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SELECTIVE TREATMENT MATCHING: SYSTEMATIC ECLECTIC PSYCHOTHERAPY

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A case of a woman with a complex phobia is presented to illustrate that treatment selection should always consider more than either the major symptom (diagnosis) or the theoretical preferences of the available therapists when recommending treatment. Various qualities that constitute the client's environment and coping styles determine what therapy can best be initiated. Moreover, the nature of specific treatment procedures must be considered in light of the setting in which treatment will be provided, the treatment intensity that will be most helpful, the method of delivery, the use of concomitant medical and social treatments, the nature of the relationship desired, the nature of pretreatment preparation of the client, and the demographic and personal qualities of the selected therapist.

In order to select a psychotherapy of choice for phobias, we must first distinguish between *Simple Phobia* as a term designating a formal clinical entity, and the term "*simple phobia*", when used to describe a noncomplex clinical condition. This distinction emphasizes that the term "simple", as used in formal diagnosis, may not accurately express the degree of complexity likely to be encountered in treatment.

Describing a phobia as being "simple" within the scope of the DSM–III–R diagnostic definition is not to say that the condition is not clinically complex—only that it is circumscribed to a defined set of stimulus events. The distinction between the diagnostic label of "simple" and the same term used to express the clinical complexity of the treatment can be illustrated with an example of a recent patient who presented to my office with an intense and persistent fear of automobiles. She exhibited intense anxiety upon entering automobiles, drove only reluctantly, and would not ride with others, reported that her marriage and job had been adversely affected, acknowledged the excessiveness of her reaction, and presented with no other symptoms of an obsessive disorder and incompletely met the criteria of PTSD.

The patient was a 34-year-old woman whose symptoms had persisted for one month, following an automobile accident in which she had suffered only minor injuries. The indicated treatment within the framework of my own form of systematic eclectic psychotherapy (Beutler, 1983), if the condition were clinically as well as diagnostically simple, would be the application of a symptom focused intervention—graduated exposure to the feared stimulus and training in cognitive coping strategies. This symptomatic focus of treatment contrasts with the focus on interpersonal or intrapsychic conflict resolution that would be elected if the presenting behavior expressed a recurrent, symbolized, and neurotic conflict.

To illustrate the decisional process, it will be helpful to evaluate the types of information used and the decisions made by the clinician when constructing a treatment plan for the foregoing patient. These decisions have recently been explicated by Beutler and Clarkin (1990), combining some of the concepts of Systematic Eclectic Psychotherapy (Beutler, 1983) with some of the prin-

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ciples of Differential Therapeutics (Frances, Clarkin & Perry, 1984).

For me systematic treatment planning is organized around four progressive steps, the selection of specific interventions constituting the last link in the chain. In each case, the information arising from one step is designed to lead to decisions that influence each succeeding step.

Step I. Assessing Predisposing Patient Variables

The first step in the process of treatment selection is a diagnostic one, broadly defined. This step emphasizes the need to understand the patient and environmental characteristics that are relevant to predicting treatment response. The initial evaluation includes an assessment of both the clinical and diagnostic complexity of the patient's current condition, the type and nature of personal and environmental resources, the patient's stage of problem resolution, and the coping strategies typically utilized to cope with threat.

If, for a moment, the eclectic clinician does not confuse diagnostic simplicity with clinical simplicity when approaching the patient described earlier, then it becomes clear that more evaluation of the patient's experience and presentation is needed before deciding if the treatment should be symptom or conflictually focused. For example, it may be relevant to know that this patient appeared at the first interview in a wheelchair, having been paraplegic since the age of 13. It will also be relevant to know that her disability resulted from several stab wounds that had been rendered by an unknown assailant who had attacked a girlfriend and her on a family outing in the woods, raping and killing her girlfriend and leaving the patient for dead. One may also be interested in knowing that her fundamental Christian family would not allow her to tell anyone about the incident, ironically attributing her injury to a "car accident" to avoid family embarrassment.

Finally, it may be important to know that the patient had always struggled with her own areas of helplessness, finding the idea of being unable to maintain herself to be extremely frightening. Motivated by this fear, she had gone through high school and college, and had been able to find a job that made her self-sufficient. In this process, her mode of transportation, her car, came to be a place of refuge in which she was able to feel in control of her world.

The patient's investment in being self-sufficient had manifested itself in a rigid resistance to emotional intimacy. She had always had great difficulty with close relationships, exhibiting considerable ambivalence when such relationships presented themselves. After several years of struggling, she had brought herself to the point of marrying just two years before the accident. Her marriage had been in trouble from the start, however, foundering around the same issues of control as had all of her previous efforts to relate intimately. She was resistant to asking for the physical care that she needed in these relationships and phobically avoided any sense of emotional attachment and sharing. These latter problems, while longstanding, had been exaggerated since the automobile accident.

From these descriptions, one sees a life-long pattern of "phobic" avoidance of intimacy and vulnerability that was largely governed by this patient's resistance to losing her sense of autonomy. While doing so at the expense of intimacy, the pattern had been successful at helping her achieve an education and a position of financial self-sufficiency. Indeed, it is doubtful that she would have received a diagnosis of anything more serious than Adjustment Disorder or Transitory Depression, if seen before the car accident. Clinically, the car accident simply served to magnify a set of interpersonal behaviors associated with old, neurotiform fears.

With the foregoing information, the systematic eclectic psychotherapist might encourage the patient to combine symptomatic treatment with a therapy regimen aimed at a broader treatment focus than that initially implied by the diagnosis of "Simple Phobia". If agreeable to the patient, we would begin with a focus on the immediate symptoms in very much the same way as initially described, but the ultimate treatment goal would be to seek resolution of the patient's recurrent conflicts around intimacy and control. This would lead us to the second step within the four step sequence of decision.

Step II. Prescribing the Treatment Context

Utilizing data gathered from the intake assessment, four domains of the treatment context would be prescribed for this patient.

1. *Setting.* What is the appropriate place to treat the patient—*in vivo, in vitro*, in the hospital, in an outpatient setting? In this case, the patient's

available social and personal resources as well as setting to rest concerns with her safety and mobility allowed outpatient, office treatment to be prescribed.

2. *Mode.* Is psychosocial treatment, medical treatment, or some combination of these, the treatment(s) of choice? The patient's fears of medication, as well as her expectations and wants all dictated the appropriateness of a psychosocial intervention.

3. *Format.* Is the treatment best offered in a group, within the marital–family system, or individually? The intensity and focal nature of the presenting phobic symptoms are indicators for beginning with individual treatment. In this, we undertook to seek relatively rapid relief of symptoms. Yet, the recurring interpersonal nature of her behavioral history, which emphasized the presence of an underlying conflict with intimacy, argued for the eventual implementation of a marital treatment format in seeking long-term resolution of the patient's struggle.

4. *Duration/Frequency.* At what intensity should treatment be given? Should it be short-term, long-term, daily, weekly, or monthly? The patient's environmental supports, personal resources, and symptom severity led us to select initial twice-per-week treatment, to be discontinued as soon as the phobia associated with automobiles was reduced to a level that permitted her to return to work. These same variables suggested that the long-term goals could be achieved in weekly sessions of open ended treatment.

Step III. Prescribing the Treatment Relationship

A central concern to treatment is the development of a relationship that is sufficiently supportive and reassuring to allow the technical interventions to be accepted and new behaviors to be attempted. It is an axiom of Systematic Eclectic Psychotherapy that the efficacy of technical procedures is limited by the nature of the treatment relationship. That is, specific procedures are only useful if the treatment relationship provides a conducive balance between freedom and support.

Many times, technical procedures are designed to enhance the quality and safety of the treatment relationship, as with the use of reflection, support, or the provision of information. At other times, the degree of trust existing in the relationship defines certain qualities that should be employed in the intervention. For example, with the possible exception of using paradoxical interventions, the use of directed procedures requires that the client experiences a measure of safety and trust in relating to the therapist.

Hence, Systematic Eclectic Psychotherapy assumes that the specific procedures of psychotherapy are valuable primarily because they facilitate and activate the healing forces of the relationship. This is not to say, however, that all healing and helpful relationships are the same. They are not. Some patients or clients can tolerate more closeness and informality than others. Others may respond negatively to a therapist who is formal and distant. The particular belief systems and philosophies that different therapists convey may be more or less acceptable to a given client, thus, enhancing or impairing the healing forces of the relationship. Such observations emphasize the needs for assuring some degree of compatibility between the client's needs, on one hand, and the values and attitudes that characterize both the therapist and the therapy, on the other. It is the therapist's task to utilize a knowledge of basic predisposing characteristics of the patient and the nature of the treatment context, to define and then to establish the type of therapeutic relationship that will be conducive to positive growth and enhanced functioning. There are two domains that must be considered in developing this level of compatibility.

1. Fit with the therapist. Does the patient's need for structure and support fit with the therapist's ability to provide it? Is the patient sufficiently dissimilar to the therapist that there is no basis for an understanding relationship in their common experiences—a quality that may give rise to distrust and noncompliance? Are there sufficient differences in perspective that the patient might find something new and fresh in how the therapist presents material and information?

A premise of my approach is that the therapist's attitudes, background, and beliefs will be conveyed in both subtle and obvious ways in the course of treatment. Another assumption is that a foundation of similarities facilitates the development of trust through shared experience. Still another assumption is that the differences that exist between patient and therapist serve a comparison function that helps the patient evaluate one's own behavior differently and inspect one's guiding philosophies. A good match, in other words, is one in which there are sufficient similarities to establish a com-

mon bond, and sufficient differences to induce cognitive dissonance and to motivate change. A working position is to encourage therapist–patient pairs that share demographic similarity, but which hold quite different attitudes around those belief systems that are implicated in the patient's problems. These differences usually revolve around perspectives of emotional and social attachments.

For example, in the case under scrutiny here, patient and therapist backgrounds were quite similiar; both were raised in rather traditional, religious, middle-class homes, and both had become oriented around the protestant work ethic. This similarity gave them a basis upon which to begin dialogue and understanding. On the other hand, the therapist's working beliefs around the issues of intimacy that formed the basis for the patient's symptoms were in some contrast to the latter's tendency to see intimacy as dangerous and debilitating. This may provide the means by which the patient will ultimately come to question the validity of her own assumptions and consider new possibilities.

2. *Facilitating the alliance.* The second domain in which the relationship was explored addressed such questions as: How realistic are the patient's expectations of what takes place in therapy? Are these sufficiently likely to be met as to keep the patient in treatment and working? Are there attitudes and expectations that are not likely to be met in psychotherapy and which might prove to be so disappointing as to drive the patient out of treatment? Given the initial compatibilities and incompatibilities between patient and therapist backgrounds, what can the therapist do to facilitate the development of a helping alliance?

Because of its assumed centrality to the patient's problem, therapeutic interventions were designed to help the patient to explore the therapist's implicit value of intimacy and sharing, to good mental health. The task of the therapist at this point was to provide the type of pretherapy education and in-therapy experience that would maximize the bases for compatibility found in initial similarity and dissimilarity. To accomplish this goal, the therapist began to develop hypotheses about how to match his own therapeutic style to the patient's coping style. For example, the patient's response to initial information about roles and objectives suggested that she would be relatively intolerant of direct guidance and rather suspicious both of therapist self-disclosure and the expression of therapeutic empathy. She was deemed to be best approached by the therapist remaining somewhat removed initially, but then to slowly become more informal and involved. The patient's tendency to react against the intimacy of all relationships set the speed with which the therapist confronted the patient with an alternative to her frightening worldview—"relationships are safe and growth enhancing, not to be equated with the loss of, but with the achievement of greater freedom".

Step IV. Prescribing Specific Procedures

Having used the clinical complexity of the condition to select a combination of symptomatic and conflictual outcome goals, the last level of analysis is designed to lead the eclectic psychotherapist to train his or her attention on three other, increasingly specific questions in order to refine the evolving treatment plan.

1. *What **level of experience** should be addressed by the procedures?* Should change be directed at behavioral, affect, cognition, or unconscious experience? The selection of the experience level to be addressed rests on an understanding of how the patient characteristically solves problems and deals with threat (e.g., Prochaska, 1984). The level of intervention is designed to operate in counterpoint to the patient's coping style in order to offset the effects of the dominant defenses. In the case of the patient exemplified here, the initial change targeted was behavioral: altering the avoidance behaviors that characterized the initial phobia. This treatment emphasized gradual and systematic *in vivo* and *in vitro* exposure over the course of 16 weeks.

However, the conflict oriented treatment objective was constructed around "insight": making her aware of long-avoided impulses, wishes, and thoughts of vulnerability, including the reinitiation of the aborted process of grieving for her lost capacities. The decision to focus on unconscious experience was based on the observation that the patient's usual method of coping with her sense of vulnerability was counterphobic denial, oversublimation, and reaction formation. Beginning with her parents' deception, she had acceded to the injunction to ignore the significance of events, to "put things out of her mind", and to "put on a good face" in spite of the realities of life. Hence, insight into how her unconscious needs and hidden wishes guided her present behavior was selected as the primary, long-term objective.

2. *What **mediating goals** should characterize treatment?* In addition to the initial goal of symp-

tom relief and the long-term goal of conflictual change, the clinician also sought to specify the mediating subgoals that will best and most directly lead to change in the targeted areas. Mediating goals are dependent on the patient's stage of problem resolution, the nature of the patient's presenting problem, and the availability and importance of social support systems. From an assessment of these variables, criteria can be used to specify the expected sequences of change and to plan the points at which treatment might shift from one treatment format (i.e., individual) to another (i.e., marital).

The movement of treatment for the patient presented here was conceptualized to take place within the fixed therapy stages defined by Beitman (1987). These goal-related stages begin with procedures designed to develop the persuasive power of the treatment relationship, and proceed through the stages of pattern recognition, the instigation of personal change in guiding schemata, applying these changes to interpersonal relationships, and preparing the termination.

For example, our phobic patient's problem-solving progress was monitored following the guidelines provided by Prochaska (1984). When she had achieved the stage defined as readiness for change, marital therapy was initiated. Later phases of treatment included procedures consistent with the mediating goals of termination planning and relapse prevention. The use of emotional support, encouraging expression of wants and needs, and shaping interpersonal behaviors became the focus of decisions and renegotiated treatment contracts.

3. What are the specific strategies to be used? The guidelines for the selection of specific procedures to achieve mediating and long-term goals are based on a knowledge of the demand characteristics of various procedures, the patient's sensitivity to direction, and a recognition of the degree to which various procedures affect in-session and out-of-session activities. For example, the techniques of psychoanalytic process fit the overall objectives of "insight", precipitate mild to moderate resistance, and are implemented largely within the session. The insight goals of free association, dream interpretation, confrontation of resistance, and analysis of transference were appropriate for our patient, but she was judged to have moderately high sensitivity—reactance—to procedures that would threaten her need for personal control. Hence, a preponderance of nonconfrontive, questioning, and reflective evocative procedures were selected for early sessions, until her reactance levels began to subside.

Other questions were also raised in selecting the procedures to be used. What balance should be sought between consideration of extra-therapy experience and intra-therapy experience? What type of homework, if any, should be assigned? Answers to these questions for our patient relied on coordinating changes in the patient's coping style to changes in the process of therapy.

We desired to implement procedures that would initiate external as well as intra-session changes. Hence, we initiated homework assignments that were initially behavioral in nature and based upon clearly defined contracts with which the patient had agreed, if not initiated. In the post-symptomatic stages of treatment, the approach was carefully balanced between therapist and patient direction. Homework tasks focused increasingly upon the nature of her interpersonal relationships, including that with the therapist, and gradually changed from a behavioral focus to an insight focus. Later, homework involved her husband and included negotiated contracts for reciprocal behavioral exchange in communication styles.

The Role of Classical Psychoanalysis

Two of the questions asked by the editor of this special section remain unanswered by the foregoing description of treatment planning. The first question is whether "classical psychoanalysis" would ever be a treatment of choice in such a case as that presented. Certainly, from the foregoing, it should be clear that I believe that there is a place for psychoanalytically oriented procedures in treating a patient whose Simple Phobia is clinically complex and when the patient presents with a repressive coping style. Yet, parsimony is a working principle of systematic eclectic psychotherapy. I would not recommend any treatment package when a simpler one would likely be equally beneficial.

I also believe that all treatments must carry the burden of proof for their effectiveness. Classical psychoanalysis is ill equipped for the task of correcting phobic symptoms. Moreover, there is little evidence that classical psychoanalysis will achieve the conflict change objectives in any more efficient a fashion than psychotherapy. Therefore, my first recommendation to the patient described here was for symptom-oriented treatment. I then recommended a more extended psychotherapeutic reg-

imen designed to achieve interpersonal and intrapsychic goals.

Following the achievement of these goals, I would be receptive to the patient's selection of classical psychoanalysis to achieve further insight based upon my belief that any treatment is appropriate if the recipient is fully apprised of the costs, alternatives, and likely benefits. This principle would require that the patient be fully informed that, (1) there is no evidence that such treatment will result in a reduction of phobic anxiety, (2) there is no evidence that benefits will be any different, by virtue of intensity or type, to that experienced in other forms of psychotherapy, and that (3) the other available alternatives are substantially cheaper in terms of time and money.

Will We Achieve Consensual Approach?

The prescriptive therapy outlined briefly here is complex, matching the complexity presented by the patient illustrated. Others have proposed simpler systems. I hope that someday we will have some data to help us sort out the wheat from the chaff in all of these approaches. However, I do not believe that we either will or should reach consensus on the method of prescribing psychotherapies. To do so would be to stifle growth and advancement. Divergent, but testable viewpoints will move science further than consensus. I believe that we must strive not for uniformity of belief, but both for theoretical formulations that are suitable to empirical testing, and for more openness to giving up our individual pet viewpoints.

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