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Compendium of treatment adaptations

JOHN C. NORCROSS AND BRUCE E. WAMPOLD

Psychotherapists have long advocated tailoring or adapting the treatment to the individuality of the patient, and recent research pinpoints how to do so systematically in ways that demonstrably improve treatment outcomes. JOHN NORCROSS and BRUCE WAMPOLD summarise the meta-analytic research and clinical practices on effective means of tailoring psychotherapy to six transdiagnostic patient characteristics: reactance level, stage of change, preferences, culture, coping style, and religion/spirituality. Psychotherapists can create a new, responsive psychotherapy for each distinctive patient and singular situation — in addition to his/her disorder.

Psychotherapists have long advocated tailoring or adapting the treatment to the individuality of the patient and the singularity of the situation. Every psychotherapist recognises that what may work for one person may not work for another; we embrace the individual difference maxim of *'different strokes for different folks'*. This matching process has been accorded different names: adaptation, responsiveness, attunement, tailoring, matchmaking, customisation, prescriptionism, and individualisation. However, the goal is identical: to increase treatment effectiveness by tailoring it to the person.

The most widely discussed and used means of adapting treatment has been to match a particular treatment to the patient's disorder. A patient presenting with, say, a specific anxiety disorder might be matched with cognitive-behavioural therapy, the most researched form of psychotherapy for anxiety. Such matching is certainly useful for select disorders; some psychotherapies make better marriages with some mental health disorders. But only matching disorder to treatment in this way is incomplete and not always effective (Wampold, 2001). As Sir William Osler, father of modern medicine, said: *'It is sometimes much more important to know what sort of a patient has a*

disease than what sort of disease a patient has'. The research demonstrates that it is indeed frequently effective to match psychotherapy to the entire person — not only to his/her disorder.

In this article, we summarise the meta-analytic research and clinical practices on effectively adapting psychotherapy to the individual patient. The research reveals evidence for six transdiagnostic features of tailoring psychotherapy to transdiagnostic patient features.

Reactance level

Reactance refers to being provoked easily and responding oppositionally to external demands. Think of this personality trait along a defiance-compliance continuum: Some people tend to respond defiantly to authority figures and power, while others tend to respond in more compliant, easygoing ways. A meta-analysis of 12 select studies (1,102 patients) revealed a medium to large effect size ($d = .76$) for matching therapist directiveness to patient reactance (Beutler, Harwood, Michelson, Song, & Holman, 2011). High-reactance patients benefit more from self-control methods and less structured treatments. Low-reactance clients, on the other hand, benefit more from therapist directiveness, explicit guidance, and more structured treatments.

All other things being equal, trait-like resistance serves as indicators for patients who respond to directive treatments. Thus, psychotherapists are advised to assess their patients' reactance level, avoid stimulating patient's reactance in session, and match their degree of directiveness to patient reactance. In select instances, client resistance to a treatment may well be the result of mismatch; for example, a structured treatment used with a patient with a high level of reactance. Skilled therapists systematically vary their degree of directiveness to enhance treatment results and to prevent dropouts. Finally, as with all of these matches to patient characteristics, beware matching the degree of directiveness to the psychotherapist's reactance level; this frequently surfaces among neophyte therapists who unwittingly project their own personality structure onto clients.

Stages of change

Patients enter psychotherapy with varying readiness to change or what researchers have called stages of change. Some minimise or deny their problems (precontemplation stage), some acknowledge their problems but are not yet ready to modify them (contemplation stage), while others are ready and eager to alter their problems

immediately (action stage). A patient's stage of change reliably predicts the success of psychotherapy. In a meta-analysis of 39 studies involving 8,238 patients, those clients starting treatment in the precontemplation stage did not fare nearly as well as those starting in contemplation or action ($d = .46$; Norcross, Krebs, & Prochaska, 2011).

Skilled therapists systematically vary their degree of directiveness to enhance treatment results and to prevent dropouts.

Another meta-analysis of 47 different studies showed large effect sizes ($d = .70-.80$) for matching treatment methods to the different stages of change (Rosen, 2000). Specifically, consciousness-raising and emotion-generating methods (traditionally associated with psychodynamic, experiential and cognitive therapies) are most effective in helping people move from contemplation, while skills training and more behavioural methods (traditionally associated with behavioural, exposure, and solution-focused therapies) are most effective for those in the action stage.

Clinically, psychotherapists can assess the client's stage of change and avoid treating everyone as though he or she is in the action stage. Optimally tailor the treatment to the client's stage and then move realistically from one stage to another. Perhaps most importantly, avoid stage-mismatching wherein the therapist and client are literally not on the same page. Disparate systems of psychotherapy will prove effective when differentially embedded in the stages of change.

Preferences

Psychotherapy can also be profitably matched in many cases to the patient's preferences in terms of the desired treatment modality (e.g., psychotherapy, medication), therapy method (e.g., psychodynamic, cognitive-behavioural, experiential), treatment format (individual, family, group), therapist characteristic (e.g., age, gender, religion), and treatment

length (brief, medium, or long). A meta-analysis of 35 studies that compared the treatment success of clients matched to their preferences versus clients who were not matched found that clients receiving their preferences did significantly better ($d = .31$) and were a third less likely to drop out of psychotherapy prematurely (Swift, Callahan & Vollmer, 2011).

Psychotherapists can recognise that desires and needs are not universal across patients, and assess client preferences accordingly at the beginning of treatment. It is recommended that therapists reduce barriers that might prevent clients from expressing their preferences directly, such as dearth of information about treatment options or a belief that it would be impudent or disrespectful to discuss preferences with a doctor. It is the wise and evidence-based psychotherapist who explicitly accommodates the client's strong

preferences whenever ethically and practically possible. Even when the therapist believes that a client's preferences will not prove best, share these concerns in session so that treatment decisions can be made collaboratively and transparently.

Culture

Evidence-based practice integrates the best available research with clinical expertise in the context of patient characteristics, culture, and preferences (American Psychological Association, 2006). A meta-analysis of 65 studies, entailing 8,620 clients, evaluated the impact of culturally adapted therapies vs. traditional (nonadapted) therapies. The results showed a definite advantage ($d = .46$) in favor of ethnic/racial clients receiving culturally adapted treatments (Smith, Rodriguez, & Bernal, 2011; see also Benish, Quintana, & Wampold, 2011).

In practice, patients will probably benefit when psychotherapists align treatment with their client's cultural backgrounds. Whenever possible, conduct psychotherapy in the client's preferred language as this emerged as one of the strongest means of adapting treatment to culture. Professionals and clients can adapt psychotherapy



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to culture in multiple ways, such as incorporating cultural content/values into treatment, matching clients with therapists of similar ethnicity/race, and adapting the explanation to fit the client's belief about their problems. The greater number of these components incorporated, the more effective the treatment. In addition, the meta-analysis suggests that the therapist's visible, genuine efforts to align treatment to culture may count as much as the specific procedures undertaken to do so.

Coping style

Another patient trait concerns coping style: how we characteristically respond to new or problematic situations in our lives. Some people tend to habitually withdraw or blame themselves (internalisers), some tend to regularly lash out or act out (externalisers), and of course, others are in the middle and use a balanced coping style. A meta-analysis of 12 studies (1,291 patients) found medium effect sizes ($d = .55$) for matching the therapist's method to the patient coping style (Beutler, Harwood, Kimpara, Verdirame, & Blau, 2011). In other words, patient coping style is a robust moderator of treatment outcome.

In practice, the research suggests assessing each patient's predominant coping style in the interest of treatment planning. Match the focus of treatment to that coping style: interpersonal and insight-oriented treatments tend to be more effective among internalising patients, while symptom-focused and skill-building treatments tend to be more effective among externalising patients. Even with internalising patients, the research highlights the value in beginning treatment with symptom-reducing, pathology-stabilising methods and then switching to more indirect, insight-oriented approaches. Psychotherapists can select among several treatment methods that fit patient personalities and preferences.

Religion and spirituality

Some patients enter psychotherapy with a definite interest in incorporating their religious beliefs or spiritual values into the work. Many research studies have investigated whether these religious or spiritual-accommodative

therapies work as well as, or better than, their secular counterparts. A meta-analysis of 46 studies, involving 3,290 clients, found that patients receiving such therapies experienced equivalent if not superior progress (Worthington, Hook, Davis, & McDaniel, 2011). When examining the most rigorous studies, in which the religious-accommodative therapies and alternative therapies shared the same theoretical orientation and treatment duration, there were no significant differences in the mental health outcomes between the treatments. However, patients receiving the religious or spiritual-accommodative therapies progressed significantly better ($d = .33$) in their spiritual outcomes than patients receiving secular therapies.

Religious and spiritual (R/S) psychotherapies perform as well if not outperform alternate psychotherapies on both psychological and spiritual outcomes. They are valid options for clients seeking or desiring them. At the same time, adding R/S to an established secular treatment does not reliably improve psychological outcomes over and above the effects of the secular treatment. But R/S therapies do offer spiritual benefits that are not usually present in secular therapies; thus, for patient and contexts where spiritual outcome are highly valued, R/S therapies may be considered a treatment of choice. Such is particularly likely for highly religious patients.

Other possibilities

Two more patient dimensions—outcome expectations (Constantino, Glass, Arnkoff, Ametrano, & Smith, 2011) and attachment style (Levy, Ellison, Scott, & Bernecker, 2011)—are related to treatment outcome. More optimistic and more securely attached patients reap greater benefits from psychotherapy, compared to patients manifesting pessimistic expectations and anxious attachment. However, we do not yet have as much or as compelling research on how to adapt psychotherapy specifically to client expectations and attachment. With empirical confidence, we can recommend that psychotherapists

assess these patient dimensions, glean from the results of those assessments as to how the patient is likely to respond to treatment and the therapist, and work assiduously to cultivate more positive expectations and secure attachments. Research indicates that patient expectations and attachment style can be modified during treatment, which also suggests that such changes can be properly viewed as proximal treatment outcomes, not only as a predictive or moderator variables.

The effectiveness of psychotherapy can be improved demonstrably by tailoring psychotherapy to one or more of these six transdiagnostic patient characteristics: reactance level, stage of change, preferences, culture, coping style, and religion/spirituality. Psychotherapists can create a new, responsive psychotherapy for each distinctive patient and singular situation—in addition to his/her disorder (Norcross & Wampold, 2011).

For more information

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