Chapter 9

Summary and Conclusions

Prescriptive therapy is an integrated intervention that adapts therapeutic procedures to fit specified patient qualities and characteristics. It is aimed at addressing complex problems such as comorbid substance abuse and depression, but the principles outlined are of general interest and application.

Prescriptive therapy training is a three-tiered system, beginning with the definition of general rules—what we define as treatment principles—and from these extrapolating differential treatment strategies and specific procedures and techniques. Accordingly, we began our description of PT with a review of the problems of applying single-theory formulations of mental health treatment to complex problems. We then reviewed findings that define patient qualities and characteristics that serve as moderators for the differential assignment of treatments. Systematic treatment selection (STS) is one of several models that extracts interventions from various approaches, integrates them, and applies them to patients based on fit. Prescriptive therapy derives from this type of selective process of decision making and cross-theory interventions.

The steps in applying PT began with the description of principles that guide the development and maintenance of the psychotherapy relationship and continued with the articulation of 10 general principles that guide the application of psychotherapy to specific patients, across theoretical orientation. We have focused on three particular matching dimensions and, accordingly, in each of the last four chapters we have identified a patient characteristic and a set of treatment strategies for adapting treatment to fit the status of a patient on one of these qualities. Specifically, we emphasized the role of patient impairment in orienting treatment intensity, the role of coping style in directing the focus of treatment, the role of resistance traits and states in determining the level of therapist directiveness and activity, and the role of patient distress in selecting interventions that increase activity and arousal levels or reduce subjective discomfort. In the case of patient distress, we emphasized the importance of selectively either reducing intense arousal through direct support and structure or increasing arousal by action, confrontation, and exposure.

Two of the ten overarching principles direct the development of the treatment relationship, one dictates the level of care, and seven of these cardinal principles of change can be used to guide the application of psychotherapeutic procedures. These principles facilitate the therapist's efforts to adapt each treatment plan to fit the unique pattern of characteristics of particular patients. These principles are as follows:

Relationship Principles

1. Therapeutic change is greatest when the therapist is skillful and provides trust, acceptance, acknowledgement, collaboration, and respect for the patient, within an environment that both supports risk and provides maximal safety.
2. Risk and retention are optimized if the patient is realistically informed about the probable length and effectiveness of the treatment, and has a clear understanding of the roles and activities that are expected of him or her during the course of treatment.

Principles of Level of Care

3. Benefit corresponds with treatment intensity among high functionally impaired patients.

Differential Treatment Principles

4. Therapeutic change is most likely when the patient is exposed to objects or targets of behavioral and emotional avoidance.
5. Therapeutic change is greatest when the relative balance of interventions either favors the use of skill building and symptom removal procedures among externalizing patients or favors the use of insight and relationship-focused procedures among internalizing patients.
6. Therapeutic change is most likely if the initial focus of change efforts is to build new skills and alter disruptive symptoms.
7. Therapeutic change is most likely when the therapeutic procedures do not evoke patient resistance.
8. 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.

9. The likelihood of therapeutic change is greatest when the patient's level of emotional stress is moderate, neither being excessively high nor excessively low.
10. Therapeutic change is greatest when a patient is stimulated to emotional arousal in a safe environment until problematic responses diminish or extinguish.

As a therapist attempts to apply these principles to real patients, it will be important to adapt and coordinate them with one another. The effective therapist must adapt not only to the patient's relationship expectations but to the patient's level of emotional intensity, defensiveness, and coping style as well.

Translated to the level of strategies, application of these 10 principles will (1) provide a safe and respectful environment; (2) expose the patient to a compatible balance of procedures that favor a focus either on the symptomatic expressions and skill deficits or to internal experiences that are avoided; (3) adopt either a predominantly directive or a nondirective role with the patient to lead him/her toward action and change; and (4) provide either support or confrontation and exposure to fit the patient's level of emotional distress. This is a complex process and requires that the therapist move flexibly among treatment procedures as the patient changes. For example, the therapist who adapts to the patient's emotional level must learn to differentiate among emotional traits that define the nature of patient problems or psychopathology and emotional states and those that define the focus and objectives of therapy. The therapist must also learn to differentiate among the qualitative differences that are associated with different emotions and to identify the level of emotional intensity or severity that is characteristic of the particular patient. This information is used to build a treatment program that is a complex interweaving of multiple responses to the many permutations that characterize patients.

A Case Example

B. K. is a 37-year-old white male. He reports having been depressed all of his life and has been using alcohol, cocaine, and heroine for the past 12 years. He currently uses heroine weekly and uses the other drugs on a daily basis. He has a college education and has been unsuccessfully employed in a variety of jobs. He is not married and has no close relationships. However, he does have a variety of rather superficial relationships with people with whom he does drugs. They provide him with most of his drugs and in return he does small jobs. He also plays music and begs for money.

B. K. has sought treatment on three other occasions but has never returned for a second treatment session. He has never been through detoxification, but on one occasion, he stopped taking heroine on his own for a period of nearly a year. He began using again after his girlfriend left him.

Recently, B. K. has become more involved with organized drug suppliers. These associations scare him, however. In the past few weeks he has had a persistent feeling that he was being followed and that undercover agents were watching him. He has also become very frightened that his drug supplier may be intending to do him harm. At the same time, he has some suicidal thoughts but no history of active suicidal behavior and no current intentions.

Functional Impairment

B. K. is currently living a marginal existence. He is isolated, has no contact with his family, and cannot identify a single individual to whom he can turn in case of serious trouble. He has been unable to sustain himself through independent work and he has lost friendships and resources because of his multiple impairments. He is seeking treatment because he has run out of other resources and his fears of being harmed have driven him to find some solution other than self-harm.

At intake, the clinician judges B. K. to have a moderate level of social impairment. This suggests the need to intensify treatment beyond the baseline expectation of once-a-week individual sessions. In consultation with the patient, a treatment plan is developed that includes three treatment sessions a week, supplemented by telephone calls, with the hope of decreasing the frequency of these sessions once drug abuse declines noticeably. The clinician also considers antidepressant medication and eventual group therapy to provide support. The patient is noncommittal about this form of treatment, as well as about the goal of becoming drug free. However, the therapist ultimately elects against using antidepressant medications, in fear that it will further weaken the patient's resolve to work toward developing a chemical-free lifestyle.

Coping Style

The patient has a history of both acting out, in the form of drug abuse and occasional brushes with the law, and depression and self-dejection. The MMPI-2 confirms the presence of mixed personality features. He has elevations on several internalizing scales, including the depression (D) subscale, social introversion (Si), and the anxiety (Pt) subscale. At the same time, he currently scores high on the paranoia (Pa) and impulse (Pd) scales. In general, the elevations favor an interpretation of externalization. The scores on the *STS Clinician Rating Form* confirmed this impression. Thus, the therapist directed attention throughout to the development of improved impulse control

and social interaction skills, to the reduction of drug use, and to the minimization of exposure to high-risk situations.

The therapist elects to begin with a focus on the patient's medium- and long-term goals and initiates a discussion of how these goals are impeded by the specific behaviors of drug use and social withdrawal. As an effort to activate the patient toward longer-term, drug-free goals early in treatment, the therapist begins to encourage the patient to become involved in a 12-step program. The goal of this effort is as much to develop a social support network and to bring the patient to action as it is to control drug use.

The therapist also begins a process of weekly tracking the patients drug use (self-monitoring), cravings, and depression (using the BDI) and initiates procedures to inspect and alter the patient's unrealistic thoughts about his inability to overcome drug use. In this process, the therapist begins to identify social deficits, noting that the patient is seldom exposed to non–drug users. In the third session, social groups are identified in which the patient may find peers who do not use drugs. Role-playing exercises related to entering new groups and making acquantainces are initiated in the next session. Only when drug use declines to once a week and social contact has increased in non–drug-using contexts does the therapist begin to raise for consideration the patient's concerns that he is being followed and that others intend him harm. These beliefs are presented and approached in a cognitive framework, inspecting the automatic thoughts and evaluating the level of distortion. Only in the final stages of therapy does the therapist move to a consideration of the schemas represented in these automatic thoughts.

Resistance Level

From the beginning, B. K. seemed cooperative and motivated, even if only out of fear. This observation bodes well for the development of a good working relationship. Indeed, the therapist's efforts to provide reassurance and direction were well received and bolstered the quality of the working alliance.

The therapist was initially uncertain about how much to trust the initial and overt appearance of cooperation, fearing that the patient could not or would not sustain this initial level of cooperation. Thus, he provided a challenge to help assess the depth of this resolve. He provided the patient with a homework task, asking him to both track his drug use and to make one new friend who is not a drug user. The patient complied with the first part of the task and made an effort to introduce himself to a neighbor, only to find out that the latter individual was a heavy cocaine abuser. But, the patient's level of compliance with this difficult initial assignment convinced the therapist that the patient could be described as moderate to low resistant, an assessment that opened the door to the use of direct teaching and instructional techniques to help the patient to address his symptomatic problems.

Subjective Distress

The patient initially appeared anxious and acutely frightened. He scored a 28 on the BDI and earned a score more than 2 standard deviations above the mean on the state portion of the STAI, confirming his anxious state. The therapist used these scores to remind himself to provide some reassurance during each session, to acknowledge even small gains, and to reinforce all efforts that the patient made that showed the ability to make decisions and to control himself.

The therapist worked to provide some structure to reduce the patient's anxiety, and this helped to cement the treatment relationship. With a little time, the patient's distress subsided somewhat and allowed the therapist to devote more time to developing the relationship and urging a change in behaviors.

Assessing Therapist Compliance with PT Principles

Two methods were used in the foregoing case to help the therapist become self-observing in evaluating whether he was providing the most optimal balance of treatment ingredients. The therapist was encouraged to audiotape each session and to review it on his own, using the STS Therapy Process Scale to evaluate the frequency of using various classes of therapeutic strategies. He checked the relative levels of task/symptom-oriented procedures to insight and awareness-oriented ones, and rated his use of supportive versus confrontational procedures. The dimensions of treatment as reflected in scores on this scale have been presented throughout this manual, but the scale itself is reproduced in its entirety in appendix A to summarize the various treatment components. It assesses the degree of directiveness, task and symptomatic focus, insight focus, confrontation, and emotional intensity of the session. It also provides information on aspects of therapist behavior and engagement, including an evaluation of the quality of the therapeutic alliance.

The STS Therapy Process Scale is quite time-consuming, and it could not be completed after each session. Thus, in addition, a briefer measure, one that focuses on the level of compliance with the 10 principles around which PT is organized, was incorporated into the supervision process. Appedix B, following this chapter, presents the *PT Adherense Scale*, and it provides a series of Likert scales by which to summarize the degree to which the therapist was following the intended plan. Using this scale, a therapist can assure him or herself that he is in general compliance with the intended balance of interventions. In the foregoing example of B. K., it provided a reminder to (1) maintain a moderately intensive frequency of treatment sessions; (2) focus on changing symptoms of drug use and depression and enhancing skills to over-

come social isolation; (3) provide structure and direction; and (4) continually monitor moment-to-moment distress levels in order to alter the interventions to either confront the patient with his reluctance to change or to provide support, structure, and acknowledgment.

Assessing General Therapist Skill

The therapist attempts to integrate the various aspects of intervention in a smooth and seamless way. The STS Therapy Process Scale includes assessments of overall as well as specific skill, in addition to the more specific dimensions of care embodied in the STS model. Thus, the following items (see appendix A) are designed to tap therapist skill and are rated by trained experts from direct observations. The rating scales themselves require the selection of responses along a continuum of agreement—strongly agree to strongly disagree.

1. The therapist makes accurate and/or meaningful interventions during the session.
2. The therapist accurately reflects the client's feelings during the session.
3. The therapist appropriately times techniques and interventions during the session.
4. The therapist smoothly and effectively employs techniques and/or interventions.
5. The therapist presents him- or herself in a professional and competent manner.
6. The therapist speaks clearly and concisely during the session.
7. The therapist presents him- or herself as being knowledgeable.
8. The therapist is able to attune to the patient's feelings.
9. The therapist effectively and smoothly facilitates closure of the session.

The results of these ratings should be considered along with the specific skill ratings that we have reviewed in chapters 4 through 8. These latter ratings indicate the degree to which the therapist adequately adapts treatment to patient needs. Measures of skill, together with the assessment of compliance derived from comparing responses to the STS Therapy Process Scale to the patient dimensions extracted from the STS Clinician Rating Form, or from the application of the more general PT Therapy Adherence Form, provide the therapist with a means of assessing his or her level of overall expertise.

Final Observations

We have seen in the foregoing example how the basic principles of treatment can be translated into a set of more specific strategies (activate social involvement, invoke the *in vivo* environment, etc.), and from there to the selection of particular techniques (behavioral charting, *in vivo* exposure, etc.). Although the level of this analysis is increasingly specific, in practice, it is important to maintain a high degree of flexibility in the use of specific techniques. Procedures and techniques have different properties depending on who is using them and how they are introduced. Thus, while the principles are sound and relatively inviolate, the selection of specific procedures will depend on the experience and familiarity of the therapist who uses them, as well as on the therapist's skill level with various procedures. The therapist should feel free to use the techniques that best fit his or her own preferences and backgrounds, wthin the constraints imposed by the guiding principles.

The therapist should remember that the level and frequency of using any set of principles is a dimension, not a simple, categorical, "do" or "don't do" decision. For example, a depressed patient who is moderately impaired, characterized by the use of externalizing coping styles, is highly resistant, and is highly distressed can be treated by a variety of procedures, but the preponderance of them should (1) provide close monitoring and frequent contact—this is favored over less frequent contact because of the patient's level of impairment; (2) be interventions that directly alter cognitions, build social activation skills, and confront social fears—these will be emphasized over insight-oriented procedures because the patient is impulsive and externalized; (3) be nondirective, self-directed, and evocative in nature—these will be emphasized over directive ones because of the resistant nature of the patient; and (4) be directed specifically to control and reduce in-session distress—these will be emphasized over abreactive interventions because the patient is highly distressed.

These strategic decisions may be activated in a variety of ways. The therapist might address specific symptoms of drug abuse by establishing contingent self-directed reporting and recording procedures, through collaborative behavioral contracting, or by a self-guided reading program. These nondirective and self-guided interventions may allow the patient to monitor emotions and keep the processes of emotional escalation in check. The creative skill of the therapist is the only limiting factor in the development of procedures that fit particular patient presentations and combinations of characteristics.

It is not only the patterning of interentions but the creative flexibility of the therapist's application that will both cement a strong working alliance and bring excitement to both parties with the prospect of change. We tend to believe that the therapist must be enthused and optimistic. Indeed, if the therapist is not enjoying him-or herself, the therapist may be doing something that is less than optimally helpful.