

Systematic Treatment Selection (STS): A Review and Future Directions

Tam T. Nguyen, Matteo Bertoni, Mylea Charvat, Anahita Gheyntanchi, & Larry E. Beutler

Abstract

Systematic Treatment Selection (STS) is a form of technical eclecticism that develops and plans treatments using empirically founded principles of psychotherapy. It is a model that provides systematic guidelines for the utilization of different psychotherapeutic strategies based on patient qualities and problem characteristics. Historically, it stems from accumulating evidence that no single theory is effective in treating all patients and common characteristics shared among different theoretical philosophies. A review of the literature and further research resulted in the extraction of four main decisional domains that are involved in determining effective treatment strategies. These domains include: (1) patient predisposing qualities, (2) treatment context, (3) relationship variables, and (4) intervention selection. These main principles provide the basis for which guidelines have been developed to systematically individualize treatment plans. The next step in the process is to effectively disseminate and implement this model, in which students and clinicians are taught to operate from a patient based rather than a theory based perspective.

Keywords: Systematic Treatment Selection, STS, Prescriptive Therapy, PT, Core Principles, Patient Qualities, Intervention Selection.

Introduction

A shared objective of those within the mental health field is to provide relief to individuals experiencing emotional, behavioral, or psychological distress. Towards this end, several hundred theoretical orientations have developed, each stressing that it is the treatment of choice. However, most of the 400+ theoretical approaches to treatment have not been experimentally tested. Of those few that have been subject to experimental test each was empirically found to produce both positive and negative effects. In other words, in every treatment, some people get better, some get worse and many stay unchanged. As a result, clinicians began borrowing strategies and techniques stemming from one treatment orientation or another or simply “using what works”, beginning the movement of eclecticism, an integrative philosophy.

Since the mid-seventies, the borrowing and assimilation of different techniques in psychotherapy was the most common approach chosen by psychologists, typically in an idiosyncratic and non-systematic fashion (Beutler & Bongar, 1995). For the most part, clinicians were borrowing techniques in an appearingly random and haphazard manner. Thus, systematic and planned judgment of assigning treatments to patients was first introduced by Lazarus (Multimodal Psychotherapy, 1976) and Goldstein and Stein (Prescriptive Psychotherapy, 1976). Beutler & Clarkin’s Systematic Treatment Selection (1990) approach extended on these earlier approaches and drew from two contemporary models of integration: Differential Therapeutics (Frances, Clarkin & Perry, 1984) and Systematic Eclectic Psychotherapy (Beutler, 1983).

Systematic Treatment Selection (STS, Beutler & Clarkin, 1990) is an empirically grounded decisional structure that uses existing research findings to define both state and trait-like patient indicators and contra indicators for utilizing different psychotherapeutic strategies, in the form of classes of interventions (Beutler & Harwood, 2002). This article provides a review of the historical background, the

significant research that led to the conceptualization of STS, and a description and application of its core principles.

Historical Background

STS was developed as a search for empirical and clinical principles with the intent of systematizing treatment decisions as a function of therapist and client dimensions, treatment strategies and therapeutic interventions. It incorporates both common therapy variables found across theoretical orientations and unique attributes of each theoretical philosophy in determining an effective treatment plan. There are two fundamental, empirically based premises of STS: (1) no treatment is effective with all individuals and (2) the majority of systematically applied treatments work well with some individuals (Beutler & Harwood, 2002; Howard, Krause, & Lyons, 1993).

STS is aimed at identifying which type of individual will likely benefit from each class of interventions or treatment. Even when the treatments are derived from the same theoretical model and are employed for the same type of problem, they have been found to be quite heterogeneous in the way they are applied (Malik et al., 2003). Although, each therapist typically identifies with a particular theoretical orientation, in clinical practice they usually employ a mixture of techniques and procedures, according to the therapist's own experience, familiarity and expertise (Beutler & Harwood, 2000).

The results of the efforts to develop a principle-based (rather than a theory-based, or technique-based) treatment, were sufficiently promising that an independent effort was initiated by the Society of Clinical Psychology (Division 12 of the American Psychological Association) and the North American Society for Psychotherapy Research (NASPR), with the aim of extending the list of treatment principles into other areas of intervention. This task force issued a report (Castonguay & Beutler, 2006) under the auspices of the two sponsoring societies. This report summarized over 60 principles that senior investigators, consensually believed were supported sufficiently by sound research to be incorporated into practice. These principles identified the use of patient, therapist, relationship, and procedural variables to treat a range of diagnostic conditions. Both common—those that cut across problem types---and specific or “unique” principles—those that applied to a single diagnostic group---were identified. These principles addressed the treatment of patients with major and minor depression, those with anxiety disorders, those with personality disorders, and those with chemical abuse and dependency. The task force, thus, expanded the list of working and empirically derived principles, relative to those originally presented by Beutler, Clarkin, and Bongar (2000) and refined the strategies that contribute to a research-based practice.

Questions and rating measures were constructed to assess each of these qualities and these items became the basis for the STS Clinician and Self-Report rating forms from which treatment recommendations were to be made. At the same time, records of treatment, including both paper records and video and audio tapes of therapy sessions for each patient were reviewed. From these treatment data, a series of measurements that reflected variables that had been identified as significant aspects of treatment in the previous literature reviews were extracted and developed. These measures allowed the development of a descriptive profile of any treatment program on a common set of scales, all of which had been empirically identified as relevant to the prediction of treatment outcome.

Together with its specific application to the individual psychotherapy of those with co-morbid depression and chemical abuse, called “Prescriptive Psychotherapy”, STS is considered as an integrative, contemporary, empirically based, conceptualization of the treatment of psychological problems. The integrative movement in psychotherapy, as described by Arkowitz (1995), encompasses three big groups: the common factors perspective (Frank & Frank, 1991), theoretical eclecticism (Wachtel, 1977, 1997), and technical (Lazarus, 1981) or systematic eclecticism (Beutler, 1983). STS is considered to be part of the

larger group of interventions, called “systematic eclecticism” (Lazarus, 1976), which is intended to overcome the limitation of the classical eclecticism through the incorporation of the systematic decision making of the appropriate class of treatment, according to diagnostic dimensions and patient’s variables. As Goldfried (1980) suggested in his classic article, STS is intended to transcend the “trademark” psychotherapies to affirm to importance and employ principles of therapeutic change.

Summary of STS Research

The development of the main principles and application of STS (Beutler, Clarkin, & Bongar, 2000) occurred in three stages: (1) iterative reviews of the literature to identify predictors and mediators of change, (2) collapsing and combining patient and treatment characteristics to identify a workable number of predictive variables, and (3) conducting a systematic test of the impact of following the principles on patient change.

The first stage consisted of a series of literature reviews of studies on mixed patients, with depression and substance abuse, with the aim to construe a list of patient characteristics and treatment qualities correlated with the intensity and quantity of change (Beutler & Clarkin, 1990; Beutler et al., 2000). The second stage consisted of collapsing and combining the patients’ and treatments’ characteristics into specific set of clusters, each of which identified particular kinds of distinction among patients and treatments that constantly relate to change. The third stage involved developing and applying a method to evaluate the specific patient qualities that emerged in the first cluster and the associated aspects with the remaining three clusters. The first two stages resulted in the identification of six reliable and specific dimensions that were associated with differential treatment, including, arranged from the most trait-like to the most state-like: (1) level of functional impairment; (2) preferred coping style, ranging from externalizing or impulsive to internalizing or reflective; (3) complexity of the problem, conceptualized as its chronicity, co-morbidity, and recurrence; (4) level of social support; (5) level of resistance from external influence; and (6) level of subjective distress.

Although most therapists report that the type of procedures that are most effective in psychotherapy is of most value to them, the efficacy of few of the procedures and models that are used in clinical practice are actually supported empirically (Beutler, Williams, Wakefield, & Entwistle, 1995). The dilemma faced by practitioners can be seen as one that draws them between the research on effective psychotherapies that delineates specific factors of a specific theoretical orientation and, on the other hand, that research that emphasizes the presence of common factors amongst the different therapeutic models that produce effective change. Beutler, Moleiro & Talebi’s (2002) review of how practitioners can systematically use evidence in treatment selection suggests that identifying the common and differentiating principles of change may be more productive than focusing on the relative value of different theoretical models.

Lazarus, Beutler & Norcross (1992) point out that the common qualities in psychotherapy as applied to “technical eclecticism” is the result of therapeutic procedures and personal styles as much as the causes of change. Furthermore, their formation is different depending on each client’s characteristics. Lazarus et al. (1992) also noted that the future of eclecticism will be more specified as psychological therapies will be matched to client variables.

As a result, Lafferty, Beutler, & Crago (1989) studied the differences between more and less effective trainee therapists and found that less effective therapists were discovered to have lower levels of empathic understanding, rated their patients as more involved in treatment and rated themselves as more supportive than the more effective therapists. Less effective therapists were found to value comfort and stimulation significantly more and valued intellectual goals significantly less than did the more effective psychotherapists. In this study, therapist effectiveness was measured by comparing the level of

symptomatic distress experienced by patients before and after treatment. The primary findings revealed that those therapist variables that are the best predictors of effectiveness relate to the in-therapy experiences of the participants in contrast to extratherapy traits. This study also supported the significance of the therapist's empathy in effective psychotherapy which is consistent with previous research on psychotherapy (Lambert & Bergin, 1983). Lafferty et al. (1989) proposed that perhaps the less effective therapists of their study placed greater emphasis on their own prosperity and stimulation than did the more effective therapist group.

Following, Beutler, Engle, Mohr, Daldrup, Bergan, Meredith, & Merry (1991) examined predictors of differential response to cognitive, experimental and self-directed psychotherapeutic procedures. It revealed that patient characteristics can be used differentially to assign psychotherapy types. It was found that externalizing depressed patients improved more than non-externalizing depressed patients in group cognitive therapy, whereas internalizing patients improved most in supportive and self-directed therapy. Furthermore, resistant patients were found to improve more in supportive and self-directed therapy than either in focused expressive psychotherapy or group cognitive therapy, whereas low defensive patients improved more in group cognitive therapy than in supportive and self-directed therapy.

Beutler & Consoli's (1993) review of the therapeutic stance revealed that it is embedded in the clinical strategies or plans that therapists choose to apply and individualize for each client which include the degree of directiveness, the focus on behavioral or unconscious level, the discussion of in-therapy or out-of-therapy material, the degree of formality of the therapy established, the quality of self disclosures, and the emphasis on symptomatic problems. Furthermore, the nature of the stance is conveyed through the use of specific therapeutic techniques.

Several comparisons of different treatment models (Beutler, Engle, Mohr, Daldrup, Bergan, Meredith, & Merry 1991) also confirmed the efficacy of using patient resistance level and coping style as a basis for treatment selection. Prospective data on therapist patient matching factors indicated that up to 90% of the outcome variance may be predicted by the collection of differential treatment indicators identified by STS (Beutler, Moleiro, & Malik, 2000).

Furthermore, Beutler, Patterson, Jacob, Shoham, Yost & Rohrbaugh's (1993) review of literature on psychotherapy research and alcohol treatment research revealed that "internalizing" alcoholics, whose drinking tends to be steady and to be functionally combined with family dynamics, will benefit more from family systems oriented treatments than from symptom focused treatment. Furthermore, "externalizing" alcoholics were found to benefit from symptom-focused cognitive and behavioral treatment.

In their own study of drinking patterns, Beutler et al. (1993) found that those with drinking patterns and were highly embedded in and maintained by marital and family relationships are likely to benefit from a treatment that focuses on altering relationship patterns. Thus, developing specific treatments for specific types of patients may also require extra-diagnostic variables.

There is little evidence that the variability among treatment outcomes has been benefited by the decision to group patients by their DSM diagnosis. The distribution of treatment outcomes continues to be relatively consistent regardless of treatment type, accounting for why the dodo bird verdict continues to be so prevalent (Howard, Krause, & Lyons, 1993; Wampold, 1997). Instead, the authors advocate use of STS, a classification system that identifies common families of interventions and dimensional perspectives of people and their problems (Beutler & Malik, 2003). Literature review resulted in the reliable identification of eight dimensions that meet these criteria and that could form the initial basis for a treatment-relevant diagnostic system: Functional Impairment, Complexity, Chronicity, Distress, Social Support, Coping Style, Readiness for Change, and Resistance Level (Beutler et al., 1999).

The STS model developed by Beutler has been used to identify and define almost 40 independent patient variables which research has supported as predictors for treatment outcome (Beutler, Clarkin & Bongar 2000). However, four specific constructs derived from the STS literature have emerged as most critical to the selection of treatment: (1) level of functional impairment; (2) patient's reported subjective distress, (3) patient coping style defined as internalized or externalized, and (4) patient resistance potential. These dimensions are identified as Patient Predisposing Variable by Beutler and Clarkin (1990) and Beutler and Hodgson (1993).

Beutler, Moleiro, Malik, Harwood, Romanelli, Gallagher-Thompson and Thompson (2003) found in a sample of 40 depressed and stimulant-abusing patients that outcome effects were stronger for therapies based on multiple factor perspectives (including patient, treatment and patient-therapy matching) than for specific manual driven treatments. Participants were randomly assigned to one of three treatment groups; a standard cognitive therapy for drug abuse, a contrasting cognitive-narrative therapy and prescriptive therapy. The results supported previous STS research indicating that patient, treatment, relationship and patient-therapy variables independently impact treatment outcomes and are more strongly associated with successful outcome than any specific intervention.

The results confirmed the variables proposed by Beutler & Clarkin to be integral in the determination of effective treatment selection. These following: patient factors, treatment factors, relationship factors, and the fit of treatment strategies to (non-diagnostic) patient variables each added power to predicting psychotherapy outcomes. In two studies (Beutler, Clarkin, & Bongar, 2000; Beutler, Moleiro, et al, 2003), it is notable that neither the patient's diagnosis nor the particular treatment model used accounted for more than a very little of the difference in treatment impact among complex and comorbid patient.

In a study reviewed by Beutler, Harwood, Bertoni, & Thomman (2006) patients were enrolled in four randomized clinical trials of psychotherapy and pharmacotherapy and one naturalistic study of treatment outcome was tapped. Nine different models of psychotherapy were represented, along with an uncontrolled treatment as usual condition. The findings resulted in clusters of patient qualities consisting of: (1) patient factors, existing in trait and state-like responses; (2) treatment factors; (3) quality of the relationship between patient and therapist; (4) the fit of the treatment procedures and the proclivities and dispositions of the patient.

Demands by legislators, public policy and healthcare administrators to reduce mental health care costs have also resulted in a plethora of changes in diagnostic and treatment modalities in psychology. These changes have forced clinicians to create changes in how patients are assessed, diagnosed and treated with a new emphasis on empirically supported treatments (Docherty & Streeter, 1993).

STS exists to provide an empirically supported framework that serves to increase the likelihood of obtaining favorable treatment outcomes (Beutler & Clarkin, 1990). STS transfers the focus of treatment planning from traditional DSM categories and theoretical perspectives to the assessment of normal and pathological patterns of behavior in a given patient, which will mediate the selection of various types of available interventions (Beutler & Clarkin, 1990).

STS Core Concepts

Findings from the literature and the previous studies mentioned, led to extraction of four core domains of variables used to guide the clinician in making treatment decisions, including: (1) predisposing client variables; (2) treatment contexts; (3) relationship variables; and (4) specific strategies (Beutler & Consoli, 1990; Beutler & Harwood, 2000). The initial step in treatment selection is determining where the individual's scores fall along several dimensions of predisposing client variables

(coping style, resistance level, level of distress). These are commonly measured with several standard personality assessment tools (i.e., the Beck Depression Inventory II (BDI-II), the Minnesota Multiphasic Personality Inventory II (MMPI-II), the Therapeutic Reactance Scale (TRS), the STS Clinician Rating Form, etc.). Once identified, the context in which psychotherapy takes place is then specified which entails establishing the setting in which therapy will take place (inpatient vs. outpatient), the format (individual, family, or group), and the frequency/duration of treatment. Following, relationship variables between therapist and patient is examined which then leads to selection of specific interventions or techniques (symptom vs. conflict focus). Optimal treatment outcome is a function of the interaction of these identified core variables.

Patient Predisposing Qualities

Traditionally, assigning a “diagnosis” was intended to establish a common classification system, and to facilitate communication among practitioners. Arriving at a “diagnosis” often paved the way for specific intervention decisions (Beutler & Clarkin, 1990). Inherently, this system presumed that individuals experiencing shared symptom clusters were suffering from a similar problem therefore could be identically treated. Although there is some validity to this, in applying a “diagnosis” to guide treatment implementation, individual differences defined as patient predisposing characteristics was often overshadowed and minimized as important variables in contributing to treatment outcome. However, conclusions from available research suggested that the single most powerful source of influence in determining effective treatments are the non-diagnostic characteristics that a patient brings to a therapy experience (Beutler & Clarkin, 1990).

Consequently, STS places less emphasis on diagnostic conclusions and concentrates more strongly on patient predisposing variables in directing clinicians in their clinical decision making process. Patient characteristics, which predispose how one will respond to treatment include sociodemographic background variables, dispositions to respond to environmental forces, and enduring patterns of personality (Beutler & Clarkin, 1990). While age, gender, and social economic status (SES) contribute to treatment length, motivation, and effectiveness, there is little indication that it is differentially associated with the value of specific therapeutic procedures, formats, or modalities (Beutler & Clarkin, 1990). Patient predisposing qualities are operationalized as both trait and state like characteristics represented as continuous variables (Beutler & Clarkin, 1990; Beutler & Harwood, 2000). In general, the following dimensions are of interest: (1) level of functional impairment, (2) patient coping style, particularly level of externalization and impulsivity; (3) level of patient resistance; and (4) level of subjective distress (Beutler & Harwood, 2000). Combined, these four factors constitute the major predisposing qualities that contribute to effective treatment planning.

Functional Impairment

Patient level of functional impairment is reflected in three concrete indices (Beutler & Harwood, 2000). The first of these is the presence of family problems, either in the nuclear or the contemporary family. Second, is the presence of social isolation and withdrawal. The third index identifies the presence of supportive relationships. The clinician can gather such information through both indirect and direct methods such as observing patient interactions, asking the patient about close friendships/relationships, obtaining a global measure of functional impairment from the Global Assessment of Functioning (GAF) scale used in the DSM-IV, or reviewing the subscales in the STS Clinician Rating Form that capture these dimensions (Beutler & Harwood, 2000). Once identified, the level of treatment intensity correlates with the number of items on which a problem is indicated. The type of treatment, length of treatment, and number of sessions is determined accordingly.

Coping Style

A coping style is a pattern of defense mechanisms an individual employs in response to situations/environments that pose as a potential danger or threat to one's wishes, values, impulses, and/or beliefs (Beutler & Clarkin, 1990; Beutler & Harwood, 2000). The specific defense mechanisms recognized in DSM IV-TR (APA, 2000) include acting out, autistic fantasy, denial, devaluation, displacement, dissociation, idealization, intellectualization, isolation, passive aggression, projection, rationalization, reaction formation, repression, somatization, splitting, suppression, and undoing (Beutler & Clarkin, 1990; Beutler & Harwood, 2000). These defenses fall into two broad characteristic clusters categorized as externalizing and internalizing coping styles. People that cope by acting out or placing responsibility on environmental factors are considered externalizers (Beutler & Clarkin, 1990; Beutler & Harwood, 2000). Contrastly, those that passively react and turn inward are classified as internalizers (Beutler & Clarkin, 1990; Beutler & Harwood, 2000). Although, individuals tend to reflect one style or the other, more frequently a patient exhibits both internalizing and externalizing patterns at different points in time or with different conflicts (Beutler & Clarkin, 1990; Beutler & Harwood, 2000). The therapist may use several MMPI-2 subscales that are specific measures of coping and/or the STS Clinician Rating Form to help identify a patient's coping style. Current understanding suggests that internalizers generally benefit from conflict-focused treatment while externalizers respond positively to behaviorally and symptom focused interventions (Beutler & Clarkin, 1990; Beutler & Harwood, 2000).

Resistance Level

Resistance level is a reflection of a trait of "interpersonal reactance" which refers to one's inclination to respond to interpersonal influence, oppositionally. Resistance occurs when a patient's sense of freedom, power, or control is jeopardized (Beutler & Clarkin, 1990; Beutler & Harwood, 2000). While it is typically thought of as an enduring quality, level of resistance is also expressed as a situational reaction to threatened loss of control or power (resistant states) (Beutler & Harwood, 2000). Patient's trait level of resistance guides the selection of a strategy that employs the use of patient-directed or therapist-directed activities. That is, low levels of resistance indicate therapist directed activities while high resistance levels suggest more patient directed interventions. This general rule is applied as therapeutic change is thought to most likely occur when therapeutic procedures do not evoke patient resistance and therapeutic change is greatest when the directiveness of the intervention is either inversely correspondent with the patient's current level of resistance or authoritatively prescribes a continuation of the symptomatic behavior (Beutler & Harwood, 2000).

Subjective Distress

Subjective distress is a measure of "how bad a patient is feeling" (Beutler & Harwood, 2000). Patients typically present for therapy when they can no longer deal with the amount of pain they are experiencing. This acts as a motivating factor for the initiation of change and is also used to assess outcomes of treatment. Thus, the management of emotional intensity is a central process in most psychotherapeutic endeavors (Beutler & Harwood, 2000). At the end of treatment, questions are asked in order to assess for the amount of change that has occurred in feelings of being sad, depressed, angry, or fearful to properly evaluate the effectiveness of treatment. In determining patient's level of subjective distress, it is useful to distinguish among different types of emotions and to identify which emotions the patient is feeling. Research has identified six emotions including love, joy, fear, sadness, surprise, and anger as primary emotions found in young children and across cultures (Beutler & Harwood, 2000). Emotions are further distinguished as either state-like or trait like and this is related to how pathological or disturbed the patient is judged to be. Persistent emotional traits are associated with poor treatment prognosis while acute emotional reactions are thought to signal a good prognosis. Hence, the level of state like emotional reactions serves as indicators for the use of specific interventions that either raise or

lower emotional discomfort. Moreover, maintaining a moderate level of subjective distress is essential in sustaining the desire for change.

Context of Treatment

The predisposing qualities that a patient brings to the therapy experience guides the therapist in determining the context of treatment with regard to the *setting* in which treatment will occur, the *mode/format* of therapy, and the *frequency/duration* of therapy. The level of patient distress and present and past environmental stressors dictates whether an inpatient or outpatient treatment setting is most appropriate. If a patient presents in crisis mode, an inpatient setting is suggested. If a patient is deemed appropriate for outpatient treatment, the next step is taken in which the mode of therapy format is decided upon. At this level, the therapist selects either a psychosocial or medical/somatic mode of treatment. If a psychosocial mode is suggested, the format of therapy in the form of individual, group, or marital/family is ascertained. On the other hand, if a medical/somatic mode is selected, a pharmacological format is taken. This then directly influences the decision for the frequency/duration of the treatment context. A crisis intervention, short-term, or long-term duration is selected. At this time, a no treatment decision may also be made. This may be done if (1) treatment is not necessary, (2) treatment may have no effect, (3) treatment may be a factor in worsening the patient's condition, or (4) the prescription of no treatment may be a therapeutic move (Beutler & Clarkin, 1990).

Relationship Variables

Too often, the role of the therapeutic relationship in treatment outcome is labeled as "nonspecific" or considered as a "placebo" or "common" effect (Beutler & Clarkin, 1990). In doing so, this incorrectly implies that they function in the same way in all treatments and for all patients. However, in a National Institute of Mental Health (NIMH) study of psychotherapy and depression, it was reported that the therapist's specific skills increased in proportion to the presence of general, facilitative qualities present in the treatment (Beutler & Clarkin, 1990; Rounsaville, et al, 1987). This suggested that general relationship qualities are more accurately viewed as "potentiating" factors which catalyze the skillful selection and deployment of specific interventions than they are as "nonspecific" or "common" factors (Beutler & Clarkin, 1990). Taken from this perspective, "treatment is the study of persuasion and influence in the process of healing, behavior change, and skill enhancement" (Beutler & Clarkin, 1990).

As an agent of change, the therapist works to influence the patient's feelings, insights, attitudes, viewpoints, or behaviors (Beutler & Clarkin, 1990). In the service of accomplishing these changes, the therapist attempts to establish an influential relationship, in which the therapist directly impacts the nature of these changes. To maximize the patient's willingness to try a suggested intervention, the therapist first needs to establish a collaborative, supportive, caring, trusting, and respectful relationship. Developing such a relationship is not an inherent aspect of the therapeutic relationship but rather a complex interaction of innate patient and therapist qualities (Beutler & Clarkin, 1990).

Specifically, in STS, the relationship variables fall into two general groups consisting of *compatibility matching criteria* and *relationship enhancement skills*. The personal compatibility matching dimensions include *demographic similarities* and *interpersonal response patterns*, while relationship-enhancing skills is further subcategorized as *role induction methods* and *in-therapy environment management* (Beutler & Clarkin, 1990).

Demographic Similarities

Generally, demographic similarities in relation to age, gender, ethnicity, and social economic status (SES) between the therapist and patient have been shown to be important in the early stages of

treatment for facilitating positive perceptions of the relationship, enhancing commitment to the therapeutic process, and enhancing the therapeutic alliance (Beutler & Clarkin, 1990). These similarities are often used by the patient as the basis for establishing trust and in determining how likely they are to be understood. Ethnic similarity has been found to be particularly important for minority patients and is associated with increased commitment to treatment. However, in producing actual change in beliefs and behaviors, the differences in interpersonal attitudes appear to be most influential (Beutler & Clarkin, 1990).

Interpersonal Response Patterns

In determining and establishing compatibility between therapist and patient, an understanding of interpersonal response patterns is also suggested. An examination of these patterns requires matching of personal strivings, beliefs, and attributions. The available research suggested that patients and therapists work most productively together when they represent contrasting viewpoints around patterns of strivings in interpersonal behavior. For example, patients that are dependent, attachment-oriented tend to work well with therapists who value personal autonomy while autonomous patients respond positively to attachment oriented and affiliative therapists (Beutler & Clarkin, 1990). When considering patient and therapist beliefs, in relation to compatibility, it appears that shared humanitarian and intellectual values is indicated while discrepant views of personal safety and the value of interpersonal intimacy and attachment are suggested (Beutler & Clarkin, 1990). Attributions in the area of control seem to be most indicative of therapist/patient compatibility. It appears that similarity of attributed locus of control facilitate a therapeutic alliance. However, more importantly, therapists should be well informed of the combative potential existing within a treatment relationship. The therapist has to be able to adapt as needed.

Relationship Enhancement Skills

Having established credibility and trust in building the therapeutic alliance, the next phase is the enhancement and maintenance of this relationship. With this in mind, it is stressed that it is the therapist's task to sustain constant sensitivity both to problems which emerge in the collaborative alliance and to the current quality of that alliance, adjusting the approach applied accordingly (Beutler & Clarkin, 1990). Procedures proposed for enhancing the therapeutic relationship fall into two broad classes: (1) role induction and (2) in-therapy environmental management (Beutler & Clarkin, 1990).

Role Induction

Role induction describes "efforts to prepare patients for treatment by educating them about treatment roles and outcomes before psychotherapy actually begins" (Clarkin & Beutler, 1990) with the purpose of creating a positive sense of the therapeutic experience and outlining appropriate expectations for treatment. The procedures of role induction are subclassified under three headings: (1) instructional methods, (2) observational and participatory learning, and (3) treatment contracting. Instructional methods consist of providing direct written or verbal information about the nature of therapy and roles expected of the patient and therapist. This is typically done in the initial session in which the therapist encourages questions and provides clarification, if necessary. The second method of role induction is the use of pre-therapy modeling and/or practice, designed to develop the skills, which facilitate treatment response (Beutler & Clarkin, 1990). Audiotapes or videotapes are used to introduce patients to the basic elements of therapy. Another common observational method is to have patients meet with someone other than their own therapist every three or four sessions to discuss problems, which may arise with therapy or the therapist and then information or suggestions are provided to effectively address these concerns (Beutler & Clarkin, 1990). The third role induction method, therapeutic contracting consists of strategies ranging from signed agreements to requiring the patient to deposit money as a contingency for

achievement of predetermined goals. The contracts can be employed within individual treatment sessions or as a general treatment agreement as a whole. Together, these role induction methods are designed to help establish treatment as a collaborative experience.

In-Therapy Environment

A number of in-therapy external factors also contribute to maintaining the therapeutic bond. These include styles of communication and interaction, which cut across theories and formal procedures such as *nonverbal styles*, *situational stimuli*, and *verbal behavioral styles* (Beutler & Clarkin, 1990).

A good deal of research has stressed the value of nonverbal cues such as intense eye contact and the use of touch in expressing empathy and understanding in the therapeutic interaction (Beutler & Clarkin, 1990). The use of touch is suggested for emotional arousal, for those with high affiliation needs, and between female therapist and patient interaction. The prolonged gaze and touch may be contraindicated between two male members of the therapeutic dyad, particularly if patient reactance level and competitiveness are high (Beutler & Clarkin, 1990).

The second variable, situational stimuli describe the messages not transmitted directly from the therapist but continue to serve as nonverbal messages of support (Beutler & Clarkin, 1990). Situational cues include the use of open or private spaces, the selection of seating arrangements, physical distance, and proximity between therapist and patient. Open spaces are contraindicated for patients who are at risk for suicide or pose a danger to others; while close proximity is contraindicated when initially attempting to establish a treatment relationship. Among the overcontrolled and emotionally insulated patients, physical distance and seating arrangement is used to increase arousal levels.

Much of psychotherapy consists of verbal activity. Thus, it is essential to utilize verbal behavioral styles that are most consistent with maintaining a positive therapeutic relationship. Indicators of therapist verbal activity level are patient disturbance level and verbal facility. It is suggested that the therapist's activity needs to match or be slightly discrepant from that of the patient. Generally, high therapist activity is contraindicated when patients have few verbal skills or are extremely distraught and agitated.

Intervention Selection

The tailoring of specific strategies and techniques to the individual needs of the patient is a complex interaction of the variables previously discussed. Depending on the combination produced by these interactions, it will direct the therapist to maneuver through several levels of decision making to select an appropriate intervention without adherence to any particular theoretical orientation. Rather, STS operates on the assumption that each theoretical philosophy has been empirically shown to have its own advantages and disadvantages. STS uses this knowledge to select optimal intervention selection. There are four layered dimensions, proceeding from relatively grossly defined distinctions among theoretical systems to specific listings of procedures. These four levels of therapeutic selection include: (1) selecting focal targets of change, (2) selecting levels of intervention, (3) determining mediating goals, (4) the intra-therapy structure required for initiating productive work, and (5) maintenance and relapse prevention (Beutler & Clarkin, 1990).

Selecting Focal Targets of Change

Determining the focus of therapy by deciding on the main areas that need change and improvement is the first step in the selection of specific strategies and techniques. This gives the therapist and patient a mutual understanding of the direction in which treatment will proceed, provides an ending point for the

treatment process, and is directly related to the assessment of patient outcome (Beutler & Clarkin, 1990). Fundamentally, there are two types of therapeutic foci, symptomatic and conflictual, corresponding to the global objectives of psychotherapy (Beutler & Clarkin, 1990). In other words, are the problems manifested representing a transient response or a persistent and recurring pattern maintained by internal conflict? Once the decision has been made, it is the task of the therapist and patient to define the specific symptoms or conflicts that require work. In general, the following guidelines provide a good rule of thumb:

- (1) patients with a simple, unidimensional symptom or situation specific problem, the treatment focus is one on behaviors that define the symptom
- (2) patients with complex problems that are not easily understood in terms of environmental stresses, the treatment foci are likely to be conflict focus, but this approach is most likely to succeed if a symptom focus is first initiated to reinforce patient confidence in the change process.

Selecting Levels of Intervention

Once the focus targets have been established, the next level of decisional treatment analysis is selecting levels or depth of intervention. The level of intervention is a direct function of level of experience and patient coping style. The available research suggested that behaviorally targeted therapies appear to induce better results among patients who have a tendency to externalize their distress. Conversely, therapies that directly address the level of unconscious motives and feelings are more effective for those patients who internalize sources of stress (Beutler & Clarkin, 1990).

Symptom Focus

When the primary focus is one of symptom/behavioral change, combined with a patient of low complexity, there is considerable flexibility in the selection of procedures. These interventions include methods of identifying contingent events, antecedent stimuli, mediating cognitions, and sustaining reinforcements. The specific therapeutic foci are commonly consistent with the behavioral or cognitive therapy foci. Common strategies utilized in symptom focused treatment include social skills training, exposure to avoided events, graded practice, reinforcement, identification of cognitive errors, evaluate degree of distortion, challenging dysfunctional assumptions/beliefs, self monitoring, self instruction, practice alternative thinking, and testing new assumptions (Beutler & Clarkin, 1990). All of these interventions are designed to produce symptom relief.

Conflict Focus

On the other hand, the range of effective interventions for patients with complex, conflictually-based patterns of disturbance is much broader than it is for patients with discrete and reactive problems. The more reliant the patient is on internalizing defenses, research suggests the more valuable experiential and expressive procedures are in producing change (Beutler & Clarkin, 1990). For instance, in working on addressing undesirable emotions in the internalized patient, the therapist may employ strategies such as two chair work on emotional “splits”, structured imagery, dream work, and free association. The general rules that apply to matching patient coping styles to the levels of experience addressed by the therapy procedures consist of the following:

- (1) patients with externalized coping styles respond positively to interventions concentrating on skills building and symptom removal

- (2) patients with internalized coping styles react well to interventions concentrating on the use of insight and relationship-focused procedures.

In summary, the procedures indicated for externalizing patients are aimed at the behavior or symptomatic level. However, for the internalizing patient, a broader range of interventions are employed that stress building insight and emotional awareness. Furthermore, among internalizing patients, with the presence of external symptoms, in order to maximize change, it is suggested that symptom reduction and risky behaviors first be addressed and under control before beginning work on conflict or insight goals (Beutler & Harwood, 2000).

Determining Mediating Goals

Having developed the main goals for therapy, the next task is to clearly delineate the steps that need to be taken to get a patient from where he/she currently is to where the patient would like to be. This can be done through determining mediating goals. Mediating goals define the sequence of anticipated change (Beutler & Clarkin, 1990). Prior to establishing mediating goals, the therapist must decide at which phase of treatment the patient is currently in—the engagement, the pattern search, the making changes, or the planning for termination phase. Mediating goals varies accordingly, depending on the phase of treatment. In particular, during the making changes phase of treatment, the therapist also needs to consider the basic “change processes” which consist of the precontemplative, contemplative, action, and maintenance phase (Beutler & Clarkin, 1990). Again, the effectiveness of the intervention applied is contingent on the phase of the change processes.

Conducting Therapeutic Work

Finally, the considerable specificity of technique selection comes from an awareness of the moment-to-moment psychotherapy transactions (Beutler & Clarkin, 1990). Throughout the therapy process, consistent fluctuation in the patient’s emotional state is to be expected. Thus, being receptive to these changes allows the therapist to capitalize on these moments and to tailor interventions to optimize treatment outcome. Indirect/direct observations and self disclosure are techniques that have been suggested to increase the therapist’s ability to recognize these ever changing moments (Beutler & Clarkin, 1990).

Maintenance and Relapse Prevention

As in most relationships, the therapeutic relationship is also one that needs constant work and attention to maintain the connection and alliance. In line with this, the therapist is advised to manage the level of arousal or distress in order to keep these experiences within a range that is conducive to effective work (Beutler & Clarkin, 1990; Beutler & Harwood, 2000). The most powerful tool for maintaining arousal is the therapist’s powers of persuasion and inference.

However, one unique quality of the therapeutic relationship is that it always results in termination. This moment in the therapeutic process is both joyous as the patient has accomplished the goals initially set in therapy and scary as the patient is about to embark towards the unwritten future. Like a child leaving home for the first time, the patient may benefit from booster sessions that serves as a reminder of the skills developed and as a support system for the patient in juggling these skills on his/her own.

Summary of Core Concepts

The four main principles of STS include patient predisposing qualities, treatment context, relationship variables and selection of specific interventions. The interaction of the first three variables guides the therapist to a systematic derivation of unique strategies and techniques. Viewed from this perspective, it can be seen as analogous to a linear equation such as $X = A + B + C$. Let's assume that the product (X) is equivalent to specific interventions and the three variables (A, B, & C) are equivalent to the three core variables (patient predisposing qualities, treatment context, relationship variables), respectively. To find the product, the variables first need to be identified. This is typically done according to a systematic procedure, in which particular steps are followed based on established guidelines. Once, each variable is determined, the additive power of each variable results in the selection of specific interventions.

Step 1: Find A (Patient predisposing variables).

To find A:

Step 1a: Determine patient level of functional impairment (low vs. high).

Step 1b: Determine patient coping style (externalizing vs. internalizing).

Step 1c: Determine patient level of resistance (low vs. high).

Step 1d: Determine patient level of subjective distress (low vs. high).

(Note: These can be determined using subscales of the MMPI-2, STS Clinician Rating Form, and other established personality assessment measures.)

Step 2: Find B (Treatment context).

To find B:

Step 2a: Determine the treatment setting (inpatient vs. outpatient).

Step 2b: Determine the mode and format (psychosocial or medical/somatic; individual, group, or marital/family or pharmacological treatments).

Step 2c: Determine frequency/duration (crisis, short term, long-term, or no treatment).

Step 3: Find C (Relationship variables).

To find C:

Step 3a: Determine personal compatibility (demographic variables: age, gender, ethnicity, & SES and interpersonal variable: strivings, belief/values, & attributions).

Step 3b: Determine relationship enhancement skills (role induction methods: instruction, observation, & contracting, and in therapy environment management: nonverbal styles, situation cues, situation cues, & verbal styles).

Step 4: Find D (Intervention selection).

To find D:

Step 4a: Add A, B, & C (behavioral or symptom focus vs. conflict focus).

The principles of STS can be applied linearly and systematically to identify specific strategies and techniques. Following this systematic procedure allows for consistency between clinicians in the application of this model and for direct assessment of the fidelity in its application.

Conclusions

The STS model of decision-making was derived from the application of 18 empirically derived principles of behavior, each one of which describes the conditions under which a given type of person

with a particular kind of problem is most likely to change. These principles permit the development of a tailored treatment plan that includes a broad range of treatment procedures, all bearing on a few defined treatment strategies. Treatment recommendations vary from procedures that are applied within a relationship-focused counseling program to those that govern the application and use of psychoactive medications, to the use of restrictive environmental controls, to the use of highly specialized techniques of individual and multi-person therapies. Ten of the 18 principles that have been applied to the STS model can be adapted to the case of individual psychotherapy. Prescriptive Therapy (PT; Beutler & Harwood, 2000) is the name given to this application of individual treatment. It is designed to address the differences that exist among individuals more effectively.

Our goal was to provide a framework from which clinicians can systematically work to help patients. The next logical step is to effectively disseminate and implement this model to professionals in the mental health field. One such strategy is the training of graduate students to work from a patient based perspective, highlighting the utility of varying techniques depending on the qualities of the patient. For those who have already developed allegiance to a particular orientation, exposure through training workshops may be useful. This is found to be most effective when combined with continued coaching and specific feedback in small group case presentations, and the utilization of tape-recorded sessions with direct feedback in supervision (Fixsen, et al., 2005). However, this is not a simple task. It requires cooperation and participation of leaders and administrators in the psychology field to work together to begin putting ideas into actions by initiating major changes in the current established structures of training programs and mental health systems.

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Author Contact Information

Tam T. Nguyen, M.S.
Pacific Graduate School of Psychology
3744 Pruneridge Ave.
Santa Clara, CA 95051
tnguyen@pgsp.edu

Matteo Bertoni, M.S.
Pacific Graduate School of Psychology
935 E. Meadow Drive
Palo Alto, CA 94303
mbertoni@pgsp.edu

Mylea Charvat, M.S.
Pacific Graduate School of Psychology
601 California Street, 18th Floor
San Francisco, CA 94108
mcharvat@pgsp.edu

Anahita Gheyntanchi, B.S.
Pacific Graduate School of Psychology
1032 Ramona Street
Palo Alto, CA 94301
agheyntanchi@pgsp.edu

Larry E. Beutler, Ph.D.
Pacific Graduate School of Psychology
935 E. Meadow Drive
Palo Alto, CA 94303
lbeutler@pgsp.edu

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