



CHAPTER ONE



Introduction to Effective Treatment Planning

A usually quiet and withdrawn young woman became verbally abusive to her supervisor and warned him that if she were not promoted to a job commensurate with her outstanding abilities, she was going to “come back with a gun.” A few weeks earlier, she had had a brief consultation with a psychiatrist, who diagnosed her as having a major depressive disorder and prescribed antidepressant medication.

A man who had been a capable and hardworking accountant was referred to an employee assistance counselor because of a sudden and extreme decline in his performance. After some brief and unsuccessful efforts were made to remotivate the man, he was fired from his job.

A woman had been treated with years of unsuccessful psychoanalysis, during which she had been told that her difficulty in concentrating and her chaotic lifestyle reflected her efforts to avoid dealing with her early losses.

THE IMPORTANCE OF SYSTEMATIC AND EFFECTIVE TREATMENT PLANNING

Poor clinical understanding, inaccurate diagnosis, and inappropriate treatment contributed to all of the situations just described. The first woman had a history of both manic and depressive episodes; in fact, she had a bipolar disorder, and

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the antidepressant medication she was given contributed to the development of another manic episode. The man was suffering from a cognitive disorder resulting from a head injury incurred in a cycling accident. The second woman had attention-deficit/hyperactivity disorder and eventually responded well to a combination of behavior therapy and medication. These examples, based on actual clients, make clear the importance of accurate diagnosis and treatment planning.

The primary goal of diagnosis and treatment planning is to help psychotherapists from all disciplines — psychologists, counselors, social workers, psychiatrists, and psychiatric nurses — make sound therapeutic decisions so that they can help their clients ameliorate their difficulties, feel better about themselves and their lives, and achieve their goals.

A need for accountability as well as for treatment effectiveness mandates systematic treatment planning. As health care costs have risen, the growth and impact of managed care have escalated, and third-party payers increasingly require mental health professionals to describe and justify their treatment plans. Case managers, who are usually mental health practitioners themselves, review treatment plans and determine whether they are appropriate. Clearly the therapist's knowledge of treatment planning is an essential element of people's ability to receive the psychotherapy they need.

Requests for accountability also come from mental health agencies and clinics; from counseling centers at schools, hospitals, and residential facilities where therapy is done; and from funding agencies. Financial support is rarely adequate for mental health services in these settings, and therapists often must provide documentation of the services' effectiveness before they can obtain continued funding.

Unfortunately, treatment planning is sometimes viewed as a process that must be carried out for no better reason than to satisfy bureaucratic requirements. On the contrary, the fundamental reason for treatment planning is to facilitate effective delivery of mental health services. The purpose of this book, as the Preface has outlined, is to provide the most up-to-date information available on differential therapeutics — that is, the study of which treatment approaches are most likely to be effective in treating each of the mental disorders. This book seeks to facilitate the process of treatment planning by linking knowledge about treatments to information about diagnoses, usually made according to the guidelines in the *Diagnostic and Statistical Manual of Mental Disorders*, now in its fourth edition text revision, known as *DSM-IV-TR* (American Psychiatric Association, 2000).

This book is not designed to present a rigid formula for treatment planning; the state of the art does not allow that, and, even if it were possible, it probably would not be desirable. Therapeutic effectiveness depends not only on the application of well-supported methods of intervention but also on such

indefinable and complex ingredients as the therapist's style, the expertise and training of the therapist, the personalities of therapist and client, their demographic characteristics, and the alliance between the two of them. Therefore, this book presents information not just on the mental disorders and their appropriate treatment but also on the probable nature of the people suffering from each disorder, those characteristics of the therapist that are likely to contribute to effective treatment, and the prognosis for the treatment of each disorder.

In therapy many roads can be taken to the same goal. This book seeks to point out which roads are likely to be smooth and rewarding and which are full of ruts and barriers. Plotting the actual course is up to the therapist and the client. Systematic treatment planning allows the clinician to map the therapeutic journey, revise the route as necessary, and repeat the trip with others if it turns out to be worthwhile, all without compromising the spontaneity of the traveler or the guide.

RESEARCH ON THE EFFECTIVENESS OF PSYCHOTHERAPY

The overall effectiveness of psychotherapy has long been established. As the meta-analytic review by Smith, Glass, and Miller (1980) concluded, "The average person who received therapy is better off at the end of it than 80 percent of those who do not" (p. 87). Lambert and Cattani-Thompson (1996) sum up the research by stating, "The research literature clearly shows that counseling is effective in relation to no-treatment and placebo conditions. The effects of counseling seem to be relatively lasting. These effects are attained in relatively brief time periods, with the percentage of clients who show substantial improvement increasing as the number of counseling sessions increases" (p. 601). So the overall verdict on the outcome of psychotherapy is positive: for most people, therapy is more effective at ameliorating emotional disorders than is no treatment at all. These conclusions do not pertain only to the treatment of adults; according to Mash (2006), great strides have been made in the past decade in developing effective intervention and prevention programs for children as well.

In the past twenty years, the movement toward effective treatments has resulted in the identification of certain treatments that work particularly well with certain disorders. In 1995, the American Psychological Association identified eighteen treatments shown to be empirically supported through randomized controlled trials for use with specific disorders — cognitive-behavioral therapy for bulimia, exposure therapy for specific phobia, and exposure and response prevention for obsessive-compulsive disorder (OCD), to name just a few (Task Force on Promotion and Dissemination of Psychological Procedures, 1995).

But the literature reminds us that clinical efficacy and clinical effectiveness are two different things. The efficacy of therapy relates to the results shown in the setting of a research trial, whereas clinical effectiveness is the outcome of the therapy in routine practice.

Matching therapy to specific disorders would seem to be the answer to improving effectiveness. Yet research has not fully supported this method, which suggests that effective therapy is more complicated and involves a host of variables that have more of a synergistic relationship than simply matching people with appropriate treatment.

Comparative research is needed, and should explore both the relative advantages and disadvantages of alternative treatment strategies for people with different disorders and the therapeutically relevant qualities of the client, the therapist, and their interaction. Study of the therapeutic process contains many challenges, however, and even the best-defined therapy is difficult to reproduce because of its interactive nature. Other challenges inherent in the process of conducting research on therapy's effectiveness include the large number of client-related variables, variations in therapists' expertise, variations in the severity of disorders, participant and observer bias, the questionable ethics of establishing true control and placebo groups with people who have emotional disorders, and the difficulty of assessing how much progress has been made.

DETERMINANTS OF TREATMENT OUTCOME

Psychotherapy outcome is determined primarily by four clusters of variables:

1. Therapist-related variables, including such factors as personality, age, gender, ethnicity, education and training, theoretical orientation, ability to inspire trust and hope, facility for communicating empathy and caring, and treatment style (Wampold, 2001; Wampold & Brown, 2005). Therapist competence and ability to form an alliance has a particularly strong relationship to better therapeutic outcomes.
2. Client-related variables, including demographic factors, diagnosis and symptoms, motivation for and expectations of treatment, history, support systems, ability to form relationships and collaborate with the therapist, personality, and the natural course of the client's disorder (Bohart & Tallman, 1999).
3. The therapeutic alliance, including the ability of the therapist and the client to agree on goals and treatment procedures, the match between therapist- and client-related variables, and their collaboration and interaction (Norcross, 2002).

4. Treatment variables, including the theories that guide the treatment, the strategies used, medication, the treatment setting and context, the frequency and duration of treatment, and such adjuncts to treatment as self-help groups (Nathan & Gorman, 2002).

Maximization of the therapy's effectiveness should take account of all four clusters of variables.

This chapter presents an integrated model for treatment planning that will help therapists think systematically about that process and explore the factors to be considered in structuring treatment. These factors include, among others, the modality of treatment (group, individual, or family), the theoretical framework for treatment, the duration of treatment, and the treatment setting. The chapter goes on to summarize the available research on the first three clusters of variables related to outcome (therapist-related variables, client-related variables, and the therapeutic alliance).

The chapters that follow focus primarily on the fourth cluster of variables (treatment variables), to help therapists deepen their understanding of the mental disorders discussed in *DSM-IV-TR* and their effective treatment. Because this book is designed to help clinicians move beyond the assumption that therapy is effective and on to an understanding of what works for whom, the large and growing body of literature on that subject is reviewed here. Some of the conclusions drawn from the literature are tentative, but they should provide a basis for future research into treatment planning, as well as for the development of effective treatment plans.

AN INTEGRATED MODEL FOR TREATMENT PLANNING

The integrated model presented here in skeleton form lists the five major elements (items I through V) that structure the information in the following eight chapters. When clinicians assess particular clients or disorders, they often do not have information about all the categories and subcategories in this outline, but effective use of the model does not depend on complete information. Indeed, gaps in the therapist's knowledge, as well as in the information available on a client, can actually be used to guide the development of a treatment plan and to indicate areas needing further research or investigation.

I. *Description of the Disorder.*

- A. *Diagnosis.* The *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*; American Psychiatric Association, 2000) is the accepted system for classifying mental disorders in the United States, as well as in many other countries. Its nomenclature will be used as the standard throughout this book. Other diagnostic manuals are available, including

the *Psychodynamic Diagnostic Manual* (PDM Task Force, 2006) and the *ICD-10 Classification of Mental and Behavioural Disorders* (World Health Organization, 2005). However, they have not attained widespread use and acceptance in the United States.

- B. *Epidemiology*. Epidemiology includes both the incidence (number of new cases) and the prevalence (number of existing cases at a given time) of a disorder. Acute disorders tend to have a higher incidence; chronic disorders, a higher prevalence. Approximately 46.4 percent of Americans will have some type of mental disorder during their lifetimes (Kessler, Berglund, et al., 2005). In general, the more common the disorder and the better established the diagnosis, the more is known about its treatment, because of the greater opportunity for research on the disorder.
 - C. *Primary and secondary symptoms*. A mental disorder typically includes a cluster of symptoms, both primary and secondary (or underlying). The primary symptoms are those that must be present to meet the criteria for diagnosis according to *DSM-IV-TR*, the major source of information on symptoms of mental disorders. Comparison of a disorder's criteria with a person's presenting symptoms is important in individualizing a treatment plan so that it meets the needs of that particular person. For example, two people may both be diagnosed with major depressive disorders. However, if one is suicidal and presents a danger to the self, whereas the other complains primarily of guilt and problems in eating, sleeping, and concentration, their treatment plans will differ. Treatment for the first person will emphasize safety; for the second, cognitive therapy to address the guilt, and relaxation and imagery to treat the vegetative symptoms related to sleeping and eating may be the most important interventions.
 - D. *Typical onset, course, and duration of the disorder*. This information can be useful to clients as well as to the clinician who is engaged in treatment planning. Disorders vary widely in terms of their course. For example, some disorders, such as schizophrenia, are often chronic and need extended follow-up; others, such as major depressive disorder, tend to run a circumscribed course but frequently recur.
- II. *Typical Client Characteristics*. The purpose of this section is to provide typical profiles of people with particular mental disorders. These profiles can facilitate diagnostic interviewing, alerting clinicians to client patterns that are likely to be present. By comparing these profiles with information gathered on individual clients, therapists can also identify areas that need exploration and can gain insight into clients' readiness for treatment, types of treatment that are most likely to be effective, adjunct and referral sources

that may be useful, and prognoses. The following client characteristics, among others, are typically relevant to treatment.

- A. *Genetic and other predisposing factors.* In this section, the etiologies of mental disorders are discussed. Many disorders tend to follow a genetic or familial pattern; these disorders or related ones are often found in a client's family. Schizophrenia and bipolar disorders are examples of disorders that are heritable. Identification of these patterns enables clinicians to plan treatments that take account of environmental or family dynamics contributing to the development of a disorder. A family history of a disorder may also imply a biological element to its transmission, suggesting that medication may be especially useful. In addition, developmental patterns (such as the age at which a disorder is most likely to emerge) and predisposing factors (such as a precipitating incident or a background common to those who suffer from the disorder) also provide data useful in determining treatment plans. That information can also facilitate the formulation of plans to prevent relapse.
- B. *Demographics.* Information about such variables as the typical socioeconomic environment, partner status, age, and family constellation of someone with a given disorder is included in this section. Information on multicultural background, including age and ethnicity, also is presented in this section.
- C. *Source of referral and apparent motivation for treatment.* Clues to a person's probable response to treatment are often provided by the nature of the referral. For example, a person who has sought therapy on the recommendation of a career counselor with whom she has worked successfully is likely to have a greater motivation to change than is someone who has been ordered into treatment by the courts. People's reports of their motivation and desire for change also are relevant to treatment planning.
- D. *Treatment history.* Information on previous treatment and its outcome is important in determining what treatments are likely to be helpful. A long treatment history, especially one including numerous treatment failures, suggests a poor prognosis, but perhaps that outcome can be averted if a treatment is provided that is different from those that have failed. Clinicians should familiarize themselves with the ways people have responded to treatment in the past, building on what was successful and avoiding what was ineffective.
- E. *Personality profile.* Clients' personality profiles are obtained through psychological assessment, interviews, and observation by clinicians. Typical interpersonal and intrapsychic dynamics of clients with each mental disorder will be considered throughout this book, including such characteristics as cognitions, affect, behavior, defenses, and lifestyle.

- F. *Developmental history.* A review of the client's background, including such areas as family relationships, work history, social and leisure activities, and medical conditions, usually provides valuable information on that person's strengths and areas of difficulty. If the client's successes and failures, support systems, and coping mechanisms are considered when treatment is planned, the treatment is likely to be more effective. Also, viewing people broadly and in context facilitates use of available resources, such as a supportive spiritual community, and helps clinicians avoid pitfalls to treatment, such as peers who encourage drug and alcohol use as well as antisocial behavior.
- III. *Preferred Therapist Characteristics.* This section reviews the available information on therapist-related variables that are relevant to the treatment of a particular disorder or client. Such information may include the therapist's experience, theoretical orientation, and training; the therapist's personal and professional qualities; and the relationship between the client's and the clinician's personalities and backgrounds.
- IV. *Intervention Strategies.* In this section, what is known about the effective treatment of a disorder is reviewed. Recommendations about treatment strategies are made, and areas where information is lacking are discussed.
- A. *Approaches to psychotherapy and counseling.* This section contains a review of the literature on those approaches to therapy that seem to work best with the mental disorder under consideration. The following dimensions of the therapeutic process are important in treatment planning and, depending on the information available, will be discussed in detail in subsequent chapters:
- Psychotherapeutic theories and strategies
 - Therapist's implementation of these theories and strategies (including level of directiveness, exploration, support, structure, and confrontation)
 - Balance of focus — affective, behavioral, cognitive
 - Modality of treatment — individual, family, group (Seligman, 2004)
- B. *Medication.* This section considers the question of whether medication enhances or is necessary in the treatment of a particular disorder. Although the focus of this book is the treatment of mental disorders by nonmedical clinicians who emphasize psychotherapy or counseling rather than drugs to effect change, a combination of medication and psychotherapy is typically more effective for some disorders than either one alone. Nonmedical therapists must be aware of these findings so that they can refer clients with such disorders for medical evaluation and provide treatment in collaboration with a psychiatrist or other medical specialist.

- C. *Duration and pacing of treatment.* This section focuses on the typical length of treatment necessary for ameliorating symptoms of a disorder and on the swiftness of the therapeutic pace.
 - D. *Treatment setting.* Inpatient settings, partial hospitalization or day treatment, and outpatient settings all have their place in the treatment of mental disorders. Which setting is preferred or needed for each disorder will be discussed.
 - E. *Adjunct services.* These services include social and personal growth activities, support and self-help groups (such as Alcoholics Anonymous), leisure and exercise groups, professional and governmental services (such as legal aid and subsidized housing), and psychoeducational services (such as assertiveness training and education on effective parenting) that may enhance the effectiveness of psychotherapy.
- V. *Prognosis.* This section provides information on how much change or improvement can be expected in a person experiencing the disorder under consideration, how rapidly progress is likely to occur, the likelihood of relapse, and the overall prognosis. Accurate assessment of prognosis depends on both the nature of the mental disorder and the motivation and resources of the person with the disorder. The severity of the client's disorder, of course, is relevant to outcome. In general, the more severe and long-standing the disorder, the poorer the prognosis. Disorders that are mild and short in duration and that have a clear precipitant tend to have better prognoses. For example, people with circumscribed, reactive, brief, situational problems, such as adjustment disorders and some mood and anxiety disorders, tend to have better treatment outcomes. In contrast, people with personality disorders, schizophrenia, and other disorders that are enduring and pervasive and that do not have an apparent precipitant typically respond to treatment more gradually and in more limited ways.

THE CLIENT MAP

The major elements of the treatment plan discussed in this chapter have been expanded and organized into a structured and systematic model for treatment planning — the Client Map. The steps of this treatment plan are represented by the acronym formed from the first letter in each of the twelve steps in this model: DO A CLIENT MAP. This acronym facilitates recall of the parts of the plan, reflects the plan's purpose, and guides its development. A clinician who supplies information about the following twelve items will have created the Client Map, a structured treatment plan for working with a particular client:

DO A CLIENT MAP

Diagnosis

Objectives of treatment

Assessments (for example, neurological tests, personality inventories, and symptom checklists)

Clinician characteristics

Location of treatment

Interventions to be used

Emphasis of treatment (for example, level of directiveness; level of supportiveness; cognitive, behavioral, or affective emphasis)

Numbers (that is, the number of people in treatment: individual, family, or group)

Timing (frequency, pacing, duration)

Medications needed

Adjunct services

Prognosis

The format represented by the DO A CLIENT MAP acronym is used throughout this book to illustrate the process of treatment planning for sample cases.

DIMENSIONS OF TREATMENT PLANNING

In general, treatment planning moves from the nature of the disorder through consideration of the client's characteristics and on to the treatment approach. That will be the sequence followed throughout most of this book. In the present section, however, the focus will be primarily on approaches to treatment and their impact on mental disorders. The parts of the Client Map considered here are diagnosis, objectives of treatment, assessments, clinician characteristics, location, interventions, emphasis, numbers, timing, medications, and adjunct services. Because information on diagnosis, assessments, interventions, and prognosis are specific to each disorder, they will be discussed separately, and at length, in the chapters relating to each disorder.

Diagnosis (DO A CLIENT MAP)

Effective treatment planning begins with the development of an accurate multi-axial assessment, made according to the guidelines in the *DSM*. Such an assessment includes information on people's mental disorders, any relevant medical conditions, their stressors, and their overall levels of coping and adjustment

as reflected by the Global Assessment of Functioning Scale. The diagnosis is the foundation for treatment planning. Once the diagnosis has been made, clinicians can move ahead to develop a complete and effective treatment plan.

Development of such a plan must take into consideration a number of variables. One of the most important considerations is to identify treatments that are likely to be effective in ameliorating the symptoms of the client's disorder. Ideally, clinicians should select treatment approaches that have received empirical support. That is not always possible, of course. Although empirically supported treatments have been identified for many disorders, especially the anxiety and mood disorders, eating disorders, and substance use disorders (Nathan & Gorman, 2002; Roth & Fonagy, 2005), a concise list of effective treatments for every disorder does not exist. In some cases, many diverse treatments have been found to be equally effective for a particular disorder; in other cases, no treatment approaches have received strong research support. We will focus on what has been proven efficacious as well as what seems most likely to be effective in order to help readers achieve the best possible treatment options in the therapy they provide.

In 1995, the Division 12 Task Force of the American Psychological Association published guidelines for identifying empirically supported treatments (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). As mentioned earlier, included with the criteria was a list of eighteen treatments that the task force identified as having empirical support for use in treatment of particular diagnoses or specific populations. Each of the eighteen treatments had been tested in randomized controlled trials and implemented using a treatment manual.

This research raised concerns about the applicability of these findings to people with diverse backgrounds and those with comorbid conditions. Questions also were raised about the use of manualized treatments and the impact and importance of the therapeutic alliance (Levant, 2005). A flurry of research since that time has focused on common factors that account for much of the variance across disorders, as well as the effect of the therapeutic alliance. Both of these important topics are discussed later in this chapter.

As research continues to explore the appropriate use of specific approaches to particular clients and disorders, the use of manualized therapy, providing clear and specific treatment guidelines and interventions, has increased. Well over 130 different manualized treatments for specific disorders now claim to be empirically validated (Chambless & Ollendick, 2001). Although some studies indicate that the use of manuals reduces variability in outcomes (Crits-Christoph et al., 1991), other research indicates that even with manual-based treatments, therapist effects on outcome are often large (Malik, Beutler, Alimohamed, Gallagher-Thompson, & Thompson, 2003). Ahn and

Wampold (2001) concur. They write that strict adherence to a treatment manual can lead to “ruptures in the alliance and, consequently, poorer outcomes” as well as thwart the therapist’s ability to adapt treatment to the “attitudes, values, and culture of the client, a necessary aspect of multicultural counseling” (p. 255). Clinicians should use sound clinical judgment and flexibility, rather than rigid application of manuals (Levant, 2005).

A growing number of studies, to be discussed in later chapters, assess the effectiveness of therapies for adults, children, and adolescents with particular disorders (Barlow, 2004; Mash & Barkley, 2006; Nathan & Gorman, 2002). Although some studies focus on only one or two approaches, others provide useful information on the effectiveness of various psychotherapies. In general, the desirable treatment approaches for a particular client or disorder are those that demonstrate a high likelihood of addressing relevant problems; maximize the client’s motivation; help the therapist and the client achieve the treatment goals; overcome obstacles; consolidate gains; and reduce the likelihood of a relapse (Beutler & Consoli, 1993).

People with more than one diagnosis are typically challenging clients. People’s cognitive and processing abilities, their premorbid functioning, and their access to resources all affect their response to treatment (Sachse & Elliott, 2001). Typically, a person who was at a lower level of functioning before therapy will still be at a lower level after therapy than a person who was at a higher level of functioning before therapy, even though both may have improved.

Also important in understanding psychopathology and treatment selection is the client’s development and life stage. A growing number of studies discuss developmental processes, such as attachment, socialization, gender identity, and moral and emotional development. Understanding the client’s stage of development is particularly important when treating children, adolescents, families, and older adults (Levant, 2005). Also important is knowing when a person developed a particular disorder and understanding the impact of that disorder on the person’s development. People with long-standing disorders, for example, may well have failed to meet important developmental milestones, especially in self-direction and socialization.

Objectives of Treatment (DO A CLIENT MAP)

Decisions on treatment objectives or goals should be made in collaboration with the client. Using the best available information — considering costs, benefits, resources, and options — the therapist and the client work together to create a treatment plan. An active, involved client is crucial to the success of treatment (Levant, 2005). No matter how wisely the therapist selects an intervention strategy, and no matter how abundantly the therapist demonstrates the personal and professional qualities that are positively correlated with a good outcome, therapy is unlikely to be effective if the client is not ready or able to benefit from

the therapeutic strategy and the therapist's positive qualities. In fact, the key to therapeutic effectiveness often is found in the client or in such client-related variables as expectations of therapy, motivation for change, degree of participation, and severity of the disorder, although it also can be found in the therapeutic alliance or the particular treatment approach that is used (Bowman, Scogin, Floyd, & McKendree-Smith, 2001; Lambert & Cattani-Thompson, 1996; Prochaska & Norcross, 2006). Attention should be given, then, to those qualities in clients that are correlated with effective treatment, as well as to clinician characteristics and treatment approaches, discussed later.

Client's Readiness for Change. Prochaska and Norcross (2006) address the importance of the person's readiness for change, which they describe as unfolding over five stages: precontemplation, contemplation, preparation, action, and maintenance. Each stage represents a period of time characterized by discrete attitudes, behaviors, and language on the part of the client. The person must achieve certain tasks before moving on to the next stage. The stages are as follows:

1. *Precontemplation.* People in this stage have no intention of changing their behavior. Although they might think about changing, or wish to change, they are unwilling to do anything that will promote change. In fact, they may be stuck in repetitive and ineffective thoughts and behaviors for years. To move beyond this stage, the person must recognize and admit there is a problem.
2. *Contemplation.* At this stage of change, the person is able to admit the problem, wants to change, and is willing to move beyond merely thinking about it. The task required to move to the next level of change is to take action — even a small first step — toward behavioral change.
3. *Preparation.* This is the stage in which behavior and intentions are aligned. The person is ready to make a change and begins to set goals and an action plan in preparation for moving on to the next stage.
4. *Action.* During this stage, people commit time and energy to modify their behavior and begin working to overcome their problems, to the point that their efforts become recognized by others. The action stage may last from one day to six months. During this time the person is acquiring skills and strategies to help prevent relapse.
5. *Maintenance.* Maintaining and continuing behavioral change for longer than six months is the hallmark of the maintenance stage.

Prochaska and Norcross warn that the process of change is not linear; rather, it is more like a spiral, with a person cycling and recycling through the five stages. For example, when people are trying to change unhealthy behaviors

such as smoking, drug use, or overeating, relapse and cycling through the stages of change are common. However, recognizing a person's pretreatment stage of change is important to effective treatment and prognosis.

These researchers and others have developed models for matching the therapist's style to the client's readiness. According to Prochaska and Norcross (2006), clients with very low levels of readiness need therapists who can focus on consciousness raising, dramatic relief, and environmental evaluation. To facilitate movement from precontemplation to the contemplation stage involves increased use of cognitive, affective, and evaluative processes.

Client's Perceptions of Psychotherapy. The research suggests that people who perceive their therapists as helping them, who have positive perceptions of their therapists' skills and facilitative attitudes, and who see themselves engaged in teamwork with their therapists are likely to show more benefits from therapy than people who do not share those perceptions. Therefore, clients' perceptions of the therapeutic process seem to play a very important role in determining outcomes.

Client's Expectations for Treatment. People enter therapy with a broad range of expectations and attitudes. The well-known self-fulfilling prophecy seems to hold true: people who expect positive and realistic outcomes from therapy, and whose expectations are congruent with those of their therapists, are more likely to achieve those outcomes, whereas negative expectations lead people to abandon efforts to reach their goals. Meyer and colleagues (2002) report that therapists who instill hope and promote the client's positive expectations of treatment foster increased client participation in treatment and a reduction in symptoms. They conclude that "expectations of treatment effectiveness are powerful predictors of outcome in psychotherapy" (p. 1051) and are an important part of building a positive therapeutic alliance.

At least some portion of the positive effect of therapy comes from what is known as the Hawthorne effect. Many people have been shown to improve simply as a result of having special attention paid to them (Prochaska & Norcross, 2006). The special attention paid to a client by a mental health professional can improve self-esteem, reduce anxiety, and promote improvement. Thus, empirical research is needed if one is to conclude that the effectiveness of any particular treatment methodology is more than just the result of person-to-person contact.

Assessments (DO A CLIENT MAP)

The development of a treatment plan for a given client begins with a thorough understanding of that person. Formats for intake interviews and mental status

examinations are readily available elsewhere (Seligman, 2004) and are beyond the scope of this volume, but a brief and useful overview of relevant aspects of the client is provided by Strub and Black (2000). They suggest gathering data on the following dimensions:

- Description of presenting concerns
- Demographic characteristics
- Mental status
- Cultural and religious background
- Physical characteristics and abilities; medical conditions
- Behavior
- Affect and mood
- Intelligence; thinking and learning style
- Family composition and family background
- Other relevant past history and experiences
- Social behavior
- Lifestyle
- Educational and occupational history
- Family history of psychiatric illness
- Any other relevant areas

Clinicians also should collect and review any relevant records and prior assessment information (for example, psychological tests and medical evaluations). Most therapists seem to be making increased use of diagnostic interviews, inventories, and rating scales. In the preliminary stages of therapy, these help the clinician gather information on the client's diagnosis and dynamics. In the termination stages, they provide information on progress and outcome. The literature offers many objective and projective assessment tools, developed in recent years, that can play an important role in deepening understanding of clients (Strub & Black, 2000). The following are some of the most useful:

- Structured diagnostic interviews, such as the NIMH Diagnostic Interview Schedule, the Schedule for Affective Disorders and Schizophrenia, the Brief Psychiatric Rating Scale, and the Symptom Checklist-90-R
- General personality inventories, including the Minnesota Multiphasic Personality Inventory-2; the Millon Clinical Multiaxial Inventory-III; the Millon Adolescent Personality Inventory; the California Psychological Inventory; the Myers-Briggs Type Indicator; and the High School, Children's, and Early School Personality Questionnaire

- Inventories for assessing specific symptoms, including the Beck Depression Inventory-II, the Beck Anxiety Inventory, the Hamilton Rating Scale for Depression, the State-Trait Anxiety Inventory, the Michigan Alcoholism Screening Test, the Conners' Rating Scale, the Behavior Assessment System for Children-2, and the Eating Disorders Inventory

Inventories also may be used to assess other aspects of the person. These might include intelligence, aptitudes, achievement, interests, and values. Assessment is an important component of the treatment planning process and should be done with care. Effective treatment planning is unlikely unless the clinician has made an accurate diagnosis and has a good understanding of the client's development, concerns, strengths, and difficulties, acquired through a careful assessment.

Variables Related to the Client's Demographic and Personal Characteristics.

On the National Comorbidity Survey Replication, a structured interview administered to a national sample of people over the age of eighteen, nearly 50 percent of respondents reported at least one mental disorder during their lifetimes, and close to 30 percent had experienced such a disorder during the previous twelve months (Kessler et al., 2005). Of those who had experienced at least one disorder, half experienced symptoms by the age of fourteen, and three-fourths by the age of twenty-four. The most common disorders included anxiety, mood, impulse-control, and substance use disorders. People who experience symptoms commonly delay seeking treatment. On average, people with mood disorders wait six to eight years before seeking treatment, and people with anxiety disorders wait nine years to as long as twenty-three years before seeking treatment (Wang et al., 2005).

What distinguishes people who seek help for their concerns and who benefit in the process from people who do not? Those who do seek treatment are more likely to be female, college educated, and from the middle to upper classes, and they are more likely to have reasonable expectations for how therapy can help them. People who continue in therapy tend to be more dependable, more intelligent, better educated, less likely to have a history of antisocial behavior, and more anxious and dissatisfied with themselves than those who leave therapy prematurely (Garfield, 1986).

Those who leave treatment early are more likely to be ambivalent about change and seeking help. Principe, Marci, and Glick (2006) found that 40 percent of clients at community mental health centers and 20 percent seen in private practice terminated therapy in the first two visits. Because the therapeutic alliance forms early in treatment (Horvath and Lathers [1993] found that it peaked at the third session), it is essential for clinicians to instill

hope and the expectation of a positive therapeutic outcome early in treatment (Meyer et al., 2002).

Many personal characteristics in clients are correlated with outcomes. Orlinsky, Grawe, and Parks (1994) found that people who are open, in touch with their emotions, and able to express their thoughts and feelings in therapy are more likely to have positive treatment outcomes. Meyer and colleagues (2002) found that clients were more likely to improve if they were actively engaged in therapy, regardless of which therapeutic intervention was used. The likelihood of a positive outcome is also increased if the client demonstrates good ego strength and can take responsibility for problems rather than viewing them as external sources of difficulty (Sachse & Elliott, 2001). Moreover, according to Miller and Rollnick (2002), motivated people as well as people with positive pretreatment functioning, who are aware of their difficulties and have positive expectations of change, stable lifestyles, and good support systems seem better able to make good use of therapy.

Research on the relationship between outcomes and clients' personal characteristics is suggestive but not yet conclusive. Overall, however, indications are that therapy is particularly effective with white females who are intelligent, motivated, expressive, and not severely dysfunctional. Therapy can be very helpful to people who do not fit this description, of course, but these findings point out some of psychotherapy's limitations, as well as the difficulty of adapting the therapeutic process to the needs of a particular client.

Clinician Characteristics (DO A CLIENT MAP)

Such therapist variables as empathic understanding, affirmation of the client, credibility, clinical skills, the ability to engage and focus the client, and the capacity to focus the client on affective experiences had been explored in more than two thousand process-outcome studies by 1994 (Orlinsky et al., 1994) and probably at least as many since that time. These factors are similar to those proposed by Carl Rogers (1951, 1965) as necessary and important to therapy and are generally associated with positive treatment outcomes. Following are descriptions of some of the most important of these therapist characteristics.

Empathy. Not just rote repetition of a client's words, true empathy involves compassion and an attitude of profound interest — almost as if the therapist were stepping into the other person's psychological shoes. In *A Way of Being*, Rogers (1980) wrote about empathy: "It means entering the private perceptual world of the other . . . being sensitive, moment by moment, to the changing felt meanings which flow in this other person" (p. 142). When clients feel truly heard, they are more likely to be comfortable exploring their feelings on a deeper level. With appropriate empathy, therapists are able to choose interventions that are appropriate for the client's needs at that time. Greenberg,

Watson, Elliott, and Bohart (2001, p. 382) identify ways in which empathy contributes to outcome:

1. Feeling understood increases client satisfaction and thereby increases self-disclosure, compliance with the therapist's suggestions, and feelings of safety.
2. Empathy provides a corrective emotional experience.
3. Empathy promotes exploration and the creation of meaning, facilitating emotional reprocessing.
4. Empathy contributes to the client's capacity for self-healing.

Unconditional Positive Regard. The therapist's regard for the client remains constant and positive. It is unconditional, nonjudgmental, and not based on anything the client might do or say but rather reflects appreciation and caring for another human being. The therapist shows this regard for a client through the use of empathy and understanding.

Congruence. The therapist is genuine and real and does not put up a false professional front or façade (Rogers, 1957). Congruence is evident among the therapist's thoughts, emotions, and behaviors.

Bowman and colleagues (2001) report that it is the therapeutic alliance and "the complex interactions involving client, therapist, and treatment variables [that] probably account for most variance in psychotherapy outcome" (p. 147). The therapist factors discussed here, and later in this chapter, are critical in developing a sound therapeutic alliance.

Demographic Variables. Therapist demographic variables appear to be weaker predictors of outcome than client variables (Bowman, Scogin, Floyd, & McKendree-Smith, 2001). In a study comparing three treatment modalities — cognitive-behavioral therapy, interpersonal therapy, and medication — such therapist variables as age, gender, race, religion, and clinical experience were not found to be related to therapeutic effectiveness (Wampold & Brown, 2005).

In a meta-analysis on the effect of therapist gender on psychotherapy outcome, Bowman and colleagues (2001) looked at more than sixty studies and concluded that the gender of the therapist has little effect on outcomes. However, a recent study indicates that female clients prefer female therapists and that female therapists tend to form stronger therapeutic alliances with their clients than do male therapists (Wintersteen, Mensinger, & Diamond, 2005). Although the gender of the therapist may be important to some clients and is worth considering (especially in short-term counseling where rapid

establishment of a positive therapeutic alliance is important), research has failed to demonstrate that gender matching leads to improved outcomes or reduced dropout rates (Cottone, Drucker, & Javier, 2003; Sterling, Gottheil, Weinstein, & Serota, 1998).

The literature also found no clear evidence that the therapist's age affects therapeutic outcomes (Butcher, Mineka, & Hooley, 2006). In general, clients seem to prefer clinicians who are mature enough to have had considerable experience in their field and who understand clients' age-related and developmental issues but who do not seem so old as to be out of touch with modern developments in the profession.

Ethnic and Cultural Diversity. The ethnic and cultural match between client and therapist has also been the focus of much attention. Socioeconomic status and race appear to bear little relationship to therapeutic outcomes. Garb (1998) notes that social class effects were not significant in children's ratings of therapists.

Nor does the race of the therapist appear to affect therapeutic outcomes. However, Thompson, Bazile, and Akbar (2004) found that African American clients prefer to see African American therapists rather than European American therapists, and an earlier study (Lambert, 1982) noted that African American clients tend to leave therapy at higher than usual rates when they are working with European American therapists. These studies suggest that race may be a factor in determining length of treatment, if not therapeutic outcomes. Moreover, according to Hess and Street (1991), "Several studies have demonstrated that subjects express a greater preference for, engage in more self-exploration with, and are better understood by counselors of their same ethnic background than by those whose background differs from their own" (p. 71).

Degree of assimilation to the majority culture seems to be a moderating variable in the relationship between clients' and their therapists' ethnicity and therapeutic outcomes. Coleman, Wampold, and Casali (1995) conclude that clients who are not highly assimilated to the majority culture have more negative attitudes toward therapy and are more likely to prefer ethnically similar therapists. By contrast, according to Sue, Ivey, and Pedersen (1996), clients who are highly assimilated to the majority culture sometimes feel stereotyped if they are automatically assigned to ethnically similar therapists. In some cases, ethnic matching between client and therapist does seem to be indicated and may result in greater trust and understanding between client and therapist (Thompson et al., 2004; Wong, Kim, Zane, Kim, & Huang, 2003), but the research generally suggests that therapists who attend to issues of culture as well as to their clients' wants and expectations in therapy are likely to be successful with both ethnically similar and ethnically different clients.

Experience and Professional Discipline. Research on the link between therapist experience or expertise and outcome has yielded inconclusive results. Two studies found that expertise was more important than theoretical orientation (Eells, Lombard, Kendjelic, Turner, & Lucas, 2005). However, two other studies that compared experienced clinicians to graduate students on their ability to conduct assessments of personality and psychopathology found no significant difference in their abilities. This was true regardless of whether the clinicians were conducting interviews, gathering biographical information, or administering and interpreting the Rorschach or the MMPI. Although these studies were conducted with clinical and counseling psychologists, Garb's research (1998) focused on social workers and other mental health professionals indicates similar results.

Beutler, Crago, and Arizmendi (1986) found no relationship between the therapist's professional discipline and therapeutic outcomes. In fact, Berman and Norton (1985) found that, overall, professionals and paraprofessionals were equally effective.

Nevertheless, Greenspan and Kulish's study (1985) of 273 clients who terminated treatment prematurely, but after at least six months, indicates that therapists with Ph.D. degrees and personal experience of psychotherapy have lower rates of premature termination by clients than do therapists with M.D. or M.S.W. degrees. Seligman (1995), however, reports that psychologists, psychiatrists, and social workers do not differ in their therapeutic effectiveness. So far, no clear and conclusive relationship has been found between the length of the therapist's training, the therapist's personal experience of psychotherapy, and the therapist's professional discipline, on the one hand, and therapeutic outcomes, on the other.

Since 1950, more than two thousand research studies have been conducted on therapists' personal characteristics and styles. The following characteristics, attitudes, and approaches on the part of therapists have been found to be correlated with therapists' effectiveness (Bowman et al., 2001; Greenberg et al., 2001; Lambert & Barley, 2001; Lambert & Cattani-Thompson, 1996; Meyer et al., 2002; Orlinsky, Grawe, & Parks, 1994):

- Communicating empathy and understanding to clients
- Having personal and psychological maturity and well-being
- Manifesting high ethical standards
- Being authoritative rather than authoritarian, and freeing rather than controlling of clients

- Having strong interpersonal skills; communicating warmth, caring, respect, acceptance, and a helping, reassuring, and protecting attitude; affirming rather than blaming clients
- Being nondefensive; having a capacity for self-criticism and an awareness of their own limitations, but not being easily discouraged; continuously searching for the best ways to help clients
- Empowering clients and supporting their autonomy and their use of resources
- Being tolerant of diversity, ambiguity, and complexity; being open-minded and flexible
- Being self-actualized, self-fulfilled, creative, committed to self-development, responsible, and able to cope effectively with their own stress
- Being authentic and genuine and having credibility
- Focusing on people and processes, not on rules
- Being optimistic and hopeful, having positive expectations for the treatment process, and being able to engender those feelings in clients
- Being actively engaged with and receptive to clients, and giving some structure and focus to the treatment process

These findings support the importance of the core conditions first identified by Rogers (1951, 1965) as necessary for effecting improvement, regardless of the therapist's theoretical orientation. The findings suggest that the therapist who is emotionally healthy, active, optimistic, expressive, straightforward yet supportive, involved, and in charge of the therapeutic process, and who is also able to temper that stance with encouragement of responsibility on the part of the client, is the one most likely to achieve a positive outcome.

Location (DO A CLIENT MAP)

Research on selection of treatment settings is fairly limited. In general, the treatment location will be determined by the following seven considerations (Seligman, 2004):

1. Diagnosis, and the nature and severity of the symptoms
2. Danger that clients present to themselves and others
3. Objectives of treatment
4. Cost of treatment, and the client's financial resources and insurance coverage

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5. Client's support systems, living situation, and ability to keep scheduled appointments
6. Nature and effectiveness of previous treatments
7. Preferences of the client and of significant others

When therapists are choosing among treatment options, Johnson, Rasbury, and Siegel (1997) recommend that the following four considerations be taken into account:

1. Finding the least restrictive setting
2. Selecting a setting that provides the most optimal therapeutic care for the particular person and disorder
3. Matching the person's needs with the specific treatment provided (settings without enough resources and those that are overly restrictive may be nontherapeutic)
4. Choosing the most cost-effective treatment (for example, if a day treatment program will suffice, inpatient or residential treatment should not be considered)

Often placement will be determined or limited by insurance providers or financial considerations. Clearly, decisions regarding the best placement for an adult, adolescent, or child will require weighing a variety of complicated and interrelated factors.

The decision about the treatment setting, like many of the other decisions that must be made as part of treatment planning, calls on clinical judgment because the literature gives only sketchy guidelines. Options typically include inpatient treatment (such as a hospital or residential treatment program), day treatment program, or outpatient treatment.

Residential Treatment. Residential treatment centers are the most restrictive environment for treating mental disorders. Placement is usually for an extended period of time, often a year or more, and most residential treatment centers are typically not located in the person's community; thus family and home visits are often not possible or are of limited duration. These programs provide a highly structured environment and may be appropriate for people with psychotic disorders, significant mental retardation, substance dependence, and other severe disorders. Residential treatment programs are sometimes necessary in the treatment of children with severe or profound mental retardation, conduct disorders, or psychotic disorders that do not respond to outpatient or pharmacological interventions. These children often exhibit chronic behavior problems, such as running away, substance use, and aggression (Johnson et al., 1997).

Inpatient Hospitalization. Inpatient hospitalization is considerably shorter than residential treatment. Hospital stays range from overnight to less than a month in most cases. Inpatient treatment programs are usually highly structured and oriented toward a rapid diagnosis and crisis stabilization. Inpatient hospitalization may be appropriate for people who pose a danger to themselves or to others and who have severe mental disorders. The following list provides examples of situations in which inpatient care might be considered:

- Suicide attempts or severe depression
- Eating disorders in which a person cannot maintain body weight
- Psychosis or irrational or bizarre thinking that makes a person a danger to self or others
- Sexual abuse or neglect of a child, or a home environment that makes it unsafe for the child to remain in the home

People with drug or alcohol problems who are physiologically dependent on harmful substances also may need a period of inpatient treatment. However, unless detoxification is needed, treatment of substance dependence can often be accomplished through day treatment or intensive outpatient programs, combined with the client's participation in self-help groups.

People are often discharged from a hospital to a less restrictive setting (generally an outpatient or day treatment program) as soon as warranted. Some studies indicate that a brief hospital stay followed by aftercare is more therapeutic than a longer stay. In general, the most efficient, least confining treatment setting should be used to reduce the stigma associated with treatment, maintain the client's independence and connection to the community, and reduce costs.

Partial Hospitalization. Day treatment and partial hospitalization programs permit people to live at home while attending a highly structured program focused specifically on their needs (such as schizophrenia, substance use, eating disorders, dual diagnosis, and others). Day treatment programs are less costly than inpatient hospitalization and often serve as transitions from inpatient or residential treatment settings to outpatient treatment. At the end of the day treatment program, stepped-down, half-day programs or weekly group meetings commonly are used to consolidate the gains that have been made.

Outpatient Treatment. Far more people will be treated for mental disorders in outpatient settings than will be seen in inpatient or day treatment settings. A wide variety of outpatient treatment programs are available including private practice, community mental health centers (which also usually offer inpatient treatment), and agencies focused on specific populations (for example, women, children, people from a particular cultural or ethnic background) or problems

(for example, anxiety disorders, phobias, relationship conflicts, or career concerns).

Current Trends. As for where treatment actually tends to take place, a variety of surveys indicate that admission to psychiatric hospitals has decreased substantially in the past forty-five years and that stays are much shorter than they were in the past (Butcher et al., 2006). The trend toward shorter inpatient stays pertains to adults, adolescents, and children alike. Managed care and the development of medications that effectively control the symptoms of severe disorders have contributed to the reduction in hospitalization. The introduction of managed care has resulted in a shift away from inpatient services to outpatient, day treatment, and community-based services (Ross, 2001). In six states, psychiatric readmission rates were higher under managed care, leading the U.S. Department of Health and Human Services to conclude that “increased hospital readmission rates may indicate persons with severe mental illness are being released from inpatient care too quickly” (U.S. Department of Health and Human Services, Office of Inspector General, 2000, p. 1). At the same time, shorter hospital stays have prevented some unnecessary and costly treatments and have enabled some people to live their lives more fully.

Interventions (DO A CLIENT MAP)

Once the clinician has identified the treatment setting for a particular person, the next step probably will be to determine the specific approaches and strategies that will guide treatment. A vast array of psychotherapeutic approaches is available to clinicians. According to Stricker and Gold (2006), more than four hundred different schools of psychotherapy have been advanced. However, few meaningful differences in outcomes seem to exist among therapies; on the contrary, therapies seem to have more similarities than differences. Earlier in this chapter, the overall effectiveness of psychotherapy was discussed. The findings of Lambert, Shapiro, and Bergin (1986) seem typical: outcome research suggests that 66 percent of clients improve, 26 percent are unchanged, and 8 percent are worse after therapy.

Once it was established that most people benefit from psychotherapy, the fundamental question became, “What forms of psychotherapy are most effective, and what are the common ingredients of their greater effectiveness?” Although conclusive answers still are not available, a considerable body of research concludes that such factors as the establishment of a healing process, a positive and collaborative therapeutic alliance, the client’s hopefulness and belief that treatment can help, a credible treatment approach to address the client’s symptoms, and the development of the client’s self-efficacy and problem

solving are key components of any successful therapy (Ahn & Wampold, 2001; Frank & Frank, 1991; Lambert & Bergin, 1994; Rogers, 1957; Rosenzweig, 1936; Wampold, 2001). Wampold (2001) conducted a meta-analysis of the literature and found that as much as 70 percent of the outcome variance between different models of therapy was attributable to these common factors shared by all successful therapies.

As we have seen, the differences in outcome are due more to the therapist, the client, and their alliance than to the particular theoretical model being used. Of course, the treatment approach and the strategies used do make an important contribution to outcome. The ability to maximize the effectiveness of psychotherapy, then, requires an understanding not only of therapeutic approaches and strategies but also of the client and clinician variables.

Theoretical Approaches. This chapter will now look at the most common theoretical orientations in practice today. A brief description of each, as well as of its application and effectiveness, is provided.

Psychoanalysis. Few studies are available on the effectiveness of classical psychoanalysis, partly because the lengthy and intense nature of the process means that each analyst can treat only a small number of clients. Therapists have generally been moving away from prolonged psychoanalysis and other treatments of long duration and toward the development of briefer psychotherapies. Nevertheless, a thirty-year study on the effectiveness of psychoanalysis was conducted by the Menninger Foundation in the 1980s. A high percentage (63 percent) of those who had been selected for psychoanalysis had good or moderate outcomes. Readers are referred to the Psychotherapy Research Project (Wallerstein, 1986) for further details.

Psychodynamic psychotherapy. As the use of long-term psychodynamic approaches has declined, brief psychodynamic psychotherapy has gained in popularity. The psychodynamic approach to treatment borrows heavily from the psychoanalytic model, but treatment with this approach takes less time, is more directive, and incorporates the use of other treatment techniques, such as cognitive therapy (Seligman, 2006).

Ideal clients for brief psychodynamic psychotherapy are motivated to change; willing to make a commitment to therapy; psychologically minded; able to tolerate and discuss painful feelings; intelligent; and in possession of good verbal skills, flexible and mature defenses, a focal issue; and have had at least one meaningful childhood relationship (Messer, 2001; Messer & Warren, 1995).

Typical outcomes of brief psychodynamic therapy include symptom relief, improved relationships, better self-esteem, greater insight and self-awareness, better problem-solving ability, and a sense of accomplishment (Budman, 1981). The approach provides a corrective emotional experience for people who are not severely dysfunctional but who may be suffering from depressive disorders, anxiety disorders (especially PTSD), adjustment disorder, stress, bereavement, and mild to moderate personality disorders (Goldfried, Greenberg, & Marmar, 1990). This approach is not recommended for treatment of severe depression that seems to have a biochemical basis, for psychotic disorders, for long-term substance misuse, and for borderline or other severe personality disorders.

Interpersonal psychotherapy (IPT) is an empirically validated form of brief psychodynamic therapy that has proven as effective as medication and cognitive therapy in the treatment of depression (Craighead, Hart, Craighead, & Ilardi, 2002; Sinha & Rush, 2006). Based on the work of Harry Stack Sullivan, IPT was designed by Gerald Klerman and colleagues specifically for the treatment of depression. It is a focused, time-limited treatment approach that emphasizes social and interpersonal experiences (Seligman, 2006). IPT has been successfully adapted for use with adolescents to decrease interpersonal problems and reduce substance use (Mufson, Dorta, Moreau, & Weissman, 2004). Readers are referred to Chapter Four for a more complete examination of IPT.

Behavior therapy. Many studies over the last thirty years have substantiated the value of behavior therapy. For example, exposure therapy has proven its effectiveness in the treatment of PTSD (Prochaska & Norcross, 2006). Exposure also is helpful in relieving symptoms of OCD. Systematic desensitization is helpful in treating symptoms of specific phobias and agoraphobia. Flooding, along with medication, has been shown to effect significant improvement in agoraphobia, although this approach must be used with great caution.

Behavior therapy also is effective in the treatment of conduct disorder, behavioral difficulties associated with mental retardation, enuresis, substance-related disorders, and family conflicts. Other disorders, including impulse-control disorders, sexual dysfunctions, oppositional defiant disorder, paraphilias, some sleep disorders, anxiety disorders, and mood disorders, are also likely to respond well to behavior therapy (Nathan & Gorman, 2002; Roth & Fonagy, 2005).

People most likely to benefit from behavior therapy are those who are motivated to change, follow through on homework tasks or self-help programs, and have friends and family members who are supportive of their efforts to

change. The literature contains many positive reports of behavior therapy's effectiveness.

Nevertheless, assessment of the effectiveness of this treatment approach is complicated by its many strategies and variations. Duration of treatment and specific techniques are critical variables in the determination of the effectiveness of behavior therapy. For example, one two-hour session of in vivo exposure seems to be more effective than four half-hour sessions, and flooding can actually increase anxiety if it is not maintained long enough for the anxiety reaction to subside. Moreover, in the treatment of phobias, OCD, and sexual disorders, performance-based in vivo exposure methods are likely to be more effective than methods employing imaginal symbolic procedures. Support is better than confrontation in promoting clients' adherence to treatment plans in behavior therapy, but more research is needed before it can be determined exactly how this powerful treatment approach can best be used.

Cognitive and cognitive-behavioral therapy. Cognitive therapy, developed by Beck and his colleagues (Beck, Rush, Shaw, & Emery, 1979), has gained widespread acceptance for its effectiveness in the treatment of anxiety disorders, eating disorders, conduct disorder, substance-related disorders, personality disorders, and depression (Beck, 2005; Hollon & Beck, 2004).

Cognitive therapy assumes that people's thoughts are a dynamic representation of how they view themselves, their world, their past, and their future (in other words, their phenomenal field). Cognitive structures are viewed as the major determinants of people's affective states and behavioral patterns. Through cognitive therapy, people become aware of their cognitive distortions and correct their dysfunctional automatic thoughts and schemas, a correction that leads to overall improvement. The focus of treatment is on the present, and between-session tasks are important.

Cognitive therapy is often combined with behavior therapy, with the early rivalry between these two approaches having evolved into mutual appreciation and recognition of the value of their integration. Indeed, the efficacy of cognitive-behavioral therapy (CBT) in alleviating many disorders has been well documented (Hollon & Beck, 2004). CBT has been found to be as effective as medication in the treatment of depression and actually offers long-term advantages over medication in the reduction of relapse rates (Craighead, Hart, et al., 2002). White and Barlow (2002) report a meta-analysis that included forty-three controlled studies of treatment for panic disorder with agoraphobia. The results showed that CBT was associated with the largest effect size. CBT also is the treatment of choice for treating bulimia (Wilson & Fairburn, 2002; Wilson, 2005).

Criticism of CBT has focused on concern that the therapy is a quick fix and does not involve insight or depth. Yet research indicates that CBT has lasting

effectiveness, in some cases at least as long as seven years after the conclusion of therapy.

Other types of cognitive-behavioral therapies, such as rational emotive behavior therapy (REBT), developed by Ellis (Ellis & Greiger, 1996), and dialectical behavior therapy (DBT), created by Linehan (1993) in her work with clients with borderline personality disorder (BPD), have also achieved some success. Based on cognitive-behavioral therapy, DBT integrates considerable support and insight-oriented therapy into treatment (Seligman, 2006). Current research on the use of DBT with adolescents and others with suicidal ideation, depression, and self-harming behavior indicates that DBT is effective in reducing hospitalization rates, self-harming behaviors such as cutting, and depression (American Psychiatric Association, 2001; Meyer & Pilkonis, 2006; Robins, Ivanoff, & Linehan, 2001). DBT has also been adapted for treating eating disorders, antisocial personality disorder, and substance use comorbid with BPD (Rizvi & Linehan, 2001).

REBT has had little empirical research behind it, and appears to be less effective than exposure-based therapies for the treatment of some anxiety disorders, including agoraphobia, social anxiety, and OCD (Butcher et al., 2006). However, Johnson, Devries, Ridley, Pettorini, and Peterson (1994) conclude that REBT is successful in reducing depression, automatic negative thinking, irrational thinking, and general pathology in people with mild to moderate unipolar depression. REBT may be most helpful in teaching fairly healthy people to cope with stress.

Humanistic-experiential therapy. Humanistic-experiential therapies, beginning with Carl Rogers's person-centered therapy (1951, 1965), emphasize the importance of client experience to effect change. Humanistic therapies assume that people value self-determination and the ability to reflect on a problem, make choices, and take positive action. Humanistic-experiential therapists serve as facilitators or coaches to help people become aware of their feelings, label them, understand them, and develop new feelings and behaviors as a result. Enhancing their emotion processing skills helps people master and modulate their emotional arousal and ultimately expand their awareness and self-esteem (Gendlin, 1996; Greenberg & Watson, 2005).

Humanistic-experiential therapies include person-centered therapy, Gestalt therapy, process-experiential therapy, emotion-focused therapy, relationship enhancement therapy for couples, and motivational interviewing. Process-experiential therapy (PE) combines Gestalt therapy (Perls, 1969) with person-centered therapy. PE shows promise as the number of outcome studies increase.

PE seems to be particularly helpful in treating depression, anxiety, trauma, and relationship difficulties.

Motivational interviewing is a form of treatment developed by Miller (1983) as a way to help people resolve their ambivalence about change and commitment to treatment. It is based on the supportive and empathic style of person-centered therapy, which had its origins in the work of Carl Rogers. Motivational interviewing is most often used at the beginning of treatment for substance-related disorders. Roth and Fonagy (2005) report that it seems to work best when paired with a more extensive treatment approach, rather than used as a single intervention. Several studies have found that adding motivational interviewing to a substance use treatment program leads to higher retention rates during treatment and decreases relapse at three-month follow-up (Connors, Walitzer, & Dermen, 2002).

Until recently, little controlled research was available on the effectiveness of humanistic therapies, but as the number of controlled outcome studies increases, evidence suggests that these treatment approaches are effective in reducing symptoms and improving functioning in a range of problems, including alcohol misuse, anxiety disorders, personality disorders, interpersonal relationships, depression, coping with cancer, trauma, marital difficulties, and sometimes even schizophrenia (Bozarth, Zimring, & Tausch, 2001; Cain & Seeman, 2001; Elliot, 2001; Gottman, Coan, Carrere, & Swanson, 1998; S. Johnson, 2004).

In the largest meta-analysis of humanistic therapy outcomes, Elliott (2001) examined nearly one hundred studies and found reinforcement of the major conclusions reached by two earlier studies (Elliott, 1995; Greenberg, Elliott, & Lietaer, 1994). Humanistic therapies are effective; they are more effective than no treatment; and posttreatment gains remain stable at twelve-month follow-up. Elliott notes that CBT shows a modest superiority to person-centered therapy and nondirective supportive treatments, but that more process-directive therapies, such as Gestalt therapy, emotion-focused therapy for couples, and process-experiential therapies, “are at least equivalent in effectiveness to CBT and may eventually turn out to be slightly superior” (p. 72). Elliott concludes that “with specific problems or particular groups, person-centered therapies proved to be as viable as the more goal-oriented therapies” (p. 168).

Other approaches to psychotherapy. Although most of the empirical research on psychotherapy’s effectiveness has focused on the psychodynamic, behavioral, humanistic, and cognitive approaches, research is growing in other areas.

Lack of empirical research does not mean that a particular therapy is ineffective. On the contrary, research consistently indicates that no one theoretical orientation is significantly more effective than another overall. Other approaches that may also be effective include the following:

- *Adlerian* approaches, which have recently grown in popularity, are particularly useful in treating behavioral disorders of children, family and other interpersonal conflicts, mild depression and anxiety, and concerns focused on goals and direction.
- *Existential psychotherapy* is best suited to relatively well-functioning people with mild depression, mild anxiety, or situational concerns that raise questions about the meaning and direction of their lives. It is often useful for people coping with life-threatening illnesses as well as those struggling to find purpose in their lives.
- *Eastern-based therapies*. Therapies that synthesize Asian and Western perspectives are increasing in use. Transpersonal psychology has integrated many Asian theories and techniques into therapy. Many clinicians view meditation and yoga as integral to stress reduction and calming the mind and include them in their treatment plans. Walsh (2000; Walsh & Shapiro, 2006) notes that hundreds of studies have been conducted on these practices and that Asian therapies are second only to behavior therapies in the amount of empirical research on their effectiveness. Many Western therapies have begun to incorporate Eastern ideas, such as mindfulness (Linehan, 1993); acceptance (Eifert & Forsyth, 2005); emotional transformation (Goleman, 2003); and focusing, altruism, and service (Walsh, 2000). Indeed many clinical practices now offer meditation and yoga as part of a holistic approach to treatment. Walsh and Shapiro (2006) report research indicating that the following difficulties benefit from the practice of mindfulness meditation: insomnia, eating disorders, anxiety, panic and phobic disorders, aggression, and substance misuse.
- *Integrated approaches*. An integrative approach is one that combines treatment approaches and strategies in a logical, systematic way so as to maximize the chances of a positive therapeutic impact. This is different from a cookbook approach that specifies the use of certain types of therapy for certain disorders and is different from an eclectic approach that employs a fairly random and unsystematic array of interventions. Surveys of practice reflect a shift toward integrated or eclectic treatment. Nearly 30 percent of psychologists, 37 percent of counselors, and 34 percent of social workers describe their primary theoretical orientation as integrated or eclectic (Prochaska & Norcross, 2006).

Again, because no one therapeutic orientation has been found to be more effective than others, clinicians with a solid background in one primary theoretical orientation can draw from other theories and interventions to create treatment plans that seem most helpful for the current needs of a particular client (Seligman, 2006), or they can combine two complementary approaches into a new integrated treatment — for example, the blending of behavior therapy with experiential therapy in the creation of acceptance and commitment therapy (Eifert & Forsyth, 2005).

As we have seen, the existence of so many common factors in therapy suggest that there are not really hundreds of discrete approaches to psychotherapy but instead are many variations on a far smaller number of well-established themes. The existence of so many commonalities among therapeutic approaches raises an interesting issue: Are the differences among therapies genuine, and do these therapies have differential effectiveness? Or is any apparent differential effectiveness among therapies due more to particular therapists' effectiveness, if not to the chemistry of particular therapeutic relationships? Let's turn now to look in more detail at a very powerful factor in the success of therapy — the therapeutic alliance.

The Therapeutic Alliance. Discussion of interventions is not complete without discussion of the therapeutic alliance. Interventions to develop this alliance should be included in the treatment plan and are essential in shaping an effective approach to treatment.

In recent years, the therapeutic alliance has become one of the most researched variables in psychotherapy, with literally thousands of articles in the literature investigating aspects of the synergistic relationship that develops between the therapist and the client. Martin, Garske, and Davis (2000) believe that this interest has increased over the past twenty years as part of the effort to explain not only why therapy works but also why research consistently finds little difference in outcomes across therapeutic modalities.

A comprehensive review of the research surrounding the effect of the therapeutic alliance was conducted by the Division 29 Task Force of the American Psychological Association. The division's Steering Committee concluded (American Psychological Association Task Force Steering Committee, Division 29, 2001) that the empirical research supports the fact that the alliance works in conjunction with variables (such as therapist and client characteristics, and the selection of interventions) to create effective therapy; that therapist behaviors that enhance the alliance should be included in practice and treatment guidelines; and that tailoring the relationship to the needs of the client enhances treatment effectiveness.

Specific elements of the therapeutic relationship found to be “demonstrably effective” (therapeutic alliance, cohesion in group therapy, empathy,

goals consensus, and collaboration); and “promising and probably effective” (positive regard, congruence/genuineness, feedback, repair of alliance ruptures, self-disclosure, management of countertransference, and quality of relational interpretations) (p. 495). These elements are provided mainly by the therapist and are common to almost all psychotherapeutic approaches. The Division 29 Task Force recommends practitioners incorporate these elements into their treatment of clients and “make the creation and cultivation of a therapy relationship characterized by the elements found to be demonstrably and probably effective ... a primary aim in the treatment of patients” (p. 496).

To what extent the therapeutic alliance contributes to successful outcomes in therapy remains a mystery, confounded by definitions of variables, theoretical definitions, and research methodology. Research studies rate the alliance as responsible for anywhere from less than 10 percent to as much as 30 percent of the variance in therapeutic outcome (Horvath & Lamosky, 1993; Lambert & Barley, 2001; Martin et al., 2000). Martin and colleagues conducted a meta-analytic review of seventy-nine studies of the therapeutic alliance and found that although the alliance had only a modest effect on outcomes (0.22), the effect is consistent across large numbers of studies and is not linked to many other variables. The authors validate the hypothesis that “the alliance may be therapeutic in and of itself” (p. 446).

In other words, if a good alliance is formed between client and therapist, the client will experience the relationship as therapeutic regardless of which treatment approach is used. Krupnick and colleagues (1996) found that even when the primary intervention is medication, the therapeutic alliance is still important to outcomes.

Establishing an alliance. Nelson and Neufeldt (1996) found that the development of a productive working alliance is facilitated by role induction (helping people learn how to be clients and to make good use of their sessions), by open disclosure of the therapist’s background and procedures, by the therapist’s and the client’s agreement on realistic goals and tasks, and by the therapist’s asking the client for feedback. Role induction also seems helpful in the development of attitudes in clients that are conducive to a positive outcome. In role induction, clients are oriented to the therapeutic process and are given clear information on what is expected of them, what the therapist can offer, and what therapy will probably be like. The client’s engagement in the therapeutic process is a variable that is correlated with a positive therapeutic outcome. Miller, Hubble, and Duncan (1997) emphasize the importance of the client having a positive perception of the therapist, believing that the focus is on his or her goals and expectations, and of being comfortable with the pace of treatment; also

important is the ability of the client and the therapist to view themselves as engaged in a common endeavor likely to succeed.

Research consistently indicates that the therapeutic alliance is a necessary but not sufficient condition for effecting desired changes and positive therapeutic outcomes. Horvath and Symonds (1991) conclude that a successful therapeutic alliance makes it possible for the client to accept and follow the treatment faithfully and bridges the gap between process and outcome. The conditions conducive to a positive therapeutic alliance have been discussed earlier in this chapter, but therapists should not limit their attention to those conditions; they should also attend to clients' preferences.

Bordin (1979) suggests three important aspects of the therapeutic alliance:

1. An affective bond between the client and therapist
2. Agreement between client and therapist about the goals of treatment
3. A sense of working collaboratively on the problem

The alliance across various therapies and modalities. Research consistently shows the importance of the therapeutic alliance in achieving good outcomes across all treatment methodologies (Barber, Connolly, Crits-Christoph, Gladys, & Siqueland, 2000). A review of empirical studies of cognitive-behavioral therapy (Keijsers, Schaap, & Hoogduin, 2000) notes two clusters of therapist behaviors that are associated with successful outcomes in CBT: the conditions of warmth, empathy, positive regard, and genuineness, first set forth by Rogers, and the formation of a positive and collaborative therapeutic alliance.

Forming a therapeutic alliance when working with families requires different skills from when working with individuals, and often involves establishing multiple alliances across a multigenerational system. Beck, Friedlander, and Escudero (2006) note that no single alliance should be considered in isolation because "a therapist's alliance with each family member affects and is affected by the alliance with all other family members" (p. 355).

Multiple studies on the alliance between therapist and families have found that a strong alliance was more likely to occur if the following conditions were met:

- The family agreed with the therapist on goals, had confidence that treatment would bring about positive change, and developed a good emotional connection with the therapist.
- The therapist promoted rapport and exhibited warmth.
- The therapist was optimistic and had a sense of humor.
- The therapist was active in sessions (Beck, Friedlander, & Escudero, 2006).

Reinforcing findings from individual therapy, Quinn, Dotson, and Jordan (1997) showed that a strong therapeutic alliance was more important than technique in family therapy and that the client's perception, rather than the therapist's perception, is the best predictor of treatment outcome. However, in their study of family research, Quinn and colleagues found that the woman's perception of the alliance was more important than the man's perception in predicting outcome.

Conversely, a weak alliance between the family system and the therapist was found when a family member had distrust of the counseling process or when there was disagreement over goals. Robbins, Turner, and Alexander (2003) showed that much like that in individual therapy, the therapeutic alliance in family therapy is also created early on — in the first three or four sessions — and is also predictive of outcome.

Clients' perceptions of the alliance. Clients' perceptions of the quality of the therapeutic alliance are formed early and tend to be stable. They are more highly correlated with therapeutic outcome than therapists' or observers' perceptions of the quality of the therapeutic alliance (Martin et al., 2000). Because clients who rate the alliance as positive are more likely to stay in therapy, to have positive outcomes, and to rate therapy as helpful, establishing an effective therapeutic alliance should be one of the most important, if not the most important, goals of the therapist from the beginning of treatment.

No Treatment. Sometimes the best intervention is no intervention at all. Despite the demonstrated effectiveness of therapy, an estimated 5 to 10 percent of people who receive psychotherapy deteriorate during treatment (Lambert & Ogles, 2004). Although little research is available on the negative effects of psychotherapy, no treatment may be the best recommendation for the following people:

- People at risk for a negative response to treatment (for example, people with severe narcissistic, borderline, obsessive-compulsive, self-destructive, or oppositional personality patterns)
- People with a history of treatment failures
- People who want to support a lawsuit or a disability claim and thus may have an investment in failing to make progress
- People at risk for no response (for example, people who are poorly motivated and not incapacitated, people with malingering or factitious disorder, and those who seem likely to regress as a result of the therapeutic process)
- People likely to show spontaneous improvement (for example, healthy people in crisis or with minor concerns)

- People likely to benefit from strategic use of the no-treatment recommendation (for example, people with oppositional patterns who are refusing treatment and people whose adaptive defenses would be supported by a recommendation of no treatment)

The no-treatment recommendation is intended to protect clients from harm, prevent clients and therapists from wasting their time, delay therapy until clients are more receptive to it, support prior gains, and give people the message that they can survive without therapy. Although this option may make theoretical sense, clinicians do not seem to use it with any frequency, at least partly because of the great difficulty of predicting who will not benefit from therapy and the risk involved in discouraging people from beginning therapy when they may really be able to make good use of it. Nevertheless, therapists may want to give more consideration to this recommendation, especially in light of the current emphasis on short-term productive treatment.

Emphasis (DO A CLIENT MAP)

The multitude of approaches to psychotherapy reflects only one aspect of the diversity that exists in treatment interventions. Variation in the implementation of therapies also greatly increases the diversity of approaches. Clinicians adapt models of psychotherapy to their own personal styles and individualize treatments to meet the needs of particular clients. Therefore, the application of an approach to psychotherapy differs from one therapeutic relationship to another. The dimensions discussed in this section reflect some of the ways to adapt treatment to an individual.

Directive Versus Evocative. The directive approach can be viewed as encompassing cognitive and behavior therapies and such techniques as systematic desensitization, flooding, positive reinforcement (including token economies, contingency contracting, and extinction), strategic techniques (such as suggestion, paradox, and metaphor), humor, homework tasks, and bibliotherapy (Malik et al., 2003). In all these approaches the therapist assumes an authoritative stance, clearly defines target concerns, and designs a specific program to change overt and covert symptoms.

A study by Malik and colleagues (2003) found that psychodynamic therapy was the least directive of eight therapies examined. Psychoanalysis is characterized by a therapist who is clearly an authority figure, but such psychoanalytic techniques as free association are evocative or experiential. The focused-expressive therapies, such as humanistic, experiential, or person-centered models, were also low on directiveness and high on evocativeness, focusing on the therapist-client interaction and encouraging clients

to choose their own topics or modes of processing. Those approaches emphasize such processes as catharsis and abreaction, ventilation, empathy and reflection of feeling, support, affection, praise, and unconditional positive regard.

Two clients are used here to illustrate how treatment emphasis differs, depending on the client. Both Anne and Bettie have similar presenting problems. Each is a woman in her early twenties who has sought counseling after a broken engagement, but their circumstances and their views of therapy are very different and thus warrant different levels of directiveness.

Anne is in her second month of an unplanned pregnancy. She is receiving little help from her family or from her former fiancé. She is unemployed and is living with a single friend who has two children. Anne is not sure what she wants to do about her pregnancy and has been using alcohol as a way to avoid thinking about her difficulties. She has not had previous therapy and is uncertain of why the nurse with whom she spoke at an abortion clinic has referred her to a counselor, although she is motivated to get some help.

Bettie's situation is quite different. Although she too is depressed that her former fiancé ended their engagement, she views this as a time to review her goals. She believes that she focused too much of her time and energy on her fiancé and has neglected her career and her education. She is interested in returning to college, learning more about some of her aptitudes and preferences, and establishing a better balance between her social life and her career. At the same time, she is angry that she feels a need for therapy, and her disappointment in her former fiancé has led her to feel mistrustful of others.

Anne does not have the leisure or the sense of direction for an evocative approach. She needs a directive therapist, not to tell her what to do about her pregnancy, but to give her a structure for expediting her decision making and helping her gain some control of her life. In addition, her use of alcohol is endangering her unborn child and creates urgency in this situation. Bettie, by contrast, would be more amenable to experiential or person-centered therapy, which would afford her the opportunity to engage in self-examination and goal setting.

In general, a directive approach has been correlated with a focus on goal attainment and with lower than average levels of therapeutic alliance (Malik et al., 2003). Alternatively, an evocative approach seems more likely to be successful with people who are self-directed and more able to participate in a sound alliance between client and therapist (Beutler & Consoli, 1993; Malik et al., 2003).

Exploration Versus Support. This is another dimension that has received little but theoretical examination in the literature. Nevertheless, it is often cited as an important aspect of treatment (Rockland, 2003; Wallerstein, 1986).

The dimension of exploration versus support, like the dimension of directive-ness versus evocativeness, exists on a continuum. Approaches that emphasize exploration typically are probing, interpretive, and analytical, stressing the importance of insight, growth, and an understanding of past influences and patterns. By contrast, approaches that emphasize support tend to be present-oriented, symptom-focused, and more action-oriented. Psychoanalysis and psychodynamic psychotherapy, using such techniques as free association, analysis of transference, examination of dreams, and interpretation, emphasize exploration. The other end of the continuum is represented by the behavioral model, with its focus on the present, on circumscribed and measurable changes, and on reinforcement of positive coping mechanisms. Person-centered counseling, although less action-oriented, also reflects a supportive approach in which client strengths and self-direction are reinforced.

Models at each end of the continuum, of course, as well as those in the middle, inevitably include both exploration and support. They are distinguished by the balance between exploration and support rather than by the absence of one or the other. Rockland (2003), for example, outlines a psychodynamic approach to supportive therapy that provides both supportive and exploratory interventions. By tailoring the appropriate levels of support to the client's needs, Rockland focuses on improving ego functioning, reality testing, and clarity of thought, rather than attempting to resolve unconscious conflicts.

One of the few studies of this dimension of therapy was conducted by Wallerstein (1986), who concluded that insight is not always necessary for change. In 45 percent of the cases he examined, changes that were achieved seemed to go beyond the amount of insight that was attained, whereas insight surpassed discerned change in only 7 percent of these cases. Overall, Wallerstein concluded, supportive therapy was more effective in these cases than had been expected, and it did not seem to be less effective than exploratory therapy.

Bettie and Anne, the clients discussed earlier, need different levels of exploration. Bettie, a strong client who is interested in personal growth and introspection, is a good candidate for an approach that is at least moderately probing in nature, such as brief psychodynamic therapy. Anne, by contrast, needs a more supportive approach that will help reduce the stress she is experiencing and enable her to draw on her existing strengths to cope with her situation.

Other Aspects of Emphasis. Other aspects of emphasis include the balance of treatment focus on past, present, and future and the relative attention paid to developing the therapeutic alliance, among others. Emphasis also entails considering how to adapt a treatment approach to a specific person. For example, a clinician may use CBT with many clients but will apply that approach differently for each one. When considering emphasis in developing treatment plans, then, clinicians should also give some thought to what elements of the chosen theoretical orientation will be emphasized and which will be downplayed as treatment progresses. For example, CBT with Anne might focus primarily on behavior, whereas CBT with Bettie probably would pay more attention to thoughts.

Although most therapists probably make intuitive judgments of whether their clients will benefit from high or low levels of exploration and high or low levels of support, and of which aspects of treatment to stress, more research on these dimensions would facilitate effective treatment planning.

Numbers (DO A CLIENT MAP)

The therapist must also decide who will be treated. Some disorders, such as OCD, are best resolved with individual therapy; others, such as oppositional defiant disorder or substance use disorders, are best treated with a family therapy component. Group treatment is another consideration.

Individual Psychotherapy. Individual psychotherapy certainly has demonstrated its effectiveness. Individual therapy seems to be the modality of choice for people whose intrapsychic difficulties cause them repetitive life problems, for people in crisis or with urgent concerns, for people with problems that might cause them distress or embarrassment in a group setting, and for people who are vulnerable, passive, and low in self-esteem (Clarkin, Frances, & Perry, 1992). Although individual therapy is generally a safe choice, it does have certain limitations. It does not offer the client the opportunity to receive feedback from anyone but the therapist, it gives the therapist only one source of information about the client, it encourages transference reactions, it affords little chance to address family dynamics, and it offers only a limited opportunity to try out new interpersonal behaviors in therapy sessions.

Group Psychotherapy. Group therapy has been shown to be effective for a variety of different problems (Pines & Schlapobersky, 2000), including substance-related disorders, eating disorders, and borderline personality disorder (Linehan, 1993). In the past, efforts were made to determine what makes group therapy effective and to compare the impact of group and individual therapy. Studies of therapeutic factors and processes contributing to clients'

improvement, such as self-disclosure, insight, catharsis, interaction, and acceptance/cohesiveness, all yielded ambiguous results. Perhaps both the nature of the group and the client- and therapist-related variables are so powerful in determining outcome in both group and individual treatment that few conclusions can be drawn about group therapy in general (Bloch, Crouch, & Reibstein, 1981). More recent research tends not to distinguish between individual and group formats in determining empirically supported treatments (Chambless & Ollendick, 2001; Malik et al., 2003).

Group therapy does, however, seem to be effective from both cost and outcome standpoints. In general, studies find its impact to be comparable to that of individual therapy. Fenster (1993) suggests that group psychotherapy usually should be the treatment of choice for interpersonal problems, including loneliness, competitiveness, shyness, aggressiveness, and withdrawal, as well as for people who have problems with intimacy and authority. Group therapy offers an environment more like everyday life and therefore provides an arena for interaction and learning from others. Group therapy can promote self-esteem, reduce resistance, and diffuse feelings of differentness and shame.

In deciding whether a particular person is likely to benefit from group psychotherapy, therapists need to consider not only the impact of the group on the client but also the impact of the client on the group. Ideal clients for group therapy seem to be those who are motivated, aware of their interpersonal difficulties, capable of taking some responsibility for their concerns, and able to give and accept feedback. People who are extremely aggressive, confused, self-centered, or fearful of others may have a harmful impact on group interaction and are unlikely to derive much benefit from that process. If group therapy is used at all with clients like these, it probably should be deferred until they have made noticeable progress in individual or family psychotherapy.

Therapy groups may be either heterogeneous (composed of people with different problems) or homogeneous (composed of people with similar problems). People with similar disorders and problems can often learn coping skills from each other, benefit from feedback and modeling, and receive support and validation. Heterogeneous groups often focus on group interaction and help people build interpersonal skills.

Couples and Family Therapy. Research has demonstrated that couples therapy and family therapy are effective in general and may be superior to alternative treatment modalities for some problems and disorders (Accordino & Guernsey, 2001; Pinsof & Wynne, 2000). Johnson and Boisvert (2001) report that the empirically supported interventions for couples include emotion-focused

couples therapy (Greenberg & Johnson, 1988; S. Johnson, 2004) and relationship enhancement therapy (Guerney, 1977, 1994).

Family therapy, of course, is often indicated for problems that stem from, are affected by, and have an impact on the family system. Empirical research has found specific types of family therapy to be an integral part of the successful treatment of many disorders, including schizophrenia, major depressive disorder (Evans et al., 2005) and anorexia nervosa (Wilson & Fairburn, 2002). Children and adolescents seen for therapy will usually have family therapy as a component of their treatment, especially for conduct disorder, oppositional defiant disorder, and ADHD (Anastopoulos & Farley, 2003). People with disorders that seem to have a genetic or familial component, such as substance-related disorders, bipolar disorders (Miklowitz & Goldstein, 1997; Sachs, 2004), and OCD, are also likely to benefit from family therapy. Additional information on each of these disorders and the integration of family therapy into treatment planning is delineated in the relevant chapters of this book.

Research continues on the appropriate uses of these treatment modalities, but most of the information in the literature about the respective strengths and benefits of the three primary modalities of therapy — individual, group, and family — is inferential. The following list summarizes this information, showing the client groups for which each of the modalities is recommended:

Individual Counseling

Highly anxious, withdrawn, isolated, or introverted clients; people who have difficulty with ambiguity; people seeking help with intrapsychic concerns; extremely suspicious, guarded, hostile, paranoid, or destructive people who have difficulty with trust; people seeking independence and individuation; people with very

Group Therapy

Anxious clients with authority concerns; people with pervasive personality dysfunction who have made progress in individual therapy; people with interpersonal concerns; people who may feel stigmatized or scapegoated as a result of individual therapy (such as the identified patient in a family); people who are likely to give the

Family Therapy

People who have problems with family structure and dynamics; people with intergenerational or other family conflicts; families with communication problems; families needing consolidation; acting-out adolescents; families with limited resources, when more than one family member needs help; families with no

intimate or idiosyncratic concerns; people with concerns of very long duration in which improvement rather than maintenance is sought; people in crisis	therapist excessive power; people who need reality testing and group feedback; people with specific behavioral concerns (such as eating disorders or alcohol dependence) that are shared with other group members; people with limited financial resources; people who have been through traumatic experiences that also have been experienced by others in their treatment group	severe pathology; children; families with a member who has a chronic or recurrent mental disorder
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Timing (DO A CLIENT MAP)

The typical client is seen once a week for a session of forty-five to fifty minutes in length, but the frequency of therapy sessions can vary. One session every other week is often used in supportive therapy, particularly toward the end of treatment, whereas clients in psychoanalysis commonly have five sessions per week. The duration of therapy also varies widely, of course, and is often difficult to predict.

The limited research comparing long-term treatment with short-term treatment is either specific to one treatment modality and one disorder (such as dialectical behavior therapy for borderline personality disorder) or combines many studies across a broad range of disorders. For example, Hansen and Lambert (2003) looked at nearly five thousand people in various outpatient settings and found that half achieved significant change in fifteen to nineteen sessions. A similar study of seventy-five people estimated that eleven sessions was the average number for 50 percent of the people to achieve significant change (Anderson & Lambert, 2001).

Bloom (2001) reviewed outcome studies on a single session of treatment. The results indicated that only clients with relationship problems benefited from a single in-depth treatment session. A study by Kadera, Lambert, and

Andrews (1996) found that the average time for recovery was eleven sessions (with 76 percent of those who would recover doing so by thirteen sessions), and that all who were going to recover had done so by twenty-five sessions.

Overall, approximately 50 percent of clients showed measurable improvement after eight sessions of therapy, 75 percent after twenty-six sessions, and 85 percent after one year of treatment (Howard, Kopta, Krause, & Orlinsky, 1986). Orlinsky and Howard (1986) conducted meta-analyses of studies that looked at the relationship between length of therapy and therapeutic outcome. They concluded that the total number of sessions — and, to a lesser extent, duration of treatment — are positively correlated with therapeutic benefit. Not all studies show the same relationship, however, and a small number show a curvilinear relationship between outcome and number of sessions.

Research has yet to indicate an optimum length of treatment for specific disorders. Relevant studies are informative but incomplete. Clearly, more empirical research is necessary to determine the most effective length of treatment for people with specific disorders. Typically, short-term therapy is not just less long-term therapy; the goals, the treatment interventions, the disorders, and the clients themselves are likely to differ. Therefore, research must consider presenting problems, diagnoses, client profiles, and other variables when the research question is one of determining outcomes on the basis of therapy's duration.

Today's emphasis on short-term therapy has increased the importance of studying approaches to brief treatment and determining the people for whom they are suitable. Many studies have demonstrated that short-term treatment can have a significant and lasting positive impact, but that is only the case for some clients and some disorders (Bloom, 2002; Cameron et al., 1999; Lambert & Anderson, 1996). Roberts (2002), for example, found that brief therapy is indicated in the immediate aftermath of a crisis, such as a suicide attempt, trauma, or national disaster such as occurred on September 11. Bloom (2002) reviewed fifty-nine outcome studies on the effectiveness of brief therapy and found that four to sixteen sessions of therapy benefited people who had anxiety disorders. Short-term cognitive therapy seems to be appropriate when problems are related to stress, dysfunctional behaviors, academic problems, interpersonal difficulties, and career concerns (Littrell, Malia, & Vanderwood, 1995), and brief psychodynamic psychotherapy is suitable for both chronic and nonchronic depression (Luborsky et al., 1996). In fact, 10 to 18 percent of clients improve before the first session of therapy just by virtue of having made contact with a potential source of help (Howard et al., 1986).

When determining whether brief therapy will be appropriate, Lambert and Anderson (1996) suggest that the following criteria should be considered:

- The nature and severity of the disorder
- The client's readiness to change
- The client's ego strength
- The client's motivation for an enduring therapeutic relationship
- The client's ability to relate to the therapist

Other researchers confirm that a thorough assessment at the beginning of treatment is essential to determine appropriateness of fit for brief therapy (Corcoran & Boyer-Quick, 2002). In general, clients with fewer symptoms and better pretreatment functioning achieve better results faster than those with more serious disorders (Roth & Fonagy, 2005).

Typically people who are motivated, who do not have personality disorders, and who have a focal concern or crisis, a positive history, good ego functioning, and a sound ability to relate well to others and express their emotions make good clients for short-term therapy.

People for whom short-term therapy usually is not indicated are those who are very hostile, paranoid, or psychotic or who have long-standing, severe problems. Eating disorders, bipolar disorders, dysthymic disorder, borderline personality disorder, and antisocial personality disorder are examples of disorders that generally do not respond well to short-term therapy.

In general, short-term therapy seems likely to be effective with a substantial percentage of clients (approximately 75 percent); in fact, time-limited treatment can encourage people to be more focused and to make more rapid progress. Again, however, candidates for this approach to treatment must be carefully selected.

Medications (DO A CLIENT MAP)

As already mentioned, this book is directed primarily toward nonmedical clinicians, who do not themselves prescribe medication as part of the treatment they provide. Nevertheless, nonmedical clinicians who understand the role that medication can play in the treatment of mental disorders can determine when a client's progress might be accelerated by a referral for a medication evaluation and collaboration with a physician, usually a psychiatrist. For clients who are taking medication for mental disorders, ongoing assessment of medication compliance often is an important part of psychotherapy and reflects a holistic approach to treatment (Pratt & Mueser, 2002).

Research indicates that the combination of psychotherapy and medication can increase the effectiveness of treatment for some disorders (Jindal & Thase, 2003). For example, people with schizophrenia who receive medication as

well as other interventions have reduced symptom levels, improved executive function, and lower rates of relapse and rehospitalization. Baker, Patterson, and Barlow (2002) and Evans and colleagues (2005) report that medication can enhance the effectiveness of cognitive-behavioral interventions in the treatment of severe anxiety and panic disorders.

Kendall and Lipman (1991) found that psychotherapy and medication can have a synergistic relationship, especially in the treatment of major depressive disorder. The medication acts first and, by energizing clients and promoting some optimism, enables them to make better use of psychotherapy; the impact of the therapy in turn promotes compliance with the recommended drug treatment. According to these researchers, antidepressant medications are particularly helpful in reducing the likelihood of relapse and in treating vegetative symptoms, while the psychotherapy aids with many facets of adjustment and coping. Although the effects of the therapy may take longer to appear than the effects of the medication, the effects of the therapy are likely to last longer.

Medication, combined with therapy, seems particularly useful for disorders involving debilitating anxiety, endogenous (melancholic) depression, mania, or psychosis. Therapy alone may be all that is needed in treating problems involving adjustment, behavior, relationships, mild to moderate anxiety, reactive depression, and some personality disorders. Many disorders in the second group, however, such as eating disorders, some personality disorders, and impulse-control disorders, are often accompanied by underlying depression. Medication is increasingly being used along with therapy to enhance the impact of psychotherapy on the primary diagnosis by alleviating the underlying symptoms.

Psychotropic medications can be divided into the following five groups (Preston, O'Neal, & Talaga, 2005):

1. *Antipsychotic medications.* These drugs are primarily for the treatment of schizophrenia and other disorders involving delusions and hallucinations. People with Tourette's disorder, pervasive developmental disorders, and severe cognitive disorders also can benefit from these drugs. This category includes the phenothiazines (such as Thorazine, Prolixin, Mellaril, and Stelazine); such antipsychotic drugs as clozapine (Clozaril), haloperidol (Haldol), and risperidone (Risperdal); and newer atypical antipsychotic medications with better tolerability and fewer extrapyramidal symptoms, including ziprasidone (Geodon), olanzapine (Zyprexa), and aripiprazole (Abilify).

2. *Antidepressant medications.* These drugs fall into the following groups:

- a. Tricyclic and heterocyclic antidepressants, which facilitate the treatment of moderate to severe major depressive disorder (especially with melancholia); enuresis; trichotillomania; panic attacks; bipolar depression; and eating, sleep, and obsessive-compulsive disorders. Examples of this type of drug include imipramine (Tofranil), clomipramine (Anafranil), and amitriptyline (Elavil).
- b. Monoamine oxidase inhibitors (MAOIs), such as phenelzine (Nardil) and tranylcypromine (Parnate), which are often effective with atypical depressions, severe phobias, anxiety disorders, panic disorder, obsessional thinking, hypochondriasis, and depersonalization disorder. They are also used to treat disorders that have not responded to other antidepressant medication.
- c. Selective serotonin reuptake inhibitors (SSRIs) are effective in the treatment of depression, as well as of such disorders as eating and somatoform disorders that are accompanied by underlying depression. They may also be effective in reducing anxiety, especially when it is combined with depression. This category includes fluoxetine (Prozac), sertraline (Zoloft), citalopram (Celexa), fluvoxamine (Luvox), and paroxetine (Paxil).
- d. Serotonin and norepinephrine reuptake inhibitors (SNRIs) affect levels of both serotonin and norepinephrine. SNRIs include venlafaxine (Effexor), duloxetine (Cymbalta), and mirtazapine (Remeron). SNRIs may be more effective than SSRIs in the treatment of severe depression (Preston et al., 2005).
- e. Bupropion (Wellbutrin) is an atypical antidepressant that is frequently used in combination with an SSRI.

3. *Mood stabilizers.* Lithium, the best-known mood stabilizer, is effective in reducing symptoms of mania, depression, and mood instability. Newer mood stabilizers include topiramate (Topamax), divalproex (Depakote), and lamotrigine (Lamictal). They are used for treatment of bipolar disorders, cyclothymic disorder, and schizoaffective disorder.

4. *Benzodiazepine/antianxiety drugs.* These medications are used for reduction of anxiety, panic attacks, and insomnia. They also can facilitate withdrawal from drugs or alcohol and can enhance the impact of antipsychotic medication. Examples of these drugs are alprazolam (Xanax), lorazepam (Ativan), diazepam (Valium), and clonazepam (Klonopin). Some of these drugs are highly addictive and dangerous and so must be prescribed and used with great care.

5. *Other drugs.* Additional drugs helpful in the treatment of mental disorders include methylphenidate (Ritalin), atomoxetine (Strattera), and amphetamine mixed salts (Adderall) for the treatment of ADHD and naltrexone (ReVia) and Methadone for prevention of misuse of alcohol and narcotics, respectively. Benzodiazepines are sometimes helpful in the treatment of irritability and agitation associated with withdrawal from substances. If withdrawal is accompanied by psychosis or paranoia, antipsychotic medications may also be helpful.

Electroconvulsive therapy (ECT) also is mentioned here because of its beneficial use in the treatment of severe depression, particularly when psychotherapy and medication have failed, and especially when the depression is characterized by melancholia or accompanied by psychotic features. Although ECT has some worrisome side effects, these have been reduced over the years, and this treatment can bring benefit to people with treatment-resistant depression.

Adjunct Services (DO A CLIENT MAP)

Adjunct services can provide additional sources of support, education, and training. Parent skills training, for example, can be a useful adjunct to treatment for conduct disorder and reinforces what the child learns in therapy. Nutrition counseling can help people with eating disorders develop realistic goals that are appropriate to their weight and type of disordered eating. A person who has lost a family member to suicide might benefit by attending a peer support group with people with similar losses. And twelve-step programs such as Narcotics Anonymous or Alcoholics Anonymous can help people with substance-related disorders during the recovery process.

Adjunct services can also be suggested for family members. For example, families coping with a diagnosis of autism or a schizophrenia spectrum disorder might benefit from receiving psychoeducation about the disorder and attending caregiver support groups. Couples counseling or family counseling often helps family members understand the client better. For example, a woman with dependent personality disorder might benefit by participating in concurrent individual and couples counseling, to help her husband understand and support the changes she is trying to make.

All adjunct services should reinforce the goals the client is working on. Whether it is an exercise program, volunteer activities to improve socialization, bibliotherapy, or biofeedback to help people recognize bodily sensations, the types of services suggested should reinforce progress that a client is making in individual therapy. Between-session assignments can help clients get the most out of their sessions. For example, those who are technologically savvy might use computerized logs and journals to chart progress or participate in Internet support groups between therapy sessions to help them stay on task. The

Internet has become one of the leading providers of health care information, and clients can reinforce their efforts through special forums, support groups, and online resources relating to their areas of concern.

Near the conclusion of treatment, therapists might want to refer clients to adjunct services to begin work on secondary issues that have been raised in therapy but were not the central focus of attention. Referrals for marital counseling, family therapy, assertiveness training, or career counseling might be appropriate at this time, depending on the person's goals.

Myriad types of adjunct services are available to suit the distinct needs of each client and the timing of treatment. Less well functioning clients might need assistance in obtaining government services, such as legal aid or housing assistance, or referrals might be needed for inpatient hospitalization or day treatment. Therapists who creatively and diligently stay abreast of the available community resources will be able to refer clients to the appropriate services as needs arise.

Prognosis (DO A CLIENT MAP)

Prognosis refers to the likelihood that clients will achieve their objectives when treated according to the plan that has been developed to help them. Prognosis depends largely on two variables: the nature and severity of the disorders and problems and the client's motivations to make positive changes.

EXAMPLES OF TREATMENT PLANNING: ANNE AND BETTIE

Application of the preceding information on treatment planning to the cases of Bettie and Anne (discussed earlier in this chapter) should clarify the type of treatment likely to benefit each of them. This format, with examples of Client Maps for specific disorders, will be followed in subsequent chapters of the book.

Client Maps of Anne and Bettie

Although both women are coping with broken engagements, Anne is also dealing with an unplanned pregnancy, and she has used alcohol and avoidance as coping mechanisms. Bettie, by contrast, has more self-confidence and more personal resources, and she is able to view her unexpected change in plans as an opportunity for personal growth.

Both women probably would benefit from short-term therapy. Bettie should be seen weekly; she has significant concerns but is in no danger. Anne should be seen more frequently, until she has resolved her immediate crisis and dealt successfully with her alcohol use. Bettie is more self-directed. Although she does evidence some cognitive dysfunction, resistance, and mild depression,

Bettie may respond well to a modified form of person-centered therapy that encourages her to develop her self-confidence and her self-awareness and to establish goals and direction, as well as interpersonal skills. Anne, by contrast, is less motivated toward self-exploration and is primarily interested in resolving her immediate concerns. Her therapy will probably focus more on cognitive-behavioral areas, emphasizing decision making and behavioral change.

Anne seems likely to respond best to individual therapy because she is in crisis, must make a rapid decision about her pregnancy, and is not currently interested in personal growth and development. Bettie, however, would probably benefit from either individual or group psychotherapy, or from a combination of the two — perhaps short-term individual therapy followed by participation in a personal growth group for women or a psychotherapy group for young adults.

Neither Anne nor Bettie seems to need medication, although Anne's therapist should make sure that Anne is receiving any necessary medical care and is aware of the risks of her alcohol use. Both Anne and Bettie are capable of self-regulation and are in touch with reality. An outpatient treatment setting, such as a community mental health center or a private practice, seems an appropriate location for treatment. Adjunct services, such as Alcoholics Anonymous and even inpatient treatment, may be considered for Anne if her alcohol misuse is severe enough.

After their immediate concerns have been resolved, both Bettie and Anne may decide to continue treatment, but their goals are likely to differ. Bettie will probably seek to improve her relationship skills, clarify her goals and direction, and enhance her self-esteem. Anne will probably need to develop better coping mechanisms and greater independence and may need to look at past issues to understand and change her poor choices.

The research on therapeutic variables does not yield definitive descriptions of the exact types of psychotherapy that would be best for each of these women. Nevertheless, it does offer guidelines for designing a treatment plan likely to be effective for each of them. Following are Client Maps for Anne and Bettie.

Client Map of Anne

Diagnosis

Axis I: 296.23 Major depressive disorder, single episode, severe, without psychotic features

305.00 Alcohol abuse

Axis II: Dependent personality traits

Axis III: No known physical disorders or conditions, but pregnancy reported

Axis IV: End of engagement, unplanned pregnancy, housing problems, unemployed

Axis V: Global assessment of functioning (GAF Scale): current GAF = 45

Objectives of Treatment

Establish and maintain abstinence from alcohol

Provide direction and structure so client can determine best outcome of pregnancy

Reduce stress

Stabilize living situation

Locate suitable employment

Improve coping skills

Assessments

Thorough medical evaluation to determine impact of alcohol use on pregnancy

Michigan Alcohol Screening Test

Clinician Characteristics

Knowledgeable about the development and symptoms of alcohol abuse

Structured and directive

Skilled at setting goals and direction

Able to promote motivation, independence, and optimism

Location of Treatment

Outpatient

Consider inpatient treatment if alcohol abuse worsens

Interventions to Be Used

Motivational therapy at the start, to enhance compliance with treatment plan

Cognitive-behavioral therapy

Emphasis of Treatment

Initial directive and supportive emphasis

Emphasis on cognitions and behavior

Numbers

Primarily individual therapy

Timing

Rapid pace

Longer duration (more than six months) to address issues of relapse prevention and dependence

Twice weekly sessions until client is out of crisis and more stable

Medications Needed

None

Adjunct Services

Support group to develop social and coping skills and provide support

Homework assignments

Twelve-step program such as Alcoholics Anonymous or Women for Sobriety

Prognosis

Good (after client gets past crisis), assuming she is motivated to stop drinking and find adequate coping skills for dealing with her problems

Relapse common

Client Map of Bettie

Diagnosis

Axis I: 309.0 Adjustment disorder with depressed mood

Axis II: V71.09 No diagnosis on Axis II

Axis III: None reported

Axis IV: Problems with primary support group: end of engagement

Axis V: Global assessment of functioning (GAF Scale): current GAF = 77

Objectives of Treatment

Reduce stress and reinforce positive coping skills

Explore and determine goals and future direction

Develop relationship skills

Assessments

Myers-Briggs Type Indicator

Strong Interest Inventory

Clinician Characteristics

Supportive and exploratory

Skilled at fostering resilience

Able to promote exploration of long-term objectives

Location of Treatment

Outpatient

Interventions to Be Used

Initially cognitive-behavioral therapy

Process-experiential therapy

Emphasis of Treatment

Initial supportive emphasis

Emphasis on emotions and values

Numbers

Primarily individual therapy

Timing

Rapid pace

Short duration (less than six months)

Weekly sessions

Medications Needed

None

Adjunct Services

Career counseling

Referral to support group for women

Prognosis

Excellent



This chapter has presented an outline for a comprehensive treatment plan, the DO A CLIENT MAP. It has also reviewed the literature on the dimensions of effective therapy and on the contributions that the qualities of the therapist, the qualities of the client, and the interaction between therapist and client can make to therapeutic outcomes. The next eight chapters describe the various mental disorders and report on research of treatment approaches that have been found to be effective with those disorders. That information, in combination with the information presented in this chapter, should help clinicians maximize the success of their efforts to help clients in psychotherapy.