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SYSTEMATIC TREATMENT SELECTION AND PRESCRIPTIVE THERAPY

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Systematic treatment selection (STS; Beutler & Clarkin, 1990; Beutler, Clarkin, & Bongar, 2000) is an empirically developed procedure for identifying the mix of therapist, treatment strategies, and psychotherapeutic interventions that are most likely to produce a favorable response in any given patient. Two basic assumptions underlie this approach: (a) There is no treatment method or model that works well on all patients, and (b) most treatment methods work well on some patients (e.g., Beutler & Harwood, 2002; Howard, Krause, & Lyons, 1993). The effects of most (if not all) treatments range from very positive to mildly negative, depending on the patient observed. STS seeks to identify which patients will respond positively to various mixes of interventions from different treatment models. Treatments are not mutually exclusive, however. Regardless of whether they are identified (e.g., by similar labels or brands), treatments are distinguished more by the pattern of interventions used than by the exclusivity of the procedures used (e.g., Malik, Beutler, Gallagher-Thompson, Thompson, & Alimohamed, 2003). Moreover, the procedures used are more closely related to the therapist's training and beliefs than to the procedures' scientific validity (Beutler et al., 2000).

Contemporary efforts to construct research-informed guidelines do not as a rule address the commonalities among treatments; practitioners prefer instead to think of each treatment model as a discrete and identifiable entity that can be applied to all patients with the same diagnosis. However, the presence of a shared diagnosis occludes the presence of important differences among patients. Thus, the appropriateness of any given treatment model depends both on the pattern of interventions used and the fit of these interventions to both the diagnostic and nondiagnostic characteristics of the patient.

In contrast to the broad approach of fitting a treatment model to a patient's diagnosis, STS seeks to identify the specific pattern of patient traits and states (*dimensions*) that best fit with a corresponding pattern of demand characteristics that constitute the amalgamation of a treatment strategy and a therapist's particular relationship style. Rather than identifying the treatment received by a patient purely in terms of the theoretical model that guides it (e.g., cognitive therapy, psychoanalytic therapy, interpersonal therapy) or the techniques that it contains (e.g., interpretation, thought records, evidence analysis), all of which may reveal more about a particular therapist's beliefs than about in-therapy behavior, STS is constructed around principles of behavior change—guiding theorems of change and relationship that cut across treatment models and theories and that can be applied by individual therapists from different perspectives (Beutler et al., 2000).

In the strictest sense, STS is not an "integrative therapy"; it does not attempt to combine theoretical concepts or to derive a unified theoretical approach of any type. To the degree that it falls within the domain of current descriptors, it is a "technical eclectic" approach, but even that label is imprecise because STS does not specify any particular set of techniques but rather allows the therapist to use procedures from any particular approach that are consistent with the application of cross-cutting principles of change and influence (e.g., therapeutic change is most likely when the therapeutic procedures do not evoke patient resistance).

The principles and applications of STS have been defined and developed through a four-step process (Beutler et al., 2000). The first step was a series of literature reviews designed to identify predictors and moderators of therapeutic change. The second step was to collapse and combine these predictors and moderators into a smaller set of clusters, each of which identified a particular fit or match between patient qualities and treatment strategies that reliably relate to change and improvement. The third step was to develop means for measuring the patient qualities and treatment strategies that emerged from the prior steps. The fourth step tested a series of hypotheses that had been extracted from the reviews of literature, all of which bore on the question of what factors accounted for optimal therapeutic change. A detailed review of these steps is contained in Beutler et al. (2000).

The application of the original STS dimensions for the task of planning treatment is illustrated in the next section, as applied to the case of Frank, a

patient experiencing comorbid depression and chemical abuse disorder and who was seen as part of a randomized trial study of the efficacy of STS predictions (Beutler et al., 2003).

CASE DESCRIPTION

Frank was a 39-year-old Caucasian male with 14 years of education who had been married for about 3 years and had no children. He had just started a home-based business with his wife, after having held several jobs in the past few years. He decided to see a psychologist because he was experiencing severe financial problems caused by his drug abuse (he was in debt to pay for his drugs), and his wife was threatening to leave him if he did not find a definitive solution to his addiction. He also reported symptoms of anxiety, sometimes feeling "overwhelmed by a lack of motivation," and talked about having "no desire to do anything," all of which are characteristics of severe depression. He was "tired of lying to himself and to others."

Frank was 15 minutes late for the first interview. His language was logical and coherent, but he was sometimes distracted. He claimed slight memory impairment because of the drug use, and therefore he was vague and found some dates and events difficult to remember. The following information was extracted from the initial evaluation interview and administration of standardized intake procedures, which included the Minnesota Multiphasic Personality Inventory—2 (MMPI–2; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989), the STS Clinician Rating Form (Fisher, Beutler, & Williams, 1999), and the Beck Depression Inventory (Beck & Steer, 1987).

The therapist learned that Frank was still taking approximately a quarter gram of heroin at least three times a week and approximately a half gram of cocaine almost every day. He reported using them together or alternately and stated that he was able to stay clean from one drug or the other just for few days. He was trying to self-titrate the doses but felt that he could not "go any lower." He had been treated twice for drug abuse, including a treatment consisting of detoxification only, but he was not able to remember the specific dates. Frank tried numerous 30-day outpatient programs but never methadone because, as he said, "It's just synthetic heroin, but with a third of the power. If I want that, I can just take less dope." He attended several Alcoholics Anonymous and Narcotics Anonymous meetings, claiming a preference for the first.

Frank reported difficulties with various cognitive functions such as concentration and decision making. He was experiencing frequent loss of appetite and insomnia; soon before starting therapy, for example, he had spent an entire week without sleeping. Everything went from bad to worse after visiting his stepbrother, who had reminded Frank of early traumatic experiences. Nonetheless, before the sessions described here, he "didn't feel like going to

a shrink," and he tried to "get into a better mood" by consuming more drugs and alcohol.

Frank was raised by his biological parents until he was 14, when they divorced and he stayed with his mother. She remarried soon after the divorce. His father disappeared, and Frank never learned if he was dead or alive. Frank reported that his father had alcoholism and that his mother had a "paranoid phobic" personality. He always suspected that she had worked as a prostitute. She committed suicide 16 years prior to this intake. Frank stated that his mother had physically abused him and his brothers. He did not remember his father abusing him, but he was hurt because of all the times the father ignored what the mother was doing to his brothers and to him. A few months after his mother's suicide, Frank had a terrible car accident.

Frank started drinking when he was a teenager and continued to abuse alcohol after that time. Sixteen years before entering treatment on the occasion under discussion, and in reaction to both the physical problems that followed his car accident and the nearly concomitant suicide of his mother, he started using heroin to "get out from the physical and emotional pain." In a short period, he developed an addiction to heroin, and he started consuming regular amounts of cocaine as well. After 6 years of drug abuse, he was arrested for the first and only time and charged with drug possession. He entered or was committed by the court to several 30-day outpatient treatment programs. He successfully stopped using drugs and remained "clean" for 4 years, during which time he started seeing a psychiatrist. He was dissatisfied and left psychotherapy without further benefit.

Seven months before initiating the treatment effort described here, he went to visit James, an older stepbrother he had not seen for a long period. James helped Frank remember some physical and emotional abuse that they both had experienced in childhood at the hands of their parents, especially the patient's mother. When he returned home, Frank felt depressed and began having suicidal thoughts. He subsequently slashed his wrists. At the time of the current admission, however, he reported no suicidal ideation. He did report continuing depression and anxiety and indicated that this had been relatively constant for more than 6 months. He reported a recurrent fear that he might "go crazy."

Frank had many friends among drug abusers and only two "good pals" who were not drug users or dealers. These two friends and his wife were the only persons he trusted. One of these friends was a physician who had sometimes helped him by prescribing narcotic drugs to cope with withdrawal symptoms.

DIMENSIONS DESCRIPTION AND CASE FORMULATION

A series of intensive analyses of the variations among commonly used psychotherapies (Beutler & Clarkin, 1990; Beutler et al., 2000; Castonguay

& Beutler, 2006), followed by research on these psychotherapies (Malik et al., 2003), has revealed that most psychotherapies can be represented by mapping the therapist's actions against the following dimensions: (a) variations in intensity of treatment, (b) variations in the focus on insight versus behavior and skill change, (c) variations in the level of directiveness used, and (d) variations in the way that patient affect is managed. In STS, it is proposed that each of these variations in therapy implementation tends to be most suitable for a patient who has a particular and corresponding quality of personal or situational attribute. In other words, variations of patient styles and environments tend to serve as indicators (and contraindicators) of different classes of therapy procedures. An analysis of Frank's history, using the cross-cutting STS dimensions of patient variations, and the associated assessment procedure, suggested the following treatment plan.

Assessment of Level of Functioning

An assessment of the level of functional impairment serves as the basis for the assignment of an appropriate level of care. A thorough assessment of functional impairment, within the STS model, includes a consideration of the patient's problem complexity (i.e., comorbidity and personality disorder) and chronicity as well as an assessment of the patient's available social support system. The level of impairment determines the level or intensity of the treatment to be provided. Intensity of treatment, in turn, may be varied by increased length, the use of multiple formats and modalities, and by increased frequency. Our reviews failed to find outcome differences among these alternatives.

Frank displayed a moderate level of impairment as indicated by his chronic history of drug abuse combined with a diagnosis of depression and a previous suicide attempt. Additionally, his MMPI–2 Social Introversion (Si) and Paranoia (Pa) scales indicated some feeling of being alienated from others. Thus, current levels of social support were considered weak, and his problem was characterized as complex because it was negatively impacting numerous areas of functioning; at the time he sought treatment, he was in danger of losing both his job and his marriage. Frank had been able to establish satisfying attachments to his wife. MMPI–2 (Butcher et al., 1989) and various indicators of work and family disturbance suggested a moderate disturbance in functioning; accordingly, the intake clinician gave Frank a Global Assessment of Functioning (GAF; American Psychiatric Association, 2000) rating of 56.

Treatment was scheduled at the rate of twice a week for the first 4 to 6 weeks of the therapy. At the end of 6 weeks, if Frank's impairment had been adequately stabilized and problematic symptoms had been addressed (e.g., the drug abuse noticeably declined, he was less depressed and anxious), the

frequency of the sessions were to decrease to once a week, supplemented by phone calls and emergency sessions if needed.

The primary goal of therapy and the initial focus of treatment was to reduce the risk posed by self-destructive behaviors (substance abuse and suicidal behavior). The need to provide a protective environment (e.g., by using inpatient treatment) was given serious consideration and remained an option throughout treatment. Eventually, however, it was decided that frequent outpatient visits would be adequate to the patient's needs.

The level of functioning also suggested that the therapist assign and monitor the patient's attendance at Narcotics Anonymous and Alcoholics Anonymous meetings on a regular, perhaps daily, basis. Antidepressant medication was considered as an eventual adjunct to psychotherapy (specifically, an antidepressant that may also help reduce the patient's symptoms of general anxiety). In the long run, Frank was encouraged to enter psychotherapy in order to learn psychological change procedures as a first-line treatment before prescribing biochemical agents in an effort to help maintain his focus on developing a chemical-free lifestyle.

In the service of this latter goal, Frank was encouraged to decrease his use of substances on the basis of a realistic schedule of reduction and titration. A medical specialist in substance abuse was consulted about the titration schedule, and a physical exam was conducted to clear him for gradual withdrawal from drugs. Additionally, Frank was provided with educational material describing the possible withdrawal effects and specific behaviors (e.g., exercise, diet, vitamin supplements, sleep hygiene, stress reduction techniques) that have proved helpful in reducing the symptoms of withdrawal.

Because of the chronicity and complexity of Frank's problems, the STS model indicated a need for long-term outpatient care. The frequency of treatment was adjusted as Frank succeeded in reducing drug use, but the therapist knew to expect periods in which Frank's symptoms would flare up, necessitating temporary increases in treatment frequency.

Coping Style

In the STS model, an assessment of the patient's coping style is designed to inform the focus of treatment, encouraging the therapist to select procedures that vary along a dimension that ranges from a focus on gaining insight to a focus on symptom, skill, and behavior change. Within the STS model, externalizing and impulsive behaviors indicate the value of problem and behaviorally focused interventions while internalizing and restraining behaviors indicate the potential value of insight and emotional awareness.

Frank presented with a mixed pattern of internalizing and externalizing symptoms. Specifically, he had a history of acting out (externalizing) through drug use and substance abuse. Additionally, his history of suicidal acts accompanied by a self-reported claim of "interpersonal conflict," suggested the

presence of impulsiveness, which accompanied a correlated pattern of self-blame emotional restriction. The MMPI–2 confirmed the presence of mixed personality features, including both internalizing and externalizing behaviors. Specifically, Frank exhibited elevations on several internalizing scales like the Depression (D), the Si, and the Anxiety (Pt) subscales. Additionally, he scored high on the Impulse (Pd) scale, and he exhibited a moderate elevation on the Pa scale, which indicated a potential to externalize.

The symptoms that placed this patient at risk for continued drug use and for suicidal behavior were given priority in the STS model and served as the initial focus of intervention. Because he presented with both externalizing and internalizing coping patterns, early therapeutic work focused directly on developing impulse control; long-term goals included achieving insight into his motivations and awareness of his unmet emotional needs.

The following example illustrates the therapist's effort to help the patient gain control over "helpless" feelings by insight and emotional awareness.

Therapist: When you take a lower dose, and you believe that nothing is happening and that you need to have another "hit," how do you feel?

Frank: I don't know—*helpless* I guess is the word.

Therapist: Because that's actually what you are likely to feel when you are at the detox program. You are not going to get the feeling that you have to have your stuff to help you feel more powerful!

Frank: That's true.

Therapist: What do you think? What do you tell yourself, when you are in that spot? Something like, "The stuff is not working, I've gotta get more"?

Frank: I don't know. Maybe.

Therapist: Let's assume that this is the feeling and thought you have—of being helpless and needing something to pull you out of it. How does that sound?

Frank: It's uncomfortable—I feel lost. I hate it.

Therapist: It feels like you don't have any options at that point?

Frank: It does! Yeah! Actually, I feel that way about a lot of things right now! I feel like my options are very limited, I feel helpless, and I don't like what I see. What I've been left with . . .

Therapist: So, even though you feel helpless and don't like that, maybe there are some options, but you just don't like them!

Frank: Probably . . . yeah, you're right!

Therapist: This is important because the more you can get an understanding of how those feelings make you do things, before going to the detox program, the easier it will be for you.

Level of Resistance

An assessment of the patient's level of resistance informs the selection of the therapist's level of directiveness. Within the STS framework, high resistance is taken as an indicator for the use of procedures that deemphasize therapist control and vice versa. *Resistance* may be defined as the level of patient opposition to perceived efforts on the part of the therapist to control the patient's behavior. Managing resistance by the selection of procedures that are either nondirective or directive and skillfully adapting to changes in resistance levels minimizes the occurrence of negative interactions in therapy and enhances the development and maintenance of the therapeutic alliance.

At the beginning of treatment, Frank showed a strong will to quit his drug abuse and his motivation seemed high—good signs with respect to treatment compliance. On the basis of quantitative assessments, Frank scored just above the mean on the Dowd Trait Reactance Scale (Dowd, Milne, & Wise, 1991), but he scored below the mean on the MMPI–2 Readiness for Treatment Scale. Taken together, these scores suggested that Frank possessed a low-to-average level of resistance; therefore, the use of therapist-directed procedures was indicated. For example, early in treatment, the therapist offered a directive homework task:

Frank: Change apartments, go to work, talk to my doctor, detox . . . I should make a list! I keep making lists, but every time my priorities change . . .

Therapist: Maybe you should make a short list and a long list. The long list is what you have to do in the next couple of weeks or so; the short list is what you have to do today. Keep it simple. Just one thing at a time, commit to one thing each day. You have to say to yourself: Today I'm definitely gonna do this for me! Can you do that?

Frank: Yeah.

Therapist: So, what can it be today?

Frank: Well, calling the detox program!

Therapist: Okay. So next time you can tell me how it went and what's your next choice.

Frank's homework assignment was reviewed and monitored in each session. His cooperation and compliance confirmed that he had a relatively low level of resistance. Thus, he continued to benefit from the structure and guid-

ance provided by symptom-focused strategies. Nonetheless, the therapist remained vigilant to any signs of increased resistance (e.g., being repeatedly late for therapy, becoming argumentative, not completing homework) throughout the course of therapy and adjusted directiveness levels accordingly.

Motivation and Subjective Distress

Motivation and subjective distress, as assessed in the STS system, involves an assessment of current levels of emotional arousal. The strategy of treatment is to maintain moderate arousal levels throughout treatment. In psychotherapy, patients usually seek treatment to reduce the intensity of painful emotional states; however, if emotional arousal levels are too low, patients may lose their incentive to continue the therapy, and they may not persist in making positive changes in their lives. Conversely, when anxiety is high, the patient may be too distressed to approach treatment in a planned and receptive manner.

An examination of Frank's State–Trait Anxiety Inventory State score (Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983) indicated that his distress levels were in the average range. An examination of his treatment history revealed that he usually entered treatment in an acute state of anxiety that dissipated rapidly, after which he had little motivation for change. On the basis of this assessment, it was decided to use a modest amount of confrontation in therapy to maintain Frank's anxiety and hence his motivation for change.

The high levels of initial distress suggested that establishing a stable routine and life structure would be needed to reduce the patient's anxiety to manageable levels. A decrease in anxiety through the development of a supportive structure and safe environment was used to enhance the development of the therapeutic alliance—a necessity for continued involvement and successful treatment. Also, because of the intensity of anxiety symptoms and the history of suicidal thoughts and behavior, the therapist was encouraged by the STS supervisor to give Frank his phone and pager numbers and encourage him to use them any time he felt the need to do so. Drawing on extant research and specific findings, the STS model emphasizes that initial goals should be directed toward symptoms and aimed at reducing risk and increasing social activity. Achieving these goals requires direct and immediate interventions that should be applied before proceeding to the longer term treatment of more chronic aspects of the patient's presentation.

The following exchange illustrates the therapist's efforts to manage and control Frank's discomfort.

> *Frank:* I'm doing better. My work, my behavior, my being with other people, the sensation of being sober and clean instead of drug motivated . . .

Therapist: When you say that you are doing better, I don't think that you completely believe that, but . . .

Frank: I believe that I'm going in the right direction and I have more desire to get clean and sober. But, like you said, it's not entirely true.

Therapist: What is really better right now?

Frank: I have that desire and, at the moment, I'm off the coke . . . and right now it just disgusts me! You know, I disgust me! When I think about using it . . . I just wanna be out of that!

From an STS perspective, the level of confrontation that produces arousal must be balanced against and integrated with the focus of treatment—in this case, the focus on insight and awareness of feelings.

Therapist: These experiences have been really, really dramatic.

Frank: You know, the drugs don't scare me one tenth as much as the idea of some of this stuff reoccurring.

Therapist: The drugs have been an escape from those memories.

Frank: I guess so. I don't remember the time when I was home . . .

Therapist: Unconsciously, they have always been there.

Frank: Sure. I would say that I didn't think about that until the day I talked to my stepbrother.

Therapist: I think it's gonna take time to process all those memories.

In an effort to manage and maintain optimal levels of emotional arousal, the therapist remained vigilant to changes in distress level throughout therapy, providing reassurance as Frank became more distressed and providing confrontation when stress became too low. The therapist attended to in-session cues regarding moment-to-moment changes in arousal levels and adjusted his therapeutic stance accordingly. For example, if in-session distress is maintained at a high level for an extended period, specific procedures for relaxation and reducing cognitive or muscular tension may be helpful for reducing discomfort (Harwood & Williams, 2003).

SUMMARY AND OUTCOME

STS defines classes or groups of interventions, on the basis of common demand characteristics and objectives, that are fitted to patients according to their personal qualities and living environments. Variations in levels of severity (functional impairment) are used to set the level of treatment intensity for the patient. However, in the spirit of basing treatment on principles

rather than recipes, the way in which therapy is intensified may vary from patient to patient. In our case example, the therapist chose to vary the frequency of sessions, but one could add treatments, extend treatment, or do some combination of these things. In all cases, how one follows the principles defined by STS is guided by available research, not by preferred theory or personal bias. Because research has not yet provided persuasive evidence that these individual ways of intensifying treatment produce different effects, therapists are left to select their own methods.

Similarly, patient coping style is used as an indicator for selecting methods of intervention that rely on insight or on direct behavioral and cognitive training. In the example used here, an insight-focused approach to the use of interpretations and working with dynamic themes was used, along with some behavior change procedures (scheduling, thought monitoring) to encourage change. This selection of procedures was based on the patient's mixed coping style, in which he vacillated between internalizing and externalizing coping behaviors.

Patient resistance level helps determine the level of directiveness to be used in implementing the interventions. Directiveness level defines the therapist's role as either teacher and authority or collaborator and student. On one hand, the therapist may assume the role of authority as in behavioral or psychodynamic therapies, and on the other, he or she may assume a reflective and questioning role, much like that used by cognitive and client-centered therapists. In the case study presented in this chapter, the therapist adopted a largely teaching and guiding role with Frank, recognizing his relatively low level of resistance.

Finally, the patient's level of distress is assessed and, in STS systems, determines how much structure is used to reduce anxiety as opposed to providing structure that confronts and arouses anxiety. It is assumed that moderate levels of distress are motivational. Thus, in the case presented here, the therapist focused initially on providing structure to help reduce Frank's anxiety to more manageable levels. This structuring comprised homework, assurance, and here-and-now discussions. This was a necessary first step that allowed Frank to engage meaningfully in treatment. Additionally, the relief or reduction in anxiety that structure provided, combined with his subsequent receptivity to various interventions, served to enhance the development of a good therapeutic alliance.

After a few sessions, Frank and the therapist were able to start establishing insight and targeting specific behaviors or skills such as drug abuse, impulse control, and the development of healthy social interaction skills. At this point, the therapy was tailored to track Frank's drug use; drug cravings; and his unique pattern of depressogenic events, thoughts, and behaviors. Considering his low resistance and his mixed coping style, the therapist elected to use primarily insight-focused and directive interventions like homework,

providing information and psychoeducation, and scheduling healthy (non–drug-use) activities and goal deadlines.

After fewer than the scheduled 20 sessions of therapy, Frank was able to begin a methadone detox program and attend Narcotics Anonymous meetings on a regular basis. By the end of this time, Frank had abstained from all drugs, and he was able to establish new social networks and increase his social contact within non-drug-using contexts. He successfully moved from his previous residence, and he started a new job in a completely new environment. Frank reported improvements in his marital relationship, and he managed to solve his financial problems through careful counseling and skills gained in budget management. All these changes gave the therapist the opportunity to partially shift his attention to Frank's life-long threatening memories and his history of loss and abandonment, very likely the primary causes of his depression and suicidal attempt. At follow-up (6 months after treatment) Frank reported that he was "on the right track," he acknowledged the therapist as an important and trusted figure, and he was ready to slowly discuss and face what he had experienced in childhood.

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