example, as problem complexity increases, technical procedures seem to become more important (e.g., Barker, Funk, & Houston, 1988). These technical procedures vary in terms of the level of client experience addressed, the phase objectives of the treatment process, and the characteristic coping styles to which they are best applied (Jones, Cumming, & Horowitz, 1988; Rounsaville et al., 1987). An understanding of the different depths of experience addressed by different procedures requires translating theoretical formulations into their implicit value systems. All theories value change at numerous levels, but some theories consider the means by which change occurs to be through the recovery of unconscious experience (i.e., insight), others attribute change to increasing awareness of feelings or sensations, and still others attribute change to alterations in either cognitive habits or overt behaviors.

Daldrup et al. (1988), for example, suggest that various therapies concentrate in various ways on one or more of five avenues to emotional change. These change processes range from accessing core beliefs through acknowledging emotions, intensifying emotional experiences, and reconceptualizing emotional experiences, to modifying emotional responses or behaviors. Most analyses of therapeutic depths or levels define three or four groupings of theories based on which combination of these levels of experience they most consistently attend.

Beutler and Clarkin (1990) propose that matching the client's style of coping with threatening experience to the level of experience affected by different procedures will allow the construction of menus composed of relatively specific treatments. Use of the procedures in these menus are thought to increase the persuasive power of the therapist.

At least one reason that the treatments cannot be specified more clearly is because of the dimensional nature of client coping patterns. Coping styles reflect a number of interrelated dimensions rather than nominal groupings (e.g., Freebury, 1984; Millon, 1969; Millon & Everly, 1985; Widiger, Trull, Hurt, Clarkin, & Frances, 1987), and clients tend to move among the dimensions as stressors vary, as levels of disturbance become more and less debilitating, and as the demand characteristics of the situation change. Hence, within some limits, variability of coping style is the norm rather than the exception for most people. Nonetheless, it is conventional (Gleser & Ilievich, 1969; Loewinger, 1966) to classify clients into discrete groups based on the most dominant coping pattern represented.

While still embryonic, clinicians and researchers are coming to recognize the potential value of matching the level of experience addressed by the therapy intervention with the nature of client coping styles. For example, Freebury (1984) has proposed that client ego development and coping pattern may be used to determine both the intensity and level of intervention (uncovering therapy vs. crisis intervention and behaviorally focused intervention). Likewise, Clark, Beck, and Stewart (1989) defined two personality styles—"sociotropic" and "autonomous" types—that they suggest respond to different therapeutic methods. The sociotropic client is described as socially active and responsive (extroverted/externalized), and is thought to need reassurance, direction, and assistance in taking risks. In contrast, the autonomous style is considered to be self-directed, self-controlled, and insensitive to feeling or sensory states (internalized/introverted). Clark et al. (1989) propose that such clients require less behavioral direction than their counterparts and may benefit from treatment that encourages them to attend to internal experiences.

Likewise, interactions between client coping styles and the levels of experience addressed by the treatment have been shown to affect the nature of the therapeutic alliance among depressed and anxious clients (Gaston, Marmar, Thompson, & Gal-
lagher, 1988), as well as to enhance treatment outcome among alcoholic clients (McLachlan, 1972). Most specifically, behaviorally targeted therapies appear to induce better results than those that focus on unconscious processes among clients who are prone to externalize their distress (e.g., Sloane et al., 1975; Beutler, 1979a). Conversely, the first author and his colleagues have confirmed that therapies that address unconscious motives and feelings are more effective than those that address the level of behavior change among these internalizing clients (Calvert, Beutler, & Crago, 1988). Other research from the same research program suggests that therapies that implement change by arousing awareness of sensations and feelings are somewhat more effective than therapies that address the level of unconscious motives, when applied to clients with externalizing coping styles (Beutler & Mitchell, 1981).

Collectively, these and other research findings suggest that there may be reliable differences in outcomes among psychotherapy procedures as a joint function of the type of intermediate changes sought and the nature of client coping or defensive styles (cf. Beutler, 1979a, 1983; Beutler & Crago, 1987).

Specific Techniques

Beutler and Clarkin (1990) proposed that there are three client dimensions, the recognition of which allows the therapist to selectively use treatment menus in order to respond to moment-to-moment changes in the therapeutic process: problem severity, reactance level, and problem-solving phase. Sensitivity to the first two of these dimensions will help the therapist optimally maintain client arousal, a condition that is deemed necessary in order to maintain therapeutic focus and client motivation. Specifically, problem severity, as indexed by client distress, serves as an indicator of whether increased arousal or decreased arousal is indicated, and client reactance level is a marker for determining how directive or evocative the therapist should be. With arousal at an optimal level, sensitivity to the client's problem-solving cycle will help the therapist maintain a helpful balance between addressing intrasession and extratherapy issues.

Because arousal is be either beneficial or inhibiting of treatment progress, depending on its level, all varieties of psychotherapy are largely devoted to managing the level of client arousal or distress in order to keep these experiences within a range that is conducive to effective work. Arkowitz and Hannah (1989) suggest that all therapies emphasize that treatment-relevant behavior must take place in the contest of affective arousal. They go on to suggest that if arousal level is optimal, it will facilitate self-observation, disconfirmation of pathognomic beliefs, and cognitive change. While different theories may value these latter consequences to a greater or lesser degree, virtually all theories acknowledge the reciprocal nature of these processes as the therapist appropriately manages client arousal level and therapy activity.

In all models of psychotherapy, the therapist introduces arousal by exposure to dissonant elements of functioning (Beutler, 1979b, 1981, 1983). Cognitive dissonance, as an exposure method, can be created either by confronting a client with those aspects of experience, behavior, and sensation that are being avoided, or by preventing the exercise of usual coping strategies. In either case, the process increases the client's arousal level. On the other hand, if problem severity and associated arousal are already very high, they can be felt as distress and subsequent efforts to reduce or cope with it may hamper the efficiency of any educative experience. A high distress level may indicate that the client's defenses are not working well. If this is a continuing aspect of the client's condition, the process of psychotherapy may be impeded and susceptibility to other illnesses is even likely to increase (Beutler, Engle, O'Ro'-Beutler, Daldrup, & Meredith, 1986; Brownlee-Duffek, Peterson, Simonds, Goldstein, Kilo, & Hoette, 1987; Coyle & Holroyd, 1982). As extreme distress can impede the process of maintaining attentional focus, increases defensive activities, and reduces behavioral flexibility, reduction of distress may advantageously precede selective arousal induction around specific issues in such cases.

Some procedures specifically are designed to have the effect of increasing arousal, while others are designed to decrease arousal. As symptoms of distress increase and begin to interfere with motivation, flexibility, and the ability to retain attentional focus, procedures such as breathing control, attention to somatic sensations, cognitive control strategies, and managed exposure (e.g. Rapee, 1987) can be expected to be advantageous for bringing client arousal levels back into manageable limits. Likewise, if clients experience too little arousal, their motivation may suffer. Increasing the level of client exposure and therapist-client activity may facilitate the arousal needed to
maintain involvement in treatment and new learning.

The experienced clinician will recognize that client arousal level also varies as a function of how the responsibilities for therapy tasks are distributed. Therapist directiveness alters the responsibility for session activity in favor of the therapist, while evocative therapy procedures, including silence, place more responsibility for the session on the client. Concomitantly, for most clients, the therapist's directiveness and assumption of responsibility are associated with reductions in client arousal level; reducing the amount of therapist directiveness will be reflected in corresponding increases in client arousal level (cf. Tracey, 1987; Beutler, 1983; Beutler, Crago, et al., 1986).

Whereas procedures such as these can be used productively to manage client arousal sufficiently to retain focus and motivation, it also should be observed that some clients respond to the intent of the procedures with a paradoxical effect. For example, most behavioral clinicians will recall clients that have become aroused and anxious when being taught to relax and those who feel quite relaxed when imagining their most feared events (e.g., Barlow & Waddell, 1985; Borkovec et al., 1987; Heide & Borkovec, 1983). These paradoxical responses identify a client as having high reactance (Brehm & Brehm, 1981) when faced with loss of perceived control or freedom. As a consequence, the methods of inducing therapeutic levels of arousal must incorporate decisions about the degree of directiveness to utilize in the therapeutic process and the degree to which extratherapy activities should receive attention.

Reactance refers to client resistance at an interpersonal level, in the way that coping style refers to client resistance at an intrapsychic level. Reactance is not only a stable trait, but is also a situationally responsive state that ebbs and flows. Indeed, when it was originally presented as a concept of clinical significance, reactance was described as a universal state that was induced by the threat of losing personal choice (Brehm, 1976). Only later was it expanded to include a characteristic and enduring response trait of significance in selecting treatments (Beutler, 1979a, 1983; Dowd & Pace, 1989).

Beutler and Clarkin (1990) proposed three working assumptions to govern therapist directiveness in response to client reactance level. First, they proposed that therapeutic effects will be enhanced if the use of evocative procedures is emphasized over directive ones among those clients for whom initial evaluation suggests high levels of reactance. Implied in this assumption are the corollary beliefs that (a) treatment will be enhanced by the use of directive procedures among clients who present with low levels of reactance, and (b) treatment may be affected negatively by mismatching client reactance levels and therapist directiveness. Indeed, there is some evidence for each of these assumptions (cf. Beutler, Crago, et al., 1986; Forsyth & Forsyth, 1982; Weary & Mirels, 1982).

The second and related assumption proposed by Beutler and Clarkin is that momentary changes of client reactance levels, occurring during the course of a session, will respond well to a therapist who shifts in counterpoint between directive and evocative procedures. These momentary changes will vary both as a function of client characteristic sensitivity to threatened loss of autonomy (trait reactance) and as a function of momentary changes in the distribution of perceived power within the relationship itself (state reactance).

Both of the foregoing points have been illustrated by Blau (1988). Emphasizing the need to differentiate among what he refers to as "unintrusive," "moderately intrusive," and intense or "probative" interventions, Blau asserted that relatively unintrusive interventions such as acceptance, empathy, encouragement, restatement, and the use of metaphor and analogy are most powerful for the client who exhibits—by disposition or by situation—high levels of resistance to the therapist's influence. In contrast, moderately intrusive interventions, including such therapist acts as structuring, asking direct questions, clarifying client feelings, setting limits and providing guidance and advice are most powerful among moderately reactant clients who, by nature or experience, have come to trust the level of safety and support provided by the therapist.

Blau emphasized that "probative" (p. 126) interventions only should be used when clients are very secure with the therapist and when their own strong and positive self-attitudes protect them from the need to resist the therapist's efforts. Such directed and interpretive activities as analysis of resistance and transference, the use of guided fantasy, dream analysis, magnification of client or therapist gestures and expressions, and confrontation of behaviors and fears tend to evoke reactance and should be employed carefully and slowly by the therapist in order to avoid negative
responses and to preserve the therapeutic attachment. Even therapist humor can evoke resistance and should be applied cautiously with reactive clients (e.g., Saper, 1987). Because of considerations, the degree of intrusiveness characterizing a given intervention is modified in accordance both with the client's general resistance and with his or her reactance level at the moment.

An additional assumption proposed by Beutler and Clarkin is directed at the special case of paradoxical interventions. Dowd and Pace (1989) have suggested that paradoxical interventions should be given lower priority than more straightforward strategies and not used unless these latter procedures are ineffective. The type of paradoxical intervention to which Dowd and Pace referred include symptom prescription, countermanded change (i.e., suggesting that change will not or should not occur during a designated period of time), and magnifying or exaggerating symptoms. These procedures rely on the client to resist the therapist's influence. While some paradoxical injunctions are designed to provide a new framework within which the client observes a pattern of ongoing behavior, the so-called "defiance-based injunction" (Seltzer, 1986) assumes that the motivational force behind the symptom is reactance—the client's need to maintain or establish autonomy. Prescribing the symptom, in this case, resets the balance of autonomy on the side of giving up the symptom rather than maintaining it.

Shoham-Salomon and colleagues (Shoham-Salomon, Avner, & Zevloder, 1988; Shoham-Saloman, & Rosenthal, 1987) have demonstrated that defiance-based paradoxical interventions have their most desirable effects among clients who exhibit high levels of reactance, especially if their symptoms are relatively intense. Among such highly reactant clients, paradoxical strategies are likely to be considerably more effective than those that rely on client cooperation. This research further suggests that, in contrast, clients who have low reactance levels respond better either to structured, directive interventions or to procedures that value client compliance than they do to defiance-based paradoxical ones.

**CONCLUSIONS**

To suggest that client-therapist similarities are central to developing a beneficial therapeutic alliance is a far too simplistic assertion. A good therapeutic alliance must also be built on the presence of different but relevant perspectives and evolves out of what transpires within the treatment to enhance or inhibit the growth of the relationship. This latter point is captured well in the writing of Kohut (1977, 1984) who proposed a tripolar concept of self, each aspect of which is associated with a certain environmental response. These tripolar needs to receive selective responses from the environment and the history of early environmental supply of these responses result in attributes that make the client selectively seek one of several types of relationships. The first two attributes, ambition and ideals, grow both from an environment that acknowledges the differences that exist between oneself and others and from a relationship with someone who embodies healthy values. If one's needs for acknowledgment are not met, anger and rebellion may become the norm. On the other hand, if desires for a stable value model are frustrated, one may attempt to construct an idealized relationship with others and consequently relate through a medium of dependency and self-deprecation. One sees in this logic the central role that a therapist may play in providing the model of personal values and ideals that the client lacked in the course of earlier experiences and on which therapeutic persuasion may depend.

Kohut also proposed that twinship needs reflect one's effort to see oneself as similar to significant others. Frustration of these needs for similarity when interacting with figures who are very different from or critical of oneself is thought to result in a sense of alienation, and in psychotherapy may drive the client to seek similarity with the therapist. Hence, to Kohut, clients both seek to know therapist's personal values and to adopt them in their search for human identity and safety. The fact that therapeutic benefit, especially as judged by the therapist, is associated with a process of client conversion to the therapist's personal beliefs (Beutler, 1981), is consistent with this viewpoint.

We may conclude that therapists who share similar humanitarian and intellectual values with their clients, and who have discrepant views of personal safety and the value of interpersonal intimacy and attachment, comprise optimally compatible pairings. When differences occur in other belief and value dimensions, therapists who are sufficiently tolerant of and able to communicate from within the client's framework may be as effective as those whose views are similar to their clients. Such therapists do not appear to exert un-
due influence over socially sensitive but valid social values.

The methods of role induction may facilitate the development of desired client-therapy matches, especially adding to the power of the therapeutic alliance, which tends to become stabilized early in treatment (Eaton, Ables, & Guttifreund, 1988). Role-induction procedures have several characteristics in common, whether constructed as direct instruction, through contracts, or through modeling and observation. Wilson (1985) noted that a central tenet of most procedures is that pretherapy training will help establish treatment as a collaborative venture. The various other aspects of role induction simply reinforce and operationalize this concept of collaboration.

Once one decides that certain client roles should be induced rather than adopting procedures that accommodate client expectations, the method to be used for role induction becomes a critical variable. A careful distinction between the induction and the treatment cannot always be maintained. Hence, the role induction should be selected to fit the client's needs for personal contact, structure, and reassurance, as well as their preferential defensive styles.

While it is clinically obvious that the nature of preparing clients for treatment should vary from client to client and from treatment to treatment, empirical literature is relatively silent on this issue. Overall, it is defensible to argue that combining procedures is more advantageous than single role-induction procedures (Mayerson, 1984), but this is seldom feasible in view of time demands and convenience. For most cases, we are left to rely on clinical experience and common sense to tell us how to prepare a given client for treatment.

Similarly, clinicians usually rely on intuition or theoretical logic in selecting specific means of intervention. Unfortunately, they are limited in their choices by their theoretical leanings and experience. A number of authors have proposed a superordinate model of interventions that would provide a method of selecting a wider variety of techniques than that encompassed in a single theoretical approach to treatment. While several of these models have been based on prevailing clinical wisdom and available empirical research, prospective research on the models themselves is just beginning. We have presented some of the conclusions and hypotheses developed by Beutler and Clarkin (1990), who have consolidated several empirically derived treatment matching models around the concept of personal persuasion.

Beutler and Clarkin have proposed matching criteria to help select the focal objectives of treatment, the mediating goals of treatment, and the use of directive and evocative measures. These selections rely on corresponding client qualities of problem complexity, coping style, and reactance potential. This model attempts to extract from notions of persuasion the principles that will allow therapists to be maximally efficient in the selection of technical strategies, but is likely to be most effective if applied in compatible therapeutic dyads, and when clients themselves are prepared in advance for accepting the assumptions and expectations that are embodied in the procedures used.

REFERENCES


Proctor, E. K., & Rosen, A. (1981). Expecta-


Shoham-Salomon, V., Avner, R., & Zevlodever, R. (1988, June). "You are changed if you do and changed if you don’t": Cognitive mechanisms underlying the operation of therapeutic paradoxes. A paper presented at the Society for Psychotherapy Research, Santa Fe, NM.


chotherapy: Theory, Research and Practice, 18, 375–378.