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Editor's Note: The following seven articles comprise this issue's special section—Prescriptive Matching in Psychotherapy: Psychoanalysis for Simple Phobias? Dr. Norcross's article introduces this section.

PRESCRIPTIVE MATCHING IN PSYCHOTHERAPY: AN INTRODUCTION

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This article introduces the special section examining the process of determining prescriptive psychotherapies through a single clinical exemplar. Six distinguished representatives of diverse theoretical persuasions address the issues involved in the treatments of choice for simple phobias and, in doing so, articulate some of the values and limitations of a prescriptive approach. The article traces the origins of the mini-series and concludes by amplifying two interacting reasons—divergent therapeutic goals and multiple decision points—for the paucity of consensus on treatments of choice.

A principal objective of clinical assessment and psychotherapy research is to enhance the optimal match between patient and treatment. This process has been assigned various names: individualized treatment planning, prescriptive eclecticism (Dimond & Havens, 1975), the matching strategy (Paul, 1967), dispositional assessment (Cole & Magnussen, 1966), differential therapeutics (Frances, Clarkin & Perry, 1984), technical eclecticism (Lazarus, 1967; Norcross, 1986), prescriptive psychotherapy (Goldstein & Stein, 1976), systematic treatment selection (Beutler & Clarkin, 1990), and the specificity factor (Lazarus, 1984). But their goal is identical: to improve the efficacy, applicability, and efficiency of psychotherapy by tailoring it to the unique needs of the client. Although this prescriptive emphasis is frequently proclaimed an elusive promise of a scientific psychotherapy, it has received inadequate attention in the literature.

Treatments of choice will probably, but not necessarily, entail use of multiple interventions and formulations traditionally associated with diverse systems of psychotherapy. Thus, there exists a natural affinity with the psychotherapy integration movement (Beitman, Goldfried & Norcross, 1989; Wolfe & Goldfried, 1988). However, the treatment of choice may in fact be a variant of a pure-form therapy. And as Wachtel (1977) has observed, a pure-form therapist even contemplating deviations from the straight and narrow path is no longer a pure-form therapist, technically speaking.

This special section was designed to examine the process of determining prescriptive psychotherapies through a single clinical exemplar. The focus on a relatively discrete and common disorder was to ensure comparability across the articles and to ground the discussion in clinical reality. Distinguished representatives of varied therapeutic traditions—multimodal (Lazarus), experiential (Mahrer), rational–emotive (Ellis), eclectic (Beutler), and integrative (Prochaska)—will address the issues involved in the treatments of choice for simple phobias. In the process, discord among the contributors will be illustrated and reservations about the value of a prescriptive approach articulated. Thereafter, psychoanalytically oriented psychotherapists (Barber & Luborsky) with an abiding interest in psychotherapy integration will offer some concluding observations.

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By way of review, DSM–III–R (American Psychiatric Assocation, 1987) presents six diagnostic criteria for simple phobia.

A. A persistent fear of a circumscribed stimulus other than fear of having a panic attack or of humiliation in certain social situations.

B. During some phase of the disturbance, exposure to the specific phobic stimulus almost invariably provokes an immediate anxiety response.

C. The object or situation is avoided, or endured with intense anxiety.

D. The fear or the avoidant behavior significantly interferes with the person's normal routine or with usual social activities or there is marked distress about having the fear.

E. The person recognizes that his or her fear is excessive or unreasonable.

F. The phobic stimulus is unrelated to the content of the obsessions of Obsessive Compulsive Disorder or the trauma of Post-Traumatic Stress Disorder.

For the purpose of this section, the focus is on choices among psychotherapies in an outpatient setting. There are obviously other important treatment decisions—to treat or not, the format, possibility of psychotropic medications, to say nothing of the fit between client and therapist—but these fall outside of our purview. We shall also assume the patient presents with the sole concern of a simple phobia without a prior history of psychiatric disturbance or treatment.

The example is relatively uncomplicated, and serves merely as an illustration; phobic behaviors only exist within the context of a unique client being helped by a unique psychotherapist. The intent is not to denigrate the psychoanalytic tradition nor to underestimate the complexity of phobias. But this example will, I believe, serve the illustrative and dialectical purpose of explicating the clinical reasoning and decision-making processes underlying prescriptive psychotherapies.

Toward this end, four questions were posed to the contributors. (1) *What would be your psychotherapy of choice for a client with a simple phobia*? A brief clinical example was encouraged. (2) *How did you reach this decision*? Specifically, on which sources of evidence—e.g., empirical literature, theoretical formulation, clinical experience—do you base your decision? Which client variables—e.g., diagnosis, motivation, interpersonal style—primarily guide you? (3) *Would (classical) psychoanalysis be one treatment of choice in this case*? If yes, under what circumstances? If no, why not? (4) *Given differences on epistomological and ontological questions, will the profession ever achieve a consensus on prescriptive psychotherapies*? What directions should we pursue to approach such a consensus?

Personal Origins

The onset of my interest in prescriptive psychotherapies predates my graduate training. I distinctly recall the shock and dismay I experienced as an undergraduate when informed that there were rarely specific treatments indicated for specific clients and disorders. There was an obligatory rendition of Gordon Paul's famous question (1967, p. 111): "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under *which* set of circumstances?" followed by an unflattering analogy of current psychotherapeutic practice to the Procrustean bed. That is, we shorten or stretch clients to fit our methods rather than tailoring our approach to fit their needs. Lazarus (1984, p. 43) later coined the term "generalization fallacy" for this propensity: "Instead of providing remedies or strategies for overcoming specific problems, the majority [of therapies] claim to have the answer for all victims of neurotic suffering, or emotional disturbance, or other global dysfunctions."

The origin of this special section was another undergraduate course in clinical psychology, but this time I was the professor. At the conclusion of our review of leading psychotherapy systems, I distributed the summary tables from *Differential Therapeutics in Psychiatry: The Art and Science of Treatment Selection* by Frances, Clarkin, and Perry (1984). These tables list relative indications, enabling factors, and relative contraindications for arriving at prescriptive recommendations on the therapeutic setting, format, orientation, duration and frequency. I pointed to progress made in this area and announced that the process of treatment selection was now more consensual and empirically based than heretofore. In recent years, I continued, we have developed a science of behavior change that necessarily differs from person to person, disorder to disorder, but in which tailoring specific clinical methods and relationship stances remains something of an art (Barlow, 1985). Academically, I had avoided the repetition compulsion of my progenitor and achieved a small Oedipal triumph.

Or, so I thought! One astute member of the class questioned the adjective "relative" before

indications and contraindications. I patiently, perhaps condescendingly, replied that the complexities of human behavior and the subtleties of the psychotherapeutic endeavor do not lend themselves to absolute rules, simplistic decisions, or a solitary cookbook. The student readily agreed, but asked if the profession had achieved consensus on the treatment of *any* disorder. Simple phobia in a person with no premorbid adjustment problems was nominated as a focal point. Other students could now sense my discomfort and joined the grand inquisitor in pursuit of blood. "Yes," they challenged, "What is the treatment of choice for simple phobias? Surely not conventional psychoanalysis!" The prescriptive challenge was thus framed: *Under which circumstances, if any, would you recommend the most intensive and expensive form of psychotherapy for one of the simplest and most discrete behavioral disorders*?

Hemming and hawing about disparities in therapeutic goals, client preferences, and structural personality deficits, I stated psychoanalysis would not be my initial or primary recommendation but that, in very rare cases, I could imagine recommending it. To my horror, I then heard my instructor's lame words from many years earlier coming out of my mouth: the challenge for future research is to determine (in Gordon Paul's words) "*What* treatment, by *whom*, is mostly effective for *this* individual with *that* specific problem, and under *which* set of circumstances?" The inquisitive student, obviously dismayed, mumbled something about the Emperor being scantily attired.

This incident proved quite sobering, both professionally and personally, for a number of reasons. First of all, despite 25 years of research on the specificity of therapeutic effectiveness, few clear prescriptions have been delivered (Lambert, Shapiro & Bergin, 1986; Stiles, Shapiro & Elliott, 1986). Second of all, the dearth of consensus on treatments of choice tends to perpetuate unitary formulations and treatments for all clinical situations (Norcross, 1990). Brand X psychotherapy fits all clients and situations—blithe adherence to the myths of patient and treatment uniformity (Keisler, 1966; Norcross, 1988). Of course, practitioners of a particular theoretical orientation may employ different formulations of a patient or problem within that theoretical framework. The psychoanalytic treatment of enuresis, for example, is likely to be quite different from that of narcissistic disorders, but the question persists of whether any psychoanalytic treatment for these disorders is the treatment of choice. Third of all, ideological commitment and partisan zealotry triumph over empirically generated guidelines in treatment selection. In his article, Lazarus (1990) writes that even asking the question—Psychoanalysis for Simple Phobias?—has a satirical ring to it and represents a stinging indictment of the field of psychotherapy.

Imposing a parallel situation onto other professions drives the point forcibly home. To take a mechanistic medical metaphor, would you trust a physician who prescribed the identical treatment, say, penicillin or cardiac surgery, for every illness encountered? Or to take a more appropriate educational analogy, do you prize instructors who employ the same pedagogical method, for example, small discussion groups or straight lectures, for every educational opportunity? "No" is probably the resounding answer, although we may selectively refer patients and students who may benefit from our inveterate colleagues' treasured proficiencies.

Whither Consensus?

I will conclude by amplifying two of the interacting reasons for this paucity of consensus: divergent therapeutic goals and multiple decision points.

Divergent Therapeutic Goals

A transtheoretical analysis of extant systems of psychotherapy shows how much therapeutic systems agree on the processes producing change while disagreeing on the content to be changed (Prochaska, 1984). In other words, different orientations probably do not dictate the specific interventions to use as much as they determine the therapeutic goals to pursue (Beutler, 1983). In his article, Ellis (1991) argues that achieving a consensus on prescriptive therapies will be most difficult until we agree more specifically on therapeutic goals. Similarly, Mahrer (1991) states a consensus on prescriptive therapies will only be attained if therapists agree on the target problem to be treated and on the kinds of evidence to be accepted for successful therapy.

Consider the treatment of simple phobias. Freud (1919), the intrapsychic master, stressed that, if the analyst actively induces the patient to expose him/herself to the feared stimulus, "a considerable moderation of the phobia" would be achieved. This observation predates the emerging contemporary consensus on the superiority of exposure and response prevention in alleviation of phobic behavior. Barlow & Beck (1984, p. 37), for in-

stance, write that, "the bulk of existing evidence points to the necessity of reducing phobic anxiety and avoidance through exposure to the feared situation or object; this approach, in its many forms, is considered the treatment of choice (Barlow & Wolfe, 1981)."

Of course, the rub is in disparate goals of psychotherapy—symptomatic, etiological, or both; action, insight, or both (*cf.* Goisman, 1983; Saltzman & Norcross, 1990). Unless or until consensus is reached on the priority of mediating goals, little consensus will be reached on prescriptive therapies. In this special section we encounter considerable divergence in goals but, at the same time, encouraging convergence.

All the contributors agree that classical psychoanalysis is contraindicated for efficient removal of simple phobic behavior. Lazarus (1991) and Ellis (1991) go still further: the former states that psychoanalysis for phobias "seems unconscionable and borders on malpractice"; the latter sees it a "quite inefficient and unethical" practice. All agree that there will be select occasions when an insight-oriented strategy, though not necessarily psychoanalysis, might be appropriate.

For Beutler (1991), if the condition is clinically and diagnostically simple, then he would apply a symptom focused intervention. If the condition is not simple, then interventions aimed at conflict resolution, including but not limited to immediate symptoms. Prochaska (1991) agrees, although he employs a slightly different decision-making process in reaching the same conclusion.

Mahrer (1991), by contrast, reframes the argument from alleviation of phobic behavior to change in the person. He states that there is no basis for comparing or prescribing therapies useful for amelioration of the phobia, but only in terms of their utility in enabling a person with a phobia to become a new and different person.

Multiple Decision Points

Even if agreement is obtained on the priority of mediating goals, the sheer complexities of treatment selection process will promote contention. The number of factors to consider in interaction with that specific client with those presenting problems can be overwhelming. Treatment decisions are interactive, contextual, and cumulative; there are no main effects, only interactions in psychotherapy matching (Horvath, 1989). Lack of compelling psychotherapy research for some clinical disorders aside, it is little wonder that we mortals have assiduously avoided operationalizing our decision-making strategies.

In a landmark effort to do just this, Beutler and Clarkin (1990) have reviewed the literature on numerous decisional criteria for designing individualized psychosocial treatment programs. These criteria include, but are not limited, to: diagnosis, patient expectations, coping ability, personality, environmental stressors and resources, therapist–patient compatibility, response to role induction, reactance level, readiness to change, and breadth of pathology. This partial list reflects not only the complexity of the therapy matching process but also one reason for lack of consensus, namely, disagreement on a single decision-making source, such as diagnosis, can lead to divergence in prescription.

Authors of the articles in this symposium adopt diverse matching criteria. Prochaska (1991) reduces the number of decision points to primarily two—the stages of change and the levels of change. What is lost in detail is gained in parsimony. Lazarus (1991) emphasizes the patient's presenting problems and favors a comprehensive multimodal assessment, from which a prescriptive treatment plan is generated.

By contrast, Mahrer (1991) and Ellis (1991) recommend their respective therapies for virtually all neurotic disorders. Although both experiential (Mahrer, 1989) and rational–emotive (Ellis, 1987) therapies integratively employ diverse clinical means to their therapeutic ends, offering the identical psychotherapy to every client may be antagonistic to the notion of prescriptive treatment. Insofar as this is typically the case, it is difficult to discern how the selection of the psychosocial treatment is individualized to that specific clinical situation. In Mahrer's (1991) words, "the rules of experiential psychotherapy are outside the rules of the prescriptive psychotherapies."

The path toward prescriptive psychotherapies will be an arduous and perilous one, necessitating substantial empirical research, clinical experimentation, and transtheoretical dialogue (Norcross, 1987; Norcross & Grencavage, 1989). Although various psychotherapies are indeed effective, the criteria for selecting one or another have not as yet been put to the ordeal of systematic study (Freedman, 1989). The following articles provide promising directions and warn of potential hazards on that journey.

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