A New Therapy for Each Patient

Personalizing the Connection

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Workshop Description

Psychotherapy will maximize its effectiveness by targeting the most powerful sources of change: the therapeutic relationship & the patient. This workshop will provide integrative methods for adapting/tailoring psych treatments to individual clients and their singular contexts. Learn to reliably assess and rapidly apply 3+ evidence-based means for demonstrably improving outcomes. Discover how research and practice converge in responsiveness that fits both clients and clinicians.

Connections

Our Objectives

At end of the workshop, participants will be able to:

- determine a client's treatment and relationship preferences in ways that improve outcomes
- assess reliably a client's stage of change within one minute and tailor treatment to that stage
- tailor therapy to a patient's level of reactance and coping style, thereby decrease dropouts

That is, "personalize" psychotherapy for each patient

Workshop Schedule

I. A Primer on Responsiveness

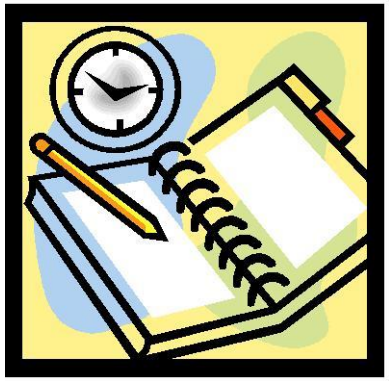
II. Evidence-Based Responsiveness

- ♦ patient preferences
- ♦ reactance level
- ♦ stages of change
- ♦ coping style

III. Integration and Limitations

Limitations & alternatives

Conclusions and a parable



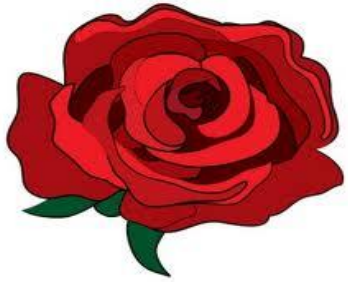
I. A Primer on Responsiveness

Basis for Responsive Matching

- Direct research evidence of effectiveness (*not* anecdotal)
- Across theoretical systems (*not* from a single theory)
- Multiple diagnostic *and* nondiagnostic features (*not* simply diagnosis)
- Treatment method *and* therapy relationship (*not* only method)
- Matching across the course of therapy (*not* only pre-treatment)

A Rose by Many Names

- tx selection
- prescriptionism
- differential therapeutics
- treatment matching
- tailoring
- customizing
- aptitude by tx interaction (ATI)
- **individualizing**
- **personalizing**
- *treatment adaptation*
- matchmaking
- specificity factor
- *responsiveness*



What Every Clinician Knows

- No treatment works for all patients; what works for one patient may not work for another
- Paul's 1967 iconic question: *What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem?
- Only matching psychotherapy to a disorder is incomplete and not always effective
- Adapt or match to the transdiagnostic features of the individual patient and the singular context

Dodo Bird for Most Disorders but NOT Most People

- Tested psychotherapies tend to produce similar outcomes for most behavioral disorders (Dodo bird verdict)
- BUT not for diverse individuals
- Individual tailoring using similarity in some cases (e.g., culture) and complementarity/theory of opposites (e.g., reactance) in others

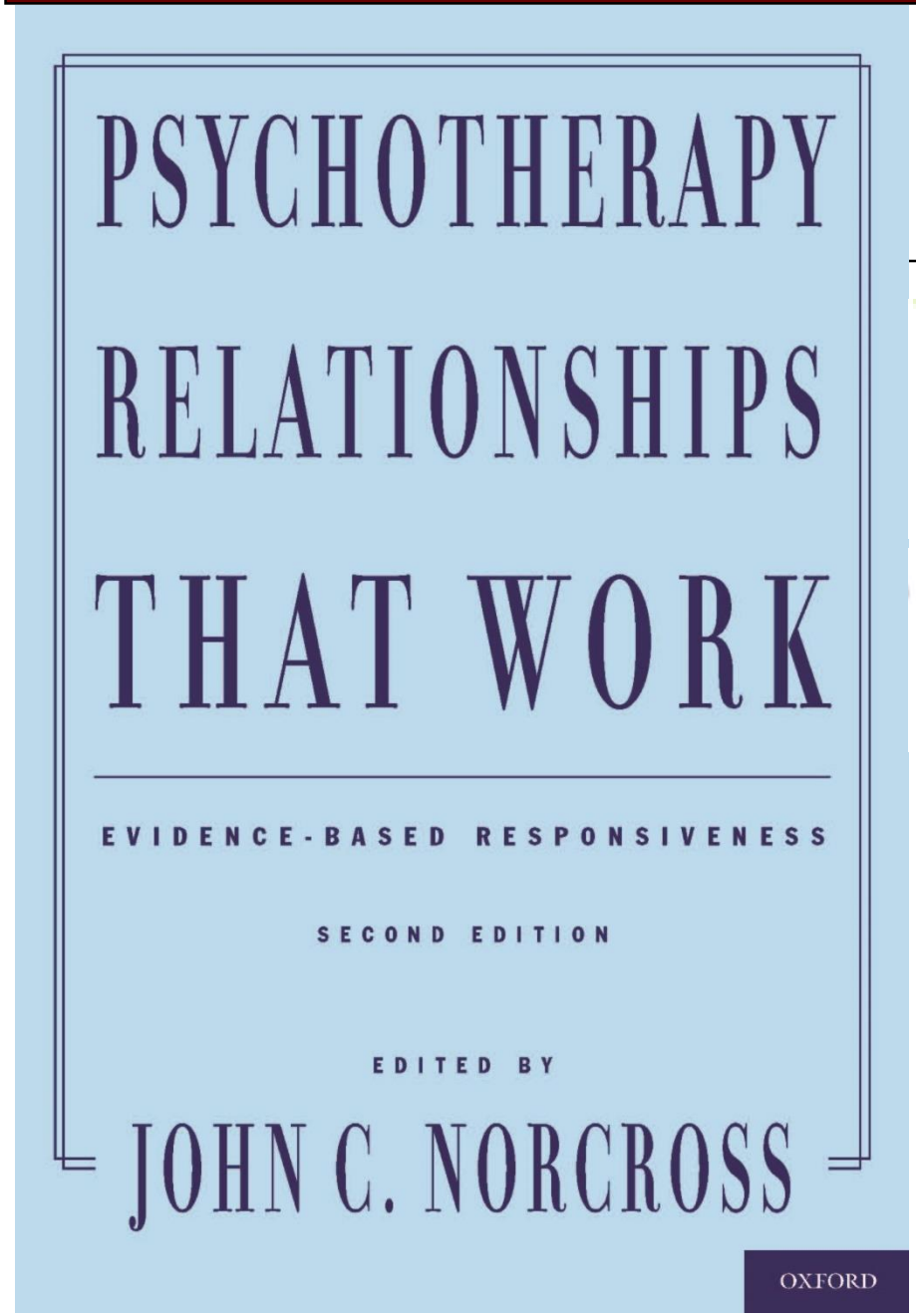
Personalized Psychotherapy

- Similar to premise of Precision Medicine
- *Sometimes* predicated on the patient's disorder/diagnosis
- *Always* predicated on transdiagnostic characteristics

When…Then

- An old idea come to evidence-based fruition
- *When* the client presents with this (feature) *then* consider doing this
- Transdiagnostic features predominate
- Matching to the entire person, not only ICD diagnoses

II. Evidence-Based Responsiveness



NREPP

SAMHSA's National Registry of Evidence-based Programs and Practices

Effective Methods of Tailoring/ Adapting Psychotherapy

Reactance Level

Stages of Change

Preferences

Coping Style

Culture

Religion/Spirituality

3+ Matching Methods

1. Patient Preferences
2. Stages of Change
3. Reactance Level
3+ Coping Style

1. Patient Preferences

…it is the *client* who knows what hurts, what directions to go, what problems are crucial, what experiences are deeply buried. It began to occur to me that unless I had a need to demonstrate my own cleverness and learning, I would do better to rely upon the client for the direction of movement in the process.

Meta-analysis Synopsis

- Meta-analysis of 35 studies comparing outcomes of clients matched vs. non-matched to their preferences
- *d* = .31 in favor of clients matched to their tx, role, and therapist preferences
- Patients receiving preferences were a third less likely to drop out of tx prematurely (*OR* = .59)
- Treatment method, relationship style, therapist characteristics, tx length, etc.

Assessing Preferences

- Ask during the initial intake or contact
- Add items to life history questionnaire
- Ask what they experience as most helpful from their friends or previous therapists
- Use semi-structured preference interviews
- Ask patient directly in session
- But ask in a confident, strong tone!

Cooper–Norcross Inventory of Preferences

- C-NIP is a brief, reliable, multidimensional scale of therapy preferences (18 items)
- Yields 4 scores: Client v. therapist directiveness, degree of emotional intensity, past v. present orientation, support v. challenge relationship
- Free of cost and in the public domain
- For research and limited clinical use

Asking In Session

Inquire what patient despises and fears

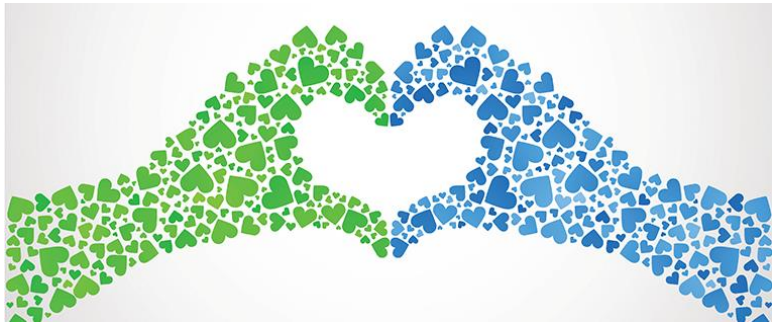
- What do you dislike in a psychotherapist?
- What do you fear happening here?

Inquire about *strong* preferences in terms of

- Treatment method
- Therapy relationship
  - Tepid – Warm (distance)
  - Passive – Active
  - Formal – Informal
- Therapist characteristics
  - Gender
  - Race/ethnicity
  - Sexual orientation
  - Religion/spirituality

Important Matching Caveats

- Conduct all therapy in client's native language (2X as effective)
- Target therapy to a specific cultural group instead of multiple cultural groups (more effective; Griner & Smith, 2006)
- Accommodate ***strong*** preferences whenever clinically and ethically possible



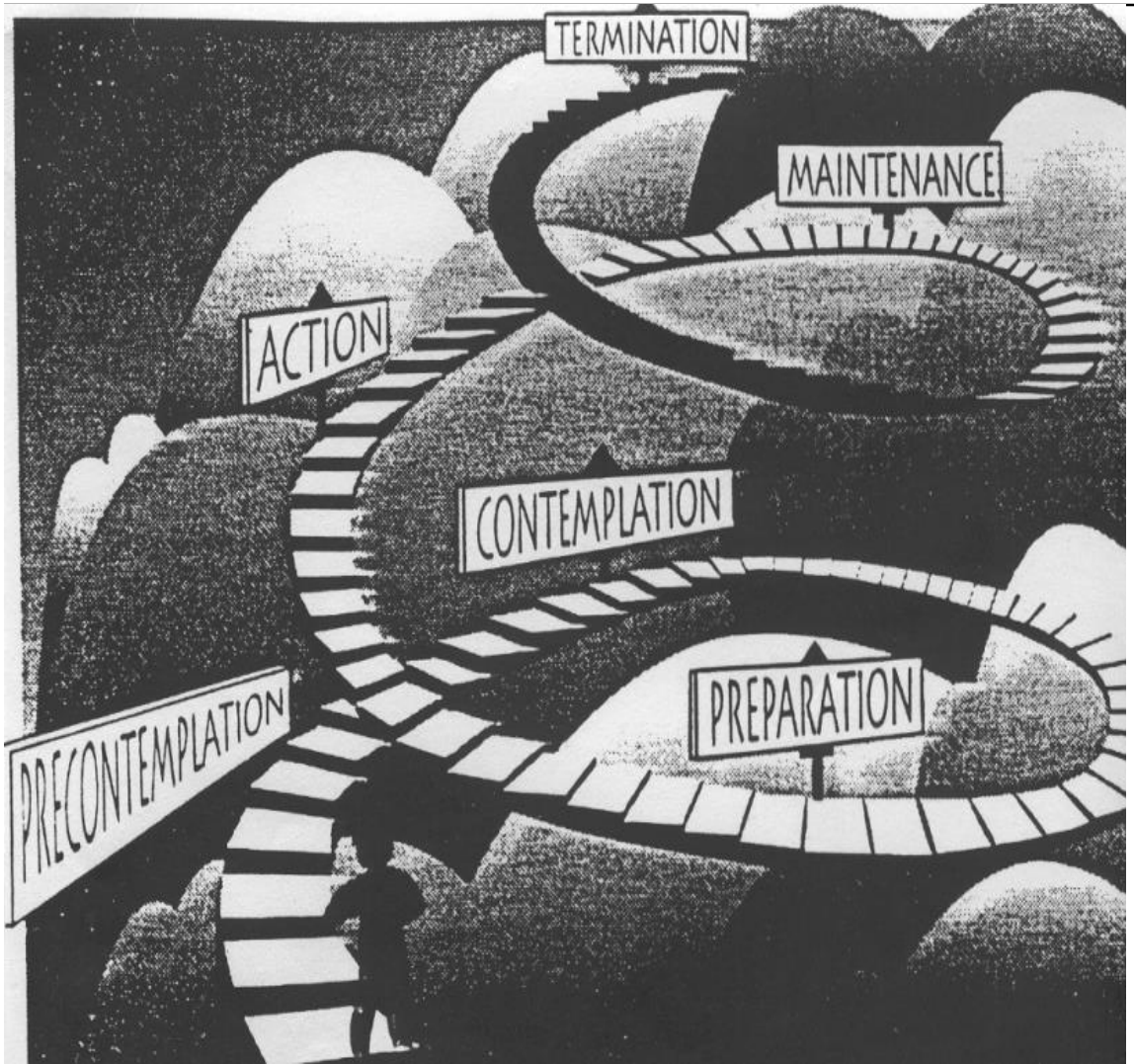
Research Does *Not* Support

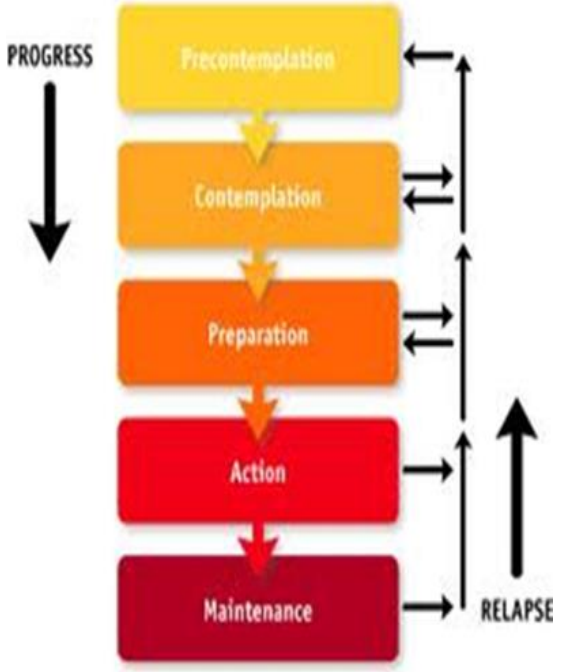
Routine matching of therapist-patient on

- Gender
- Ethnicity
- Religion/Spirituality

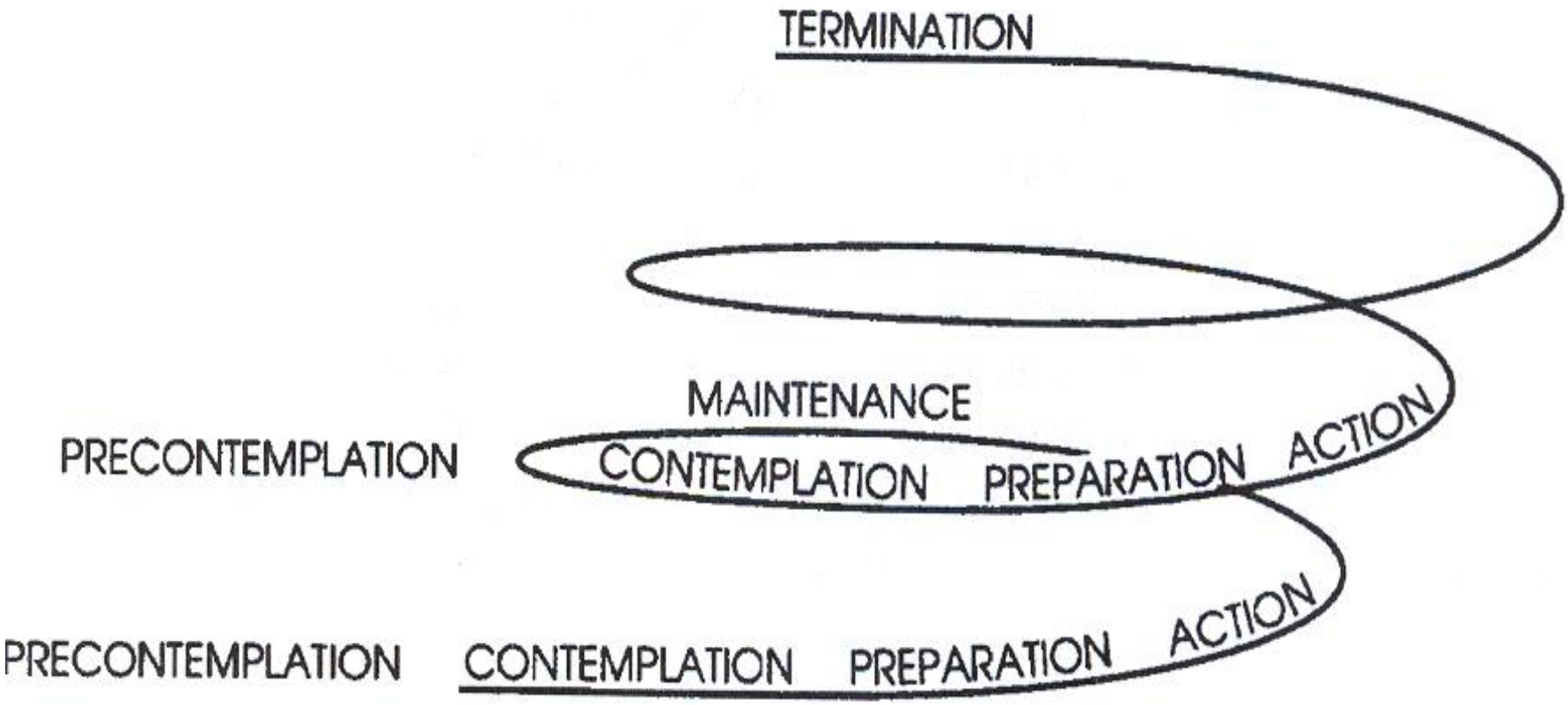
unless client expresses strong preference

2. Stages of Change
(single attempt)





The Spiral of Change
(multiple attempts)



Prevalence

40 - 40 - 20 rule

- 40% precontemplation
- 40% contemplation
- only 20% preparation/early action

Meta-analysis Synopsis

- Meta-analysis of 39 studies (N = 8,238): d = .46 for stages predict psychotherapy outcomes
- Meta-analysis of 47 studies: d = .70 - .80 for different change processes in different stages of change
- The therapist's optimal relational stance also varies with stage of change

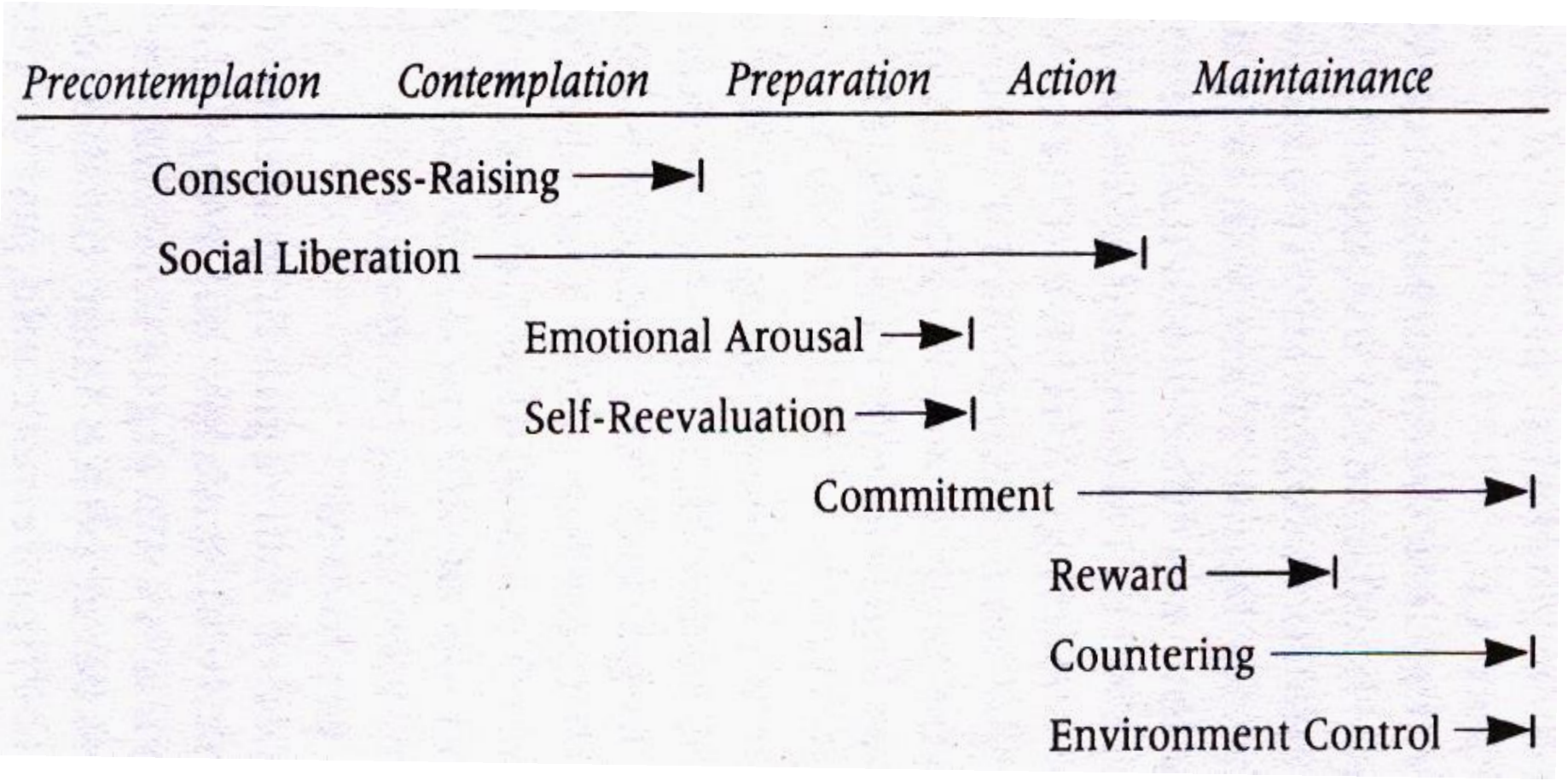
Stages of Change: Discrete Measure

Do you currently have a problem with _____? (If yes, then in cont, prep, or action stage. If no, then precontemplation or maintenance.)

If yes, when will you change it? (Someday = contemplation stage; In the next few weeks = preparation stage; Right now = action stage).

If no, what leads you to say that? (Because its not a problem for me = precontemplation stage; Because I have already changed it = maintenance stage.)

Stages of Change in Which Particular Change Processes are Most Useful



Counterconditioning/Countering

Principle: Substituting healthy responses for problem behaviors. Reciprocal inhibition: two incompatible behaviors will simultaneously inhibit each other. "Do the opposite or something else."

Representative techniques:

Teaching new skill

Active diversion

Behavioral redirection

Exercise

Relaxation/desensitization

Imagery of new behavior

Acceptance/mindfulness

Cognitive restructuring

Assertiveness/social skills training

Delay/impulse control training

Stages of Change: Continuous Measure

Precontemplation

As far as I'm concerned, that behavior doesn't need changing.

Contemplation

I've been considering changing that part of myself.

Action

Anyone can talk about changing; I'm actually doing something about it.

Maintenance

I have been successful in working on my problems but I'm not sure I can keep up the effort on my own.

Your Behavior

Integration of Psychotherapy Systems within Stages of Change

Stages of Change				
Precontemplation	**Contemplation**	**Preparation**	**Action**	**Maintenance**
Motivational interviewing			Behavior therapy EMDR and exposure	
	Adlerian therapy		Rational-emotive behavior therapy Cognitive therapy	
Sullivanian therapy	Transactional analysis		Interpersonal therapy (IPT)	
Strategic therapy	Bowenian therapy		Structural therapy	
Psychoanalytic therapy	Existential therapy		Gestalt therapy	

Prescriptive Guidelines for Stages of Change

- Assess the patient's stage of change
- Educate patient about the stages – change as a developmental process
- Guide patient in reviewing a successful behavior change through the stages
- Beware treating all patients as though in action
- Recognize that patients in action achieve better outcomes
- Begin sessions by reinforcing maintenance behavior(s) & then move backwards to other stages

Prescriptive Guidelines for Stages of Change II

- Set realistic goals; assist clients one stage at a time
- Facilitate the awareness-action crossover
- Think processes/principles, not techniques
- Do right things (processes) at right time (stages)
- Prescribe stage-matched treatments *and* relationships
- Avoid mismatching stages and processes
- Anticipate recycling (build-in relapse prevention)
- Think theoretical complementarity

3. Reactance Level

- Refers to being easily provoked & responding oppositionally to external demands
- Exists on normally distributed continuum of compliance – defiance
- A client marker for optimal degree of therapist directiveness
- How directive are you as a therapist? It depends!

Meta-analysis Synopsis

- Matching therapist directiveness to client reactance improves patient outcomes in 80% plus of studies
- Meta-analysis of 12 select studies (N = 1,102) reveals d = .76 for matching therapist directiveness to patient reactance
- In concrete terms, this large ES suggests matching (vs. unmatched) increases success rates by 20%

Assessing Reactance

- History of high defensiveness or resistance
- Interpersonal style during intake or session
- MMPI scales (e.g., paranoid, defensive, hostility, resistance to treatment scales)
- Response to early interpretations or homework assignments
- Reactance challenge
- Ask directly!

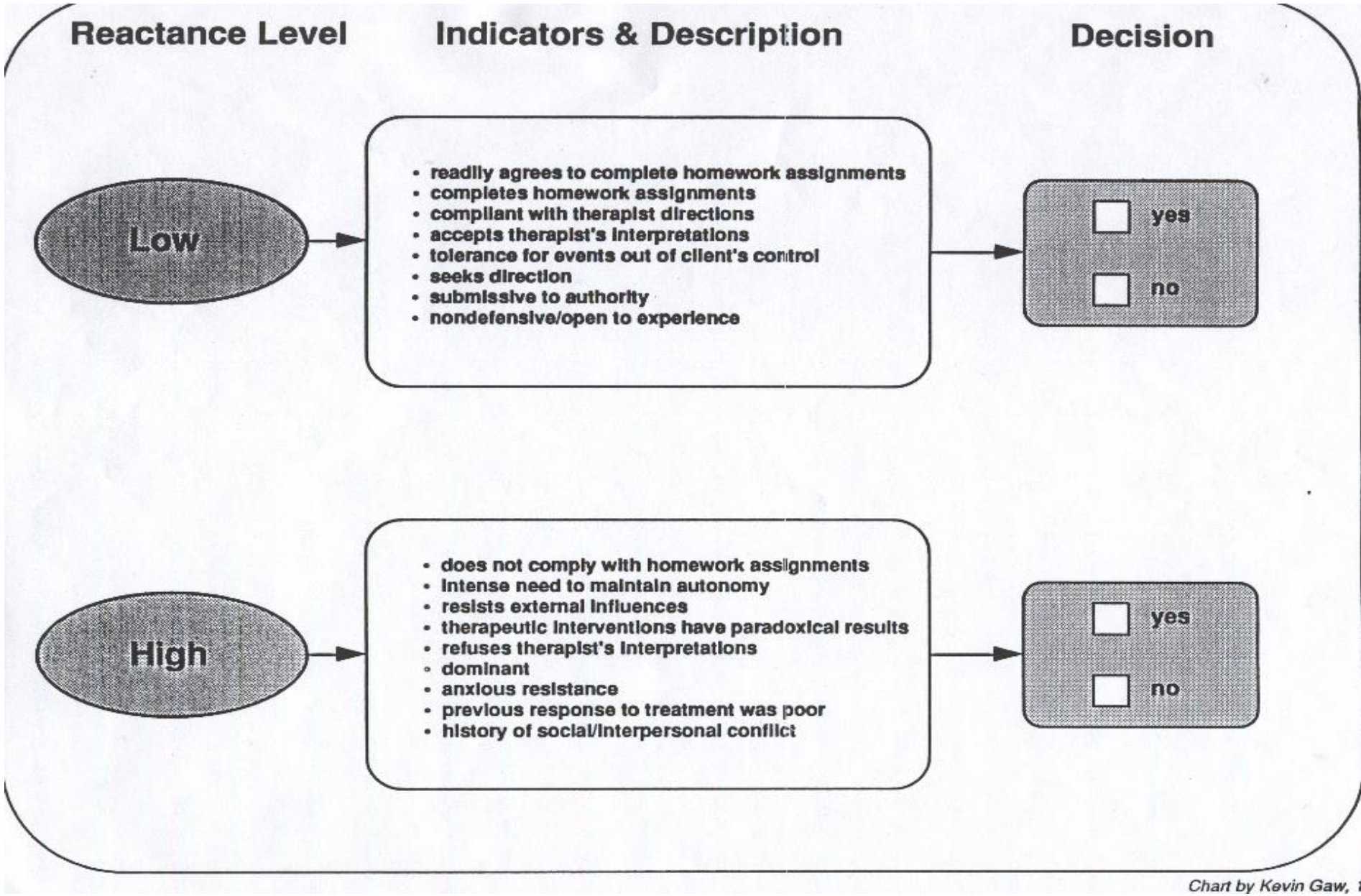


Chart by Kevin Gaw,

Matching to Reactance

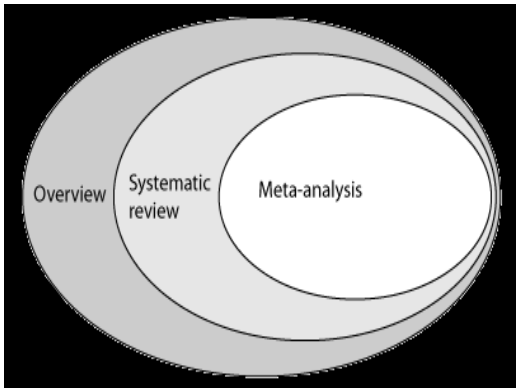
- Remember: match to the patient's reactance level, *not* the therapist's reactance
- High-reactance patients benefit more from self-control methods, minimal therapist directiveness, and paradoxical interventions
- Low-reactance clients benefit more from therapist directiveness and explicit guidance

3+ Coping Style

- Refers to individual's habitual & enduring patterns when confronting new or problematic situations
- Externalizing (impulsive, task-oriented, stimulation seeking, extroverted) vs. internalizing (self-critical, reticent, inhibited, introverted)
- Stable, cross-situational trait (as opposed to stages and other state measures)

Meta-analytic Synopsis

- Well-established among child populations (internalizing vs externalizing disorders)
- Meta-analysis with adult populations indicates medium effect sizes (d = .55) for matching therapist method to patient coping style (k = 12, N = 1,291)
- A strong patient marker for relative balance of insight or skill focus
- Also related to dx in some instances



Assessing Coping Style

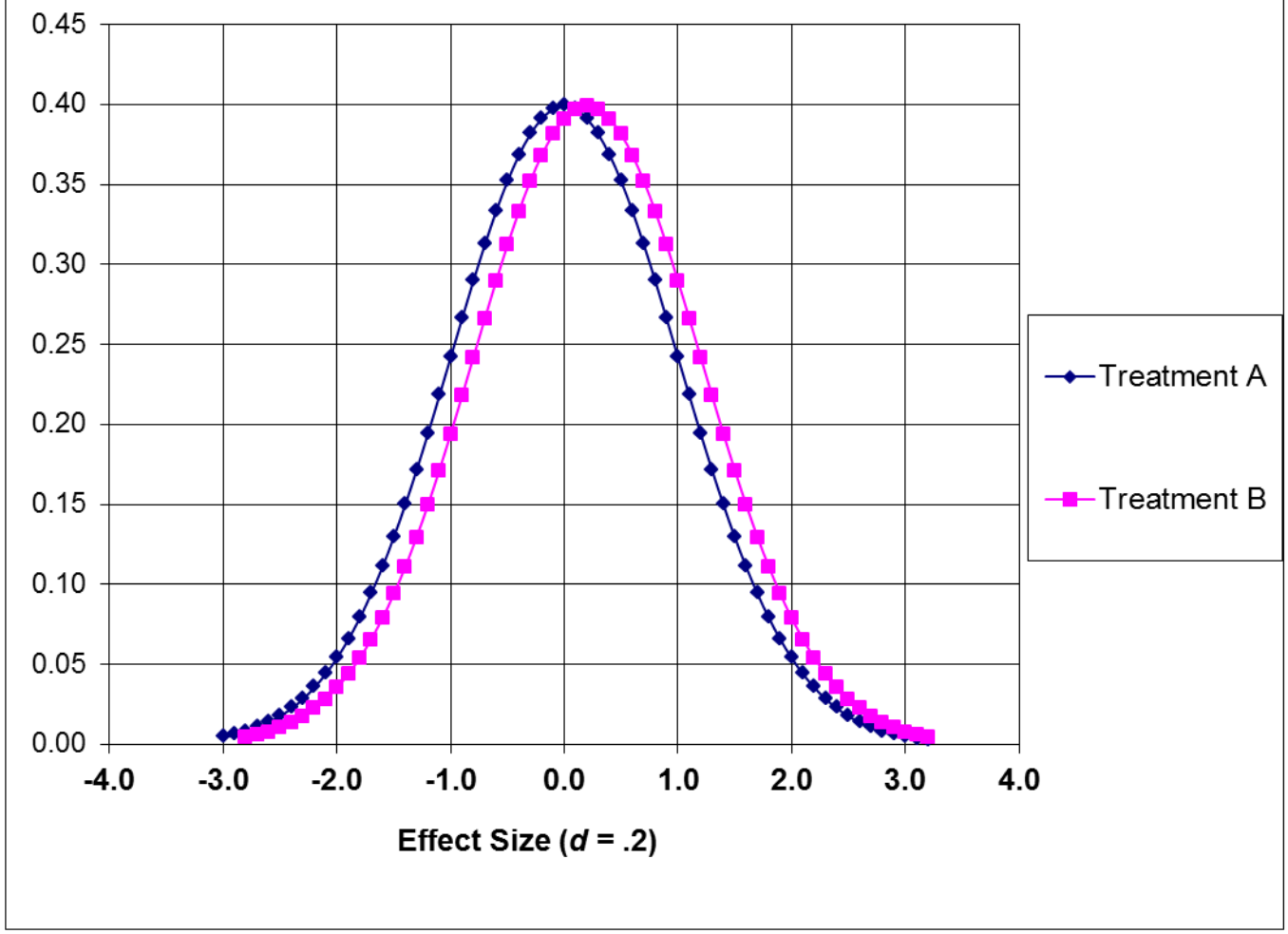
- Clinical observation & patient's presenting problem frequently sufficient to determine if internalizing/introverts, balanced/mixed, or externalizing/extroverts
- Omnibus psych tests, such as MMPI, have internalization ratio (IR) for adults
- Multiple self-report I-E & coping style scales available as well

Matching to Coping Style

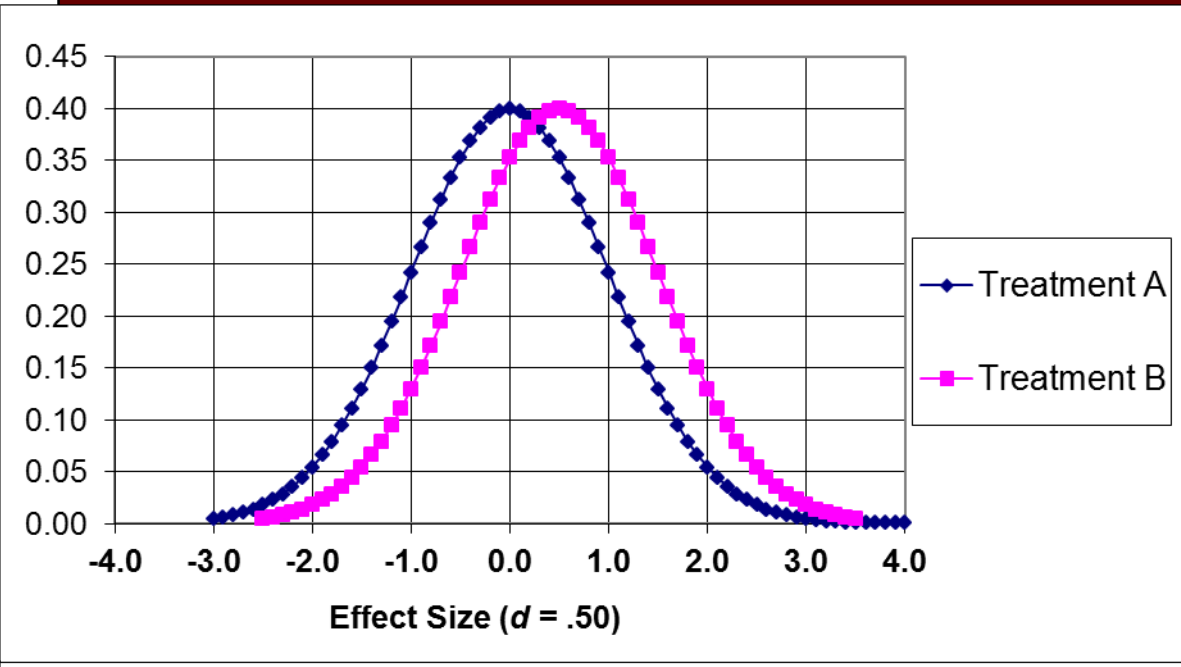
- Interpersonal & insight-oriented therapies more effective among internalizing patients
- Symptom-focused & skill-building therapies more effective among externalizing patients
- But all patients benefit first from clinical stabilization and symptom reduction

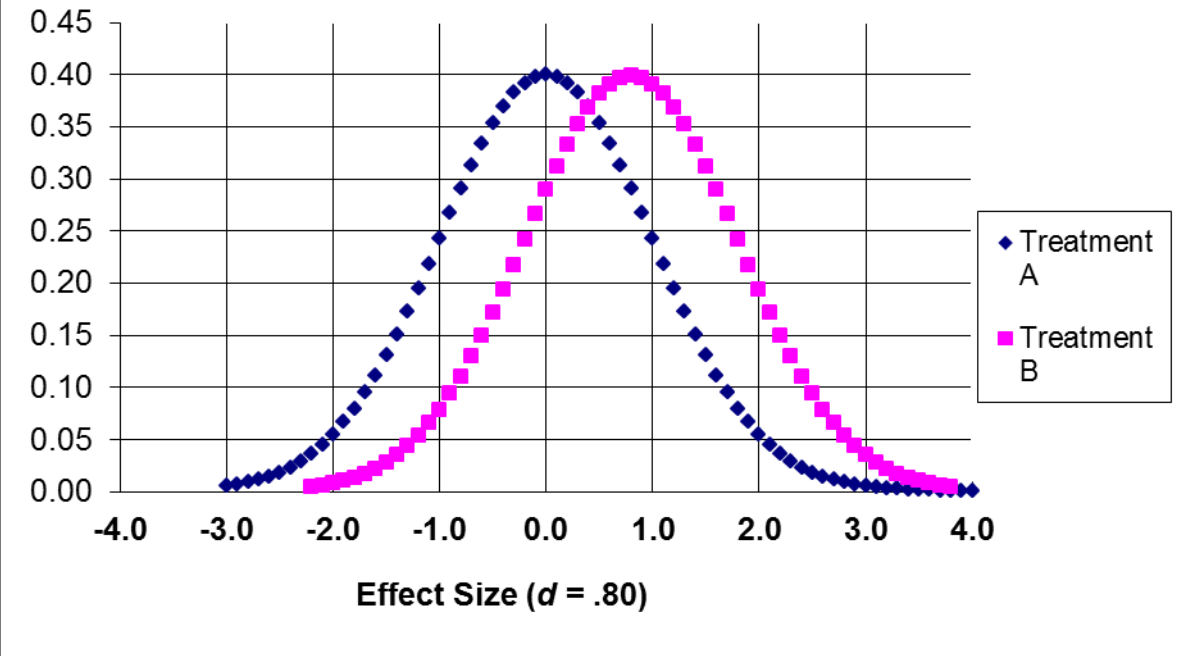
III. Integration and Limitations

Responsiveness Works



Typical ES of 0 to .20 ***when*** there is a difference between tx methods

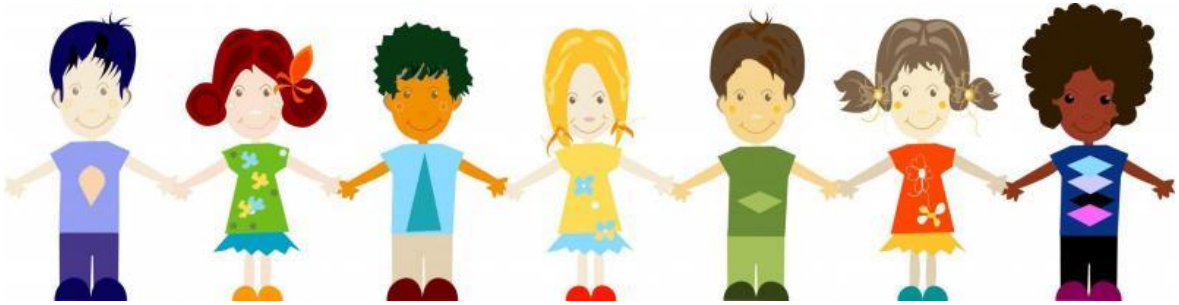




Typical ESs for responsiveness /tx adaptations

Which Therapy Works Best?

- It depends!
- It depends in particular on the client
- Both diagnostic and transdiagnostic features
- And it depends more upon responsiveness than a tx method



Limitations

Limits of human capacity

Possibility of capricious posturing

Moral connotations of flexibility

Alternatives

Practice limits

Differential referrals

Other alternatives

Be a Scientist-Practitioner

Cultivate and customize the therapy relationship

Use research generalities to fit patient particulars

Tailor responsively to the total person

Useful Websites

- www.scranton.edu/faculty/norcross (home page of John Norcross)
- www.uri.edu/research/cprc/ (home of the stages of change)
- www.MyOutcomes.com and www.oqmeasures.com (systems for real-time client feedback)
- www.innerlife.com (Systematic Treatment; matching on reactance and coping style)
- www.ChangeologyBook.com (self-help materials for clients based on stages of change)

Recommended DVDs

- *Client-directed outcome-focused psychotherapy*. (2005). (DVD; approx. 100 minutes). In APA's *Psychotherapy Videotape Series*. Washington, DC: APA. (Scott Miller)
- *Evidence-based treatment.* (2007). (DVD; approx. 100 minutes). In *APA Psychotherapy Videotape Series.* Washington, DC: APA. (Larry Beutler)
- *Integrative therapy*. (2013). (DVD; approx. 65 minutes). In *APA Psychotherapy Videotape Series.* Washington, DC: APA. (John Norcross)
- *Stages of change for addictions.* (2006). (videotape; approx. 100 minutes). In *Brief therapy for addictions video series.* Needham Heights, MA: Allyn & Bacon. (John Norcross)

Recommended Readings I

- APA Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61,* 271-285.
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- Prochaska, J.O., & Norcross, J.C. (2018). *Systems of psychotherapy: A transtheoretical analysis* (8th edition). Pacific Grove, CA: Brooks/Cole.

Recommended Readings III

- Prochaska, J.O., Norcross, J.C., & DiClemente, C.C. (1995). *Changing for good*. New York: Avon.
- Prochaska, J.O., Norcross, J.C., & DiClemente, C.C. (2005). Stages of change. In *Psychologists' desk reference* (2nd ed.). New York: Oxford University Press.
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