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STRATEGIC ECLECTICISM: A TECHNICAL ALTERNATIVE FOR ECLECTIC PSYCHOTHERAPY

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The development of an eclectic paradigm has been hampered by fundamental differences in theoretical conceptualization. This article proposes a technical eclecticism that extends a strategic model to include the contributions of diverse therapy approaches. A strategic eclecticism is presented that attempts to maximize common factor effects, as well as to enable the selective application of both content and technique from multiple models of psychotherapy.

The desire for a prescriptive specificity which would enhance the efficiency and efficacy of psychotherapy has fueled interest in the development of an eclectic paradigm for clinical practice (Norcross, 1986). Unfortunately, fundamental philosophical and theoretical incompatibilities among approaches may preclude the development of an integrated, unitary model of psychotherapy theory and practice. While theoretical integration offers the greatest intellectual appeal, technical eclecticism (integration of technical procedures within a preferred theory base without requiring a connection between metabeliefs or theoretical underpinnings) may provide the least obstructed route to a broadly based prescriptive specificity (Lazarus, 1967; Norcross, 1986).

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Addressing the problem of inherent content differences between theories, Goldfried and Safran (1986) suggest that integration efforts might best be attempted at an "intermediate" level of abstraction, i.e., the level at which the common principles of change operate. Supportive of this argument is Lambert's (1986) work which suggests that positive outcome is in large part related to "common factors." Garfield (1986) argues for an eclecticism based in these common or nonspecific factors which characterize successful approaches to psychotherapy. Given the findings relative to common factors and orientation specific factors (technique), an eclecticism emphasizing common factors as well as the selective application of specific techniques may yield promising results (Garfield, 1986; Lambert, 1986).

This article offers a rationale for a technical eclecticism that extends the strategic model of the Mental Research Institute (MRI) (Fisch, Weakland & Segal, 1982) to include the contributions of diverse psychotherapy approaches. This eclectic framework has evolved from earlier efforts utilizing an MRI approach within other psychotherapy orientations. Held's (1984) proposal for a strategic eclecticism advocates for the use of the MRI resistance minimizing interventions within any orientation to enhance compliance to therapeutic directives. Held (1986) expands her position by asserting that the MRI problem formation model is relatively void of specific theoretical content, thereby enabling a strategic use of theoretical content from any approach to design interventions.

Narrowing the focus of Held's strategic eclecticism, Duncan, Rock and Parks (1987) propose an integration between MRI strategic and cognitive–behavioral approaches based on their many similarities and complementary domains of expertise. Using a behavioral view as an example,

they suggest that an MRI model may provide a flexibility which allows for the use of technique from a variety of approaches (Duncan et al., 1987).

Expanding the MRI model, this article presents an evolving strategic eclecticism (Duncan, 1984, 1989; Duncan & Parks, 1988; Duncan, Parks & Rusk, 1990; Duncan et al., 1987; Duncan & Solovey, 1989), conceptually based in systems theory and constructivism, that attempts to maximize common factor effects as well as enable the selective application of diverse psychotherapy technique, language, and content. The theoretical and pragmatic assumptions underlying a process oriented, constructivist rationale for strategic eclecticism is discussed and illustrated with clinical examples.

A Process Constructive Description of Eclecticism

The theoretical foundation for strategic eclecticism is built upon two primary concepts, constructivism (Von Foerster, 1981; Watzlawick, 1984), and a systems view of process, derived from the works of Buckley (1967), the MRI (Fisch et al., 1982; Watzlawick, Weakland & Fisch, 1974), and Held (1986).

Constructivism

The constructivist position holds that individuals do not discover "reality"; rather, they invent it (Watzlawick, 1984). Reality is evident through the constructed meanings which shape and organize experience. Simply put, meaning is reality. The creation of meaning frames and organizes perception and experience into rule governed patterns through which individuals predict, describe, and direct their lives.

Two levels of meaning construction are posited by Buckley (1967). Initially, meaning is created during the ongoing interaction between an individual and the social environment. The human capacities for symbol manipulation and self awareness enable a second level of meaning construction. Humans can continue to experience a transaction entirely at a covert level, permitting the continuous generation of meaning apart from the actual transaction(s). Therefore, a meaning system can be said to be generated by the actual transactional experience, its covert rehearsal, and the meaning constructed to organize both (Buckley, 1967).

The inherent flexibility of the constructivist view bears implications for technical eclecticism. Therapists, like clients, endeavor to create a predictable, structured reality. Models of psychotherapy and human development order and organize the clinician's perception and experience regarding the client's presenting concerns. Paradoxically, the structure which the therapist selects also limits the search for solutions. From a constructivist vantage point, theoretical language and content conceptualizations may be viewed as somewhat arbitrary metaphorical representations which explain and organize the therapist's "reality." A technical eclecticism therefore may be facilitated by a preferred theory base that allows for a more flexible therapist reality.

Process Level Systems

According to Buckley (1967), systems may be classified at three levels, each applicable to a specific domain, i.e., mechanical/equilibrial (inorganic, chemical, and mechanical systems), organismic/homeostatic (biological systems) and process/adaptive (social systems). At the process/adaptive level, process is primary; structure, which is fluid and ever changing, is created through the actions and interactions of system members and their continuously developing relationships. Structure is but a temporary, accommodating representation of an ongoing process. Unlike biological systems, characterized by fixed structures (e.g., the hypothalamus) which perform recognizable and invariant functions across systems (e.g., temperature regulation), social systems are possessed of no immediately identifiable structures of invariant function.

Inherent to process level systems is a capacity for evolution and elaboration; these systems are not only sensitive to change (variation), but are essentially dependent on change to remain viable. Individual and shared meanings constructed through the interaction surrounding the variation both guide and are shaped by the ongoing interactional process. Variation stimulates the interactional process, construction of meaning, and the continual movement toward greater complexity, flexibility, and differentiation.

Buckley's process view of systems provides a flexible theory base for technical eclecticism (Fraser, 1986). The emphasis on the interactional process surrounding variation and its importance to meaning construction and growth of the system can be applied to the process of psychotherapy. The therapist offers variation through conversation and behavioral prescriptions. Both avenues of

variation stimulate interactive process and meaning construction, thereby enabling change and client growth.

Problem Process

It is when adjustment or adaptation to a variation is perceived as a difficulty that problems develop. The MRI posits two conditions as necessary for problem development: 1) the mishandling of the difficulty and 2) upon failure of the original solution attempt, more of the same is applied, resulting in a vicious cycle (Watzlawick et al., 1974). The inter/intra personal interaction which surrounds the difficulty, the process by which individual and shared meaning related to the difficulty is constructed, and the interplay of both are seen as significant to the problem process. Constructed meanings both influence and are influenced by the difficulty itself, creating a problem-oriented system (Goolishian & Anderson, 1987), or one in which interpersonal interaction and meaning construction are organized around the problem.

According to the MRI, problems develop from chance or transitional circumstances encountered by individuals and families evolving through the life cycle. While presenting complaints and concerns may be highly content-laden and idiosyncratic to the individual or the situation, the *problem* is defined in terms of the interactive process. Significant etiology resides in the process itself, rather than in related factors such as personality or history.

Although the MRI does not present its approach as compatible with other theoretical orientations, Held (1986) argues that the MRI approach can subsume other individual and interpersonal models and therefore may be utilized as a basis for eclecticism.

Process versus Content

Building upon the work of Prochaska and DiClemente (1982), Held (1986) argues that the MRI problem process model is a general and inclusive view of problem formation and maintenance. It posits no particular theoretical "true maintainer" or "real cause" of the presenting problem (e.g., fixated psychosexual development, confused hierarchy, existential anxiety, irrational beliefs) other than redundant solutions. While all models of psychotherapy are built upon theoretical content, they vary in the degree to which content is emphasized and elaborated (Held, 1988). Although variation exists in the extent to which the therapeutic process is ordered by theoretical "reality," most therapies fall to the content-oriented pole of the content–process continuum. For example, a psychodynamic clinician may view the presenting complaint as a result of fixated psychosexual development. The therapist may pursue information from the specific stage of development under question and make interpretations to allow the client to integrate unconscious material.

An MRI therapist may view the presenting complaint as a vicious cycle of unsuccessful solution attempts by the client and others attempting resolution. The therapist may pursue an interruption of the problem maintaining process. The psychodynamic approach posits a particular content path (psychosexual fixation) to follow, while the MRI attends to the process surrounding the problem. Accordingly, Held (1986) has identified the MRI as a process oriented, rather than content oriented, approach to psychotherapy.

Held's process/content distinction bears implications related to decisions regarding treatment goals. The theoretical reality of the therapist necessarily structures problem definition as well as outcome criteria. The more content oriented the approach, the more content directed are the goals.

Client focus must necessarily be content oriented and value laden. For a client to articulate a complaint requires that it be framed in a content-rich meaning system; even the most general and nonspecific of client articulated goals (e.g., "I just want to feel better") must be ordered by the content of an idiosyncratic meaning system. The MRI change model shifts therapist focus from content ordered goals to process-based goals and outcome criteria. The only goal which this model dictates is that of changing the interactive process which permits the problem. A process-oriented approach such as the MRI's can provide a foundation for a technical eclecticism in which the content structured goals of the client are facilitated by the process structured goals of the therapist.

Pragmatic Assumptions

The conceptual foundations discussed above suggest several assumptions regarding people, problems, and the practice of psychotherapy. The result is a process oriented, eclectic approach which seeks change rather than cure as the ultimate therapeutic goal. Although not all-inclusive, these three assumptions represent the basic premises which characterize a process constructive frame of reference for strategic eclecticism.

Assumption 1: Problems, and their solutions, are embedded in the interactive process.

Despite its relationship to the past, or to individual factors, all behavior is continually being shaped or maintained by ongoing interaction in the social system (Watzlawick et al., 1974). The evolving biopsychosocial unit (e.g., individual, couple, family, group) will inevitably encounter chance or transitional/developmental difficulties as it moves through the life cycle. Problems result from the interaction of the developing/evolving unit and its constructions of the environment: they are maintained and/or exacerbated by a vicious cycle of attempts to adjust to the difficulty. Whatever their origins, problems are amenable to change through intervention in the ongoing interactive process (Watzlawick et al., 1974). Therapy focuses on the interaction among system members and between the meaning-creating individual and the environment.

Since therapy focuses on process variables, individual or systemic pathology is not emphasized, nor are symptoms seen as necessarily functional to the individual or interpersonal system (Duncan, 1984). People are generally viewed as possessing the necessary resources and skills for problem improvement to occur unless overwhelming evidence to the contrary is presented. At the very least, this nonpejorative and nonjudgmental perspective encourages the creation of a change enhancing therapeutic context, given the therapist's constructed meaning that change will occur.

Although this is a health based rather than a medical/disease view, psychopathology is neither discounted nor ignored. However, the construct of psychopathology may not necessarily focus the content of the therapeutic endeavor; rather, it is the client's meaning system and content formulation that order the therapeutic focus. The information that accompanies diagnostic nomenclature is attended to by the therapist, but may not be utilized to direct the therapeutic conversation or intervention design.

For example, a client presenting himself as a messenger from God was arrested for disturbing the peace, because he was awakening strangers in the middle of the night to spread God's word. The therapist included the diagnostic information from "schizophrenia" in the formulation of the problem. However, the client's complaint of being unable to spread God's word was accepted and the therapeutic conversation and intervention were focused on the difficulties inherent in being a messenger from God, rather than sole reliance on content taken from a psychopathological view of schizophrenia. It is the intent of strategic eclecticism to enable the informed and pragmatic use of historical, diagnostic, and personality knowledge bases without the restrictions of their sole reliance.

The problem process, or the interaction between the client and others attempting resolution, and the interaction between the meaning constructing client and the environment is the "problem" primarily attended to by the therapist. The client content ordered description of that problem process offers the entry point for intervention.

Assumption 2: The client presentation, rather than the therapist's orientation, determines therapy goals, the content of the therapeutic conversation, and intervention strategies.

It is the client's construction of meaning around the problem that is of importance to the problem process, as well as to the intervention selected. To the extent that it emphasizes the primacy of the client's subjective reality, strategic eclecticism is phenomenological and client-centered. Assessment focuses on establishing a consensual understanding of the complaint from the client's perspective; it is the client's presentation of the problem which establishes the entry point for change. Presentation involves the client's verbal and nonverbal description of and beliefs regarding the nature and meaning of the complaint as well as the affective experience which attends the problem. Explicit empathy not only validates experience, but also provides the therapist with invaluable information for effective intervention.

A major contribution of both constructivism and Held's process/content distinction is the suggestion that reality exists only as a construct of each participant in the problem process. As a member of the problem oriented system, the therapist participates in the ongoing, interactive development of individual and consensual realities regarding the presenting complaint. However, the therapist's "reality" is just as but no more "real" and "true" than the client's version.

Therapist allegiance to any particular theoretical content involves a trade-off which simultaneously enables and restricts intervention options. Process oriented therapists walk a tightrope, balancing themselves between the flexibility and uncertainty of process and the directionality and limitations of content (Held, 1986). Since a process oriented approach focuses on changing the interaction which

maintains the complaint or concern, establishing *The One True Reality* is neither a function nor a goal of strategic eclecticism.

A purpose of the therapeutic conversation is to make explicit the client's reality related to the problem process. The content of the therapeutic conversation provides a meaningful framework which may allow the client to reorganize perception and experience, thus shifting the problem-enabling meaning system. The therapist may respond to the client's complaint with content selected from a number of sources: 1) generic response patterns; 2) specific clinical content areas and techniques; and 3) specific theoretical or philosophical orientations.

Generic response patterns [e.g., the grief process (Kubler-Ross, 1969); rape trauma syndrome (Burgess & Holmstrom, 1979)] describe culturally typical patterns or phases of response to developmental transitions or incidental crises, and may provide the basis for an intervention strategy which shifts the meaning system surrounding the problematic response. Likewise, content derived from a specific clinical area (e.g., anxiety, AIDS, etc.) may provide an organizing framework for the therapeutic conversation and intervention. This new information may provide a reorganization of the solution patterns or a rationale for the intervention.

Sometimes clients present with discrete, clearly delineated concerns. With some complaints the literature strongly indicates the efficacy of a particular approach, specific conceptualization, or technique (e.g., performance anxiety, relaxation training). Attending to the literature and selecting interventions associated with documented, successful outcomes serves the client by extending the options for intervention and enhancing therapeutic flexibility. Content drawn from this source may be utilized as a primary framework for intervention or as an adjunct to other interventions (Duncan & Parks, 1988).

By the same token, should the presentation appear congruent with a particular theroetical orientation, the therapist may utilize that content to structure the intervention. Presenting the concern in the language of a particular approach (e.g., framing client complaints of depression, malaise, and meaninglessness from an existential perspective) may enable a reorganization of the meaning system which supports the problem process.

The selection of content is not data based or empirically driven and is not directed by a concrete prescriptive specificity because the matching decision operates at a level of abstraction that views content as metaphoric. Content is selected to match the client's worldview and circumstances, rather than the theoretical predilection of the therapist: content is only the vehicle through which the problem process is influenced. While the content matching decision is not determined by diagnosis, symptom complexity, client coping style (Beutler, 1986), or other content based decision trees, intervention may incorporate any of these factors. The matching decision is based entirely in the content laden description of the presenting concern offered by the client. Therefore, any client or problem quality could be relevant if directed by the idiosyncratic content focus of the client.

Assumption 3: Problem improvement occurs by influencing the context of the problem via the actual interaction and/or its acquired meaning system.

When a developmental transition or chance circumstance is experienced as a problem, the current meaning system somehow lacks the information necessary to organize resolution of the problem. The meaning system limits the available solution patterns that the client can employ; consequently these limited solutions are repetitively applied, thus exacerbating the problem (Watzlawick et al., 1974).

Change may be facilitated at either of the two levels at which meaning is constructed (Buckley, 1967). At the first level, interaction generates the meaning which organizes perception. Influence at this level entails changing the interactional context, thereby challenging the limits of the client's constructed meanings. Placing clients and the problem process in a different context creates a situation through which new meaning may be ascribed (Erickson, 1980), as well as interrupting the current problem-maintaining solution attempts.

Level I strategies, which are action-oriented, involve changing the problem's interactional context. These strategies include prescribing different behaviors based on an accepted client meaning, and prescribing tasks and current behaviors. The new context competes in a behavioral, cognitive, or affective way with the prevailing meaning system, enabling the formation of a different (and possibly helpful) meaning. This emergent, revised meaning is constructed by the client, rather than the therapist. The therapist only suggests change

in the context; change in the meaning system occurs in the course of the actual interaction.

Level II strategies are meaning-oriented and seek to alter, revise, or replace a particular meaning system. Since individuals can recall and review an interaction following its termination, acquired meaning systems can be influenced independently of the actual transaction. Direct exploration of the client's problem-oriented reality may promote the construction of alternate ascriptions by the therapist or the client. Level II interventions include empowering client ascribed meaning and ascribing different meanings to problem situations.

The distinction between Level I and II interventions is somewhat arbitrary given the inherent reciprocity of meaning and behavior. The distinction represents an attempt to delineate avenues by which the problem process may be influenced and to illustrate the salient features of the different strategies.

Level I Interventions

Intervention 1: Prescribing Different Behaviors Based on an Accepted Client Meaning

To varying degrees, clients possess firm meaning systems which must somehow be altered if change is to occur. Direct confrontation which challenges the meaning system risks further entrenchment of the problem-maintaining process. Instead, the therapist may elect to utilize the existent meaning system as the basis for prescribing different behavior(s). Utilizing the existent meaning system to generate new/altered and competing behaviors is seen as a useful, as well as respectful, stance.

Change in behavior may result in a change in the contingencies surrounding the problem, enabling new or different behaviors to occur in place of the old problem behaviors. The competing behaviors may generate the construction of a new meaning system that does not include the presenting complaint: the particular change in meaning is constructed by the client's behaviorally altered interaction with the environment (Duncan, 1989).

Case Illustration

L, a 43-year-old woman, presented with concerns regarding her nine-year-old daughter's irritability and unhappiness, which L viewed as possible signs of a genetically transmitted depression. L cited her own history of depression, as well as her own mother's depression history, as evidence for an inherited, genetic depression in her daughter. She stated that her efforts to comfort, reassure, and cheer the child were ineffective and feared that these early signs would exacerbate, dooming her daughter to the bouts of depression which had characterized the two previous generations. Given the strength of the client's beliefs regarding the biological, genetic risk to her daughter, as well as the client's implicit values regarding a mother's role, the therapist chose to intervene within the parameters of the client's meaning system, and accepted the client's view of depression. Accordingly, the therapist utilized clinical content derived from literature on biological/genetic depression, and linked it to a diathesis–stress paradigm (Davison & Neale, 1986). The therapist suggested that, given the familial predisposition to depression, environmental factors could be critical in the expression of the predisposition. Since the depressive tendency appeared to be a given, perhaps the mother could assist her child in learning how to cope with her depression by simply acknowledging and validating the child's complaints. This would implicitly encourage the child to "work through" her feelings and develop competence in coping.

This intervention was specifically designed to influence the mother to back off and lessen her involvement in her daughter's everyday activities. The problem was viewed as embedded in the interactive process surrounding L's attempts to help her daughter. The therapist believed that directly suggesting that L withdraw her involvement from her depressed child would be met with noncompliance, and lessen the therapist's credibility. The therapist did not assess anything other than normal nine-year-old behavior, but also did not believe that L would respond to a suggestion that her daughter was normal and not depressed, and therefore could be left to her own devices.

Accepting L's meaning of her daughter's behavior enabled the therapist to prescribe different behaviors based upon that meaning. Such an acceptance and utilization of a strongly held client meaning not only provides the direction for intervention, but also enhances compliance and therefore the likelihood of outcome success. The selection of the content for both the therapeutic conversation and intervention was directed by the client's idiosyncratic presentation of genetic depression. L returned for two more sessions following the intervention described above. She reported that her daughter seemed happier and was complaining less. L reported that although it was difficult for her, she was not attempting to rescue her daughter from her depression any more. She also added that perhaps her daughter was only mildly predisposed to depression.

Intervention 2: Prescribing Tasks and Current Behaviors

The common thread which unites the prescription of tasks and current behaviors is an experience that competes behaviorally, affectively, or cognitively with the presenting concern, thus permitting the construction of a different meaning. Tasks challenge the limitations in ascribed meanings, and force a re-evaluation of the meaning system. Prescriptions can take many forms, ranging from general and vague to specific. They can be directed to affective and cognitive levels as well as the behavioral level. Their particular form is limited only by the creativity of the therapist and the problem oriented system.

The goal of prescribing current behaviors is to provide a competing experience so that current

solution attempts are interrupted and/or the client ascribes a different meaning to the complaint. Prescription of the symptom/current behavior alters the problem's context, enabling clients to explore alternative solutions on their own because of their newly constructed meanings (Duncan, 1989).

Case Illustration

J, a 32-year-old business executive, was recently promoted and was now required to fly to regional meetings. Her first trip was scheduled and she presented her flying phobia to the therapist with opportunities for two sessions before her trip. J reported that she had successfully avoided flying for many years, to the point of even leaving situations in which flying was discussed. She also stated that although her fear existed, she knew that most people were not fearful and that she was probably overreacting. The therapist ended the first session with both a task and symptom prescription. The client was instructed to go to the airport and observe ten people waiting to get on airplanes and rate their anxiety levels on a scale of one to ten. The therapist also suggested that J spend at least 15 minutes, but not more than 30 minutes, considering the dangers of flying and experiencing her fears intensely. J returned for session two and had complied with both suggestions. She reported surprise that seven of ten people observed had ratings of six or more and that she was pleased to see that not everyone took flying in stride. J was able to think about the dangers of flying, but the fears seemed to be more manageable. The client was instructed to repeat the rating exercise on the airplane. The therapist also taught J a relaxation exercise in session two.

The prescription of the symptom and the task had two purposes: 1) to create an experience that interrupted the current solutions (problem process) and/or competed affectively, behaviorally, or cognitively with the experience of the primary complaint; and 2) to construct a new context that enabled the client to ascribe a different meaning to the problem. J's solution attempts of avoidance and willpower were interrupted and her meaning system that her fear was an overreaction was challenged. The content of the therapeutic conversation was directed by the client's description of her flying fear; the interventions were designed from that content laden description. The relaxation strategy was selected as an obvious alternative for the attenuation of arousal caused by the flying phobia. By telephone follow-up, the therapist learned that although J felt anxious, she was able to fly to her meeting. She also added that she believed she was not the most uncomfortable person on the flight.

Level II Interventions

Intervention 3: Empowering Client-Ascribed Meaning

It is not uncommon for clients to report new perceptions regarding themselves or the complaint as a result of their attempts to follow a homework assignment. Created by the client, this reconstructed meaning reinforces or empowers continued change, and vice versa.

Client-ascribed meaning is distinguished from insight in two ways (for a full discussion, see Duncan & Solovey, 1989). Insight is therapist generated, i.e., the client's response to the carefully selected interpretations offered by the therapist and directed by the therapist's frame of reference or orientation. Client-ascribed meaning, on the other hand, is client generated, i.e., the client's interpretation of a prescribed task or event. While insight has traditionally been held to be a necessary precondition for change, client-ascribed meaning develops either during the process of change itself or as a postcondition of change. Through questions which encourage the client to articulate and embellish the reasons behind the changes of circumstances or heart, the therapist punctuates the change that has transpired. Further change is empowered through the client's own positive ascriptions, without the therapist taking responsibility for the change or assuming the cheerleader role. In its essence, the use of client-ascribed meaning to promote change is a growth-enhancing intervention.

Case Illustration

B, a 41-year-old management consultant, described himself as depressed, which he presented as listlessness, fatigue, and a general lack of motivation and happiness. B described his frustrations with his job and the lack of romance in his marriage as possible factors. He also reported that he felt as if there were no point to life most of the time. The therapist and client discussed the problems inherent in midlife transition and the pursuit of personal meaning. A task was assigned in which B was asked to monitor his depression, rate it, predict his rate for the next day, and then compare the actual versus predicted rate (see de Shazer, 1985).

Tasks are assigned to promote change by offering a vehicle through which clients may actively construct meanings that organize their perceptions and experiences in a manner conducive to problem improvement. B returned and reported that he had contacted an employment recruiter and had discussed the lack of romance in his marriage with his wife. He added that as he looked at the events of the day and rated his depression, he became certain that as long as his job and marriage remained dull, he would stay depressed and unfulfilled. The therapist responded with surprise, amazement, and a sequence of questions that encouraged the client to articulate what had happened that such changes could occur. The client continued to ascribe self-enhancing meaning to the changes, which culminated to an expression of a belief that he had discovered that his pursuit of happiness was under his control only.

This case illustrates the use of client-ascribed meaning to empower and encourage change. Following a discussion of content selected from a generic response pattern (midlife crisis) a homework assignment was suggested without a rationale.

The client gave meaning to the task and was able to do something different (contact employment recruiter, talk to wife) in relation to his problem. After making a behavior change, he continued to ascribe self-empowering meanings to the task and to the changes he was making.

Intervention 4: Ascribing Different Meanings to Problem Situations

The therapist's ascription of different meanings to problem situations is a somewhat extended version of reframing, i.e., changing "the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame that fits the facts equally as well or even better, and thereby changes its entire meaning" (Watzlawick et al., 1974, p. 95). Unlike interpretation, which emerges from the therapist's orientation/frame of reference and seeks to offer a particular, and perhaps inherently better or more "correct" view of the problem, therapist ascribed meaning is intended to present alternative ways of viewing the client's concerns. Whereas the goal of interpretation is to promote insight which *ultimately* results in behavior change, therapist-generated reframes seek to promote *immediate* behavior change (Duncan & Solovey, 1989).

The meaning ascribed is dependent upon the clients' observations about themselves and their concerns, as well as the specific clinical situation and its historical presentation. The particular ascribed meaning is collaborative in the sense that it emerges from the interaction between the therapist and the client. Since no particular theoretical or content path must be exclusively utilized, meaning may be ascribed from any content area as long as it is consistent with the emergent reality that is constructed in the therapeutic conversation. The goal of meaning ascription is not to establish a "true" or "better" meaning, but to encourage a change in meaning which will permit clients to reorganize the experience that maintains the problem.

Case Illustration

H, a 42-year-old married female, entered therapy following hospitalization for depression. She presented as passive and somewhat affectively flat as she described her depression of ten years' duration. She reported that her husband, whom she loved, was impotent, yet refused to seek treatment, despite the fact that she very much missed sexual intimacy. Using a structural frame (Minuchin, Rosman & Baker, 1978), the therapist suggested that perhaps her depression functioned to protect her marriage from conflict or other serious consequences. Were it not for her depression, she would think enough of herself to find a partner capable of providing the desired intimacy, and to have an affair which could threaten her marital relationship. The client returned with her husband, stating that she had given him the ultimatum (for the first time) that he would enter therapy or she would leave.

This case illustrates the significance of the client's content laden description of the presenting complaint to the selection of different meanings ascribed by the therapist. The therapist-ascribed meaning of "protecting the marriage" was not based in the belief in any given theoretical orientation (i.e., structural family therapy) or viewed as representing an ultimate truth or better way of understanding her depression. Rather, the therapist designed the ascribed meaning based upon the idiosyncratic content focus of the client in the hope of influencing the client to take immediate and different action (i.e., confront her husband) which enabled her also to shift her view of her depression from something totally out of her control to something which she could proactively address. This case also illustrates the selection of content from a specific theoretical orientation.

Discussion

It has long been recognized that the therapeutic process may be hampered by the limitations of any single theoretical reality. For many practitioners, efforts at matching techniques and procedures to individual clients has been likewise hampered by content related incompatibilities. A constructivist and process oriented perspective may provide a framework for the selection of interventions matched to the client's worldview and goals. While strategic eclecticism offers freedom in choosing intervention options, it also imposes on the therapist a responsibility to broaden content and procedural repertoires, since no one or two theories are seen as sufficient to explain and effectively address the diversity of presentations clinicians routinely encounter. Acceptance of the process/content distinction largely challenges the need for an integrative meta-theory to guide eclectic practice, because language and theory are viewed as metaphors which structure and organize the therapist's reality.

The primacy of the client's worldview would appear justified in light of Lambert's (1986) conclusions regarding outcome variables. Based on his review of the psychotherapy outcome literature,

Lambert suggests that only 15 percent of positive outcome appears to be related to specific technique; expectancy (placebo) variables likewise account for 15 percent of the improvement. Common factors, those variables which cut across therapies (e.g., warmth, respect, empathy, acceptance, identification with the therapist, positive relationship, insight, rationale, cognitive learning, reality testing, risk taking) appear to be related to 30 percent of positive outcome; spontaneous remission factors (i.e., client variables, social support, out-of-therapy events) account for 40 percent of the improvement. A constructivist, process oriented stance empowers common factor effects through explicit recognition of the client's meaning system as hierarchically superior to the content-based theoretical frame of reference of the therapist. Working within this context fosters client identification with the therapist and the development of a relationship which encourages clients to risk reordering the meaning system which supports the problem process.

The selection of techniques and rationales which are congruent with the client's unique meaning system would appear to implicitly enhance the effect of placebo variables, creating a cognitive set which expects change. Those factors which Lambert characterizes as spontaneous remission variables are significant in a process orientation. Remission (i.e., improvement) from a process perspective may not be truly spontaneous, but rather one possible result of the inevitable responsiveness to variability. Empowering client-ascribed meaning utilizes the effect of those variables which clients identify as significant to their improvement, whether directly or indirectly related to in-therapy events.

This article has presented a technical eclecticism which extends an MRI oriented strategic approach to include diverse clinical and theoretical contents. A process constructive perspective of strategic eclecticism (Held, 1984) was described as a derivation of Buckley's schema of systems and constructivist philosophy. The suggestion that theoretical content is but a metaphorical representation that should be placed secondary to the client's presented content may offend some theorists and clinicians. Rather than alienate, it is hoped that these ideas will stimulate continued dialogue among eclectic practitioners who recognize and value the contributions and theoretical realities of multiple, diverse approaches.

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