

Differential Therapeutics: Teaching Treatment Selection to Trainees

Seymour Hoffman

There exists today, unfortunately, many therapists who graduated from the “Procrustean School of Psychotherapy” (named after the mythological giant who “accommodated” his captives to the size of his beds). (Hoffman, 1992) They come from all orientations, persuasions and disciplines, and have firm beliefs in their theory of human nature, of the causes of psychopathology and the means to ameliorate the latter. Other views are rejected or are relegated to a minor or insignificant position. They are equipped with a small toolbox that contains a sturdy, unique, fourteen-carat gold tool that they boldly and confidently apply to all problems, situations and people that seek their professional attention. Maslow’s caution, “If the only tool you have is a hammer, you will treat everything as if it was a nail” (1966), is dismissed with a smirk and derisive smile.

During my years as a student, clinical intern, staff psychologist and supervisor, I have come across many examples of the “procrustean therapeutic approach” and below are recorded several egregious examples of the above.

1. A colleague of mine made the following points to a new group of interns working in the student counseling center, regarding how to conduct the initial interview with a patient:

“Inform the patient that you will be meeting with each other on a weekly basis for a year (“Parkinson’s Law”), ask them to bring in dreams to the sessions and to free associate, and don’t ask questions or raise topics not brought up by the patient”.

2. A 30 year old patient was being treated by a clinical intern for a year for marital difficulties with little success. When asked by his new supervisor why he didn’t invite the patient’s spouse for a conjoint meeting, his response was, “I don’t know how to do marital therapy”.

3. A dynamic oriented psychotherapist was treating a patient who had a severe obsessive-compulsive disorder, in dynamic therapy, for two years, even though the professional literature clearly indicates that the above approach is ineffective and counter-productive with this disorder and that a cognitive-behavioral approach is the treatment of choice.

4. A 16 year old religious boy developed a severe case of agoraphobia and had refused to attend school for several months. His behavior oriented therapist, after several months of failure in attempting to reduce his anxiety via desensitization and other behavioral techniques, terminated treatment and recommended psychopharmacological treatment with a psychiatrist. The boy however, refused to take medication and therefore was seen by another psychologist who was able to help the patient address and cope with his fears of acting out his homosexual impulses and return to school after several months of dynamic therapy. Treatment was terminated after eighteen months with bi-monthly follow-up meetings.

Unfortunately, most psychology clinical internship training programs and treatment facilities offer a relatively narrow range of treatment alternatives, either because this is all that is available because of the absence of therapists and supervisors skilled in alternative treatments or because it is part of the staff’s belief system that only this narrow range is really necessary or because of financial and manpower limitations and reality factors (patients are referred to short-term or group therapy because of a long waiting list).

Perry and his colleagues (1985) have concluded, “Too often patients receive the treatment known best to, or practiced primarily by, the first person they consult, rather than from which they might benefit”. Trainees and supervisors also are likely to spend the bulk of their time together discussing phenomenology or psychodynamics and devote little or no time to choice of treatment.

There is great value in having trainees exposed at the outset of their training to the non-dogmatic notion that many treatments are possible and that no one teacher or supervisor has a monopoly on the truth. They should be taught to determine what treatment is most likely to be optimal even if they don't know how to do it. Learning when and how to refer is an important part of clinical training. Instilling the notion of flexibility and openness at an early juncture of their training is crucial. Interns should be exposed to a dynamic atmosphere where different views are presented and creativity and experimentation are encouraged, to an environment enriched by the tension of clinical decision making and feedback.

One of the basic tenets of prescriptive eclecticism in psychotherapy (Dimond, et. al., 1978) is that the psychotherapist must be able to draw upon a vast array of theories and techniques in treating people and not be bound by a single orientation or approach to therapy. A competent psychotherapist uses his clinical judgment to decide what theory, technique and approach is best, given the specific patient, therapist, presenting problem and situational variables.

Knowledge and training in differential therapeutics (Frances, et. al., 1984) equips and enables the therapist to develop an appropriate strategy and treatment plan for his patient, rather than tailor the patient to fit his "procrustean therapy bed", thus increasing his effectiveness in his therapeutic endeavors.

Ideally, the comprehensive three-year training program in differential therapeutics and treatment selection described by Frances and his colleagues in their excellent book (1984) should be adopted by all training facilities. However, because of limited funds and manpower resources and the existence of well entrenched and long standing ideologies, beliefs and views of many establishments, the feasibility of accomplishing this is highly unlikely.

I would like to suggest a less ambitious and more modest and limited proposal on how to introduce the values and views expressed above into clinical training programs where the demands on resources and change are minimal, and therefore, the chance of its implementation is high. New ideas and changes have to be introduced in small doses and gradually – "Truth should glitter gradually or all men be blind".

Training in differential therapeutics can be introduced into the clinical psychology internship training program on a small scale by adopting the following format:

A weekly two-hour group supervision therapy meeting with the clinical psychology trainees and two supervisors (one, the primary supervisor and the other, a consultant) with contrasting theoretical orientations and treatment approaches (e.g., experiential, dynamic, long-term versus directive, strategic, short-term) should be held. At these meetings, one of the interns presents a new case assigned to him, which includes the patient's history, presenting problem, etc., and a "DO A CLIENT MAP" outline developed by Seligman (1990) that was previously filled out by the presenter with the aid of his primary supervisor. The above acronym (Diagnosis, Objectives of treatment, Assessments needed, Clinician characteristics viewed as therapeutic, Location of treatment, Interventions to be used, Emphasis of treatment, Nature of treatment, Timing, Medications needed, Adjunct services, Prognosis) provides a comprehensive outline, encompassing the major elements that therapists should consider when formulating a treatment plan.

After the intern completes his presentation, the group participants are invited to ask questions, challenge and react to the presentation. Afterwards, the primary supervisor and the consultant share their reactions, perceptions, views and conclusions with the group, which, it is predicted, will stimulate further discussion and debate, until a consensus is reached regarding what if any revisions should be made in the client map. Three months later, the same presenter provides an update to the group regarding the progress of the treatment. At the end of the deliberations, a decision is made if modifications of the treatment plan are indicated.

At these group supervision meetings, each intern would have at least two opportunities in working with the above format. The goal of this experience is to instill and inculcate a flexible and broad-minded attitude and approach to psychotherapy in the trainees and to equip them with systematic ways of thinking in their clinical work with clients.

Below is a completed "DO A CLIENT MAP" outline of a depressed, female patient filled out by a therapist and his supervisor and (abridged) comments by the consultant (in parentheses) to illustrate the above suggestion.

Do a Client Map

Diagnosis

Axis 1: 296.23 – Major Depressive Disorder, single episode, severe, without psychotic features.

Axis 2: 301.6 – Dependent Personality Disorder.

Objectives

1. Reduce level of depression
2. Improve social and occupational functioning
3. Increase self-esteem, independence, activity level
4. Reduce marital stress
5. Reduce cognitive distortions
(Increase insight into intra-psychic conflicts.)

Assessments

Psychiatric consultation.

(Postpone until rapport has been established.)

Clinician

Female therapist is recommended in view of the patient's distrust of male figures as a result of abuse by them in the past. The therapist should be supportive and patient, yet structured and confronting when need be.

(Male therapist – corrective emotional experience)

Location of treatment

The patient should be seen in an outpatient setting. However, if she does not respond to treatment in a short period of time and remains immobilized by her depression, a brief period of day hospitalization should be considered.

(Psychopharmacological treatment as an outpatient should be tried before hospitalization is considered.)

Interventions

Supportive therapy is indicated initially. After rapport has been established, a cognitive-behavioral approach seems indicated in order to reduce the patient's cognitive distortions. Role playing and assertive training can be helpful in modifying the nature of the patient's social interactions.

(Exploratory approach indicated in order to increase patient's awareness of her suppressed and internalized anger.)

Emphasis

In view of the patient's relative immobilization, a high level of directiveness, initially, will be required. As she improves, this directiveness will be reduced in order to increase her own sense of mastery and competence and taking responsibility for her life. Because the precipitant of her depression seems to have been marital, emphasis of treatment will be on her relationship with her husband.

(Depression seems to be of long standing and related to dynamic issues. Focus should be on increasing patient's insight into her unresolved conflicts.)

Nature of treatment

Individual therapy is recommended. At an appropriate time, a conjoint meeting is indicated to evaluate the marital relationship and determine if further conjoint meetings should be scheduled. Participation in group therapy may be helpful after the patient's depression has lifted. (Long-term dynamic psychotherapy indicated. Conjoint meetings should be postponed until individual treatment is concluded).

Timing

Initially, patient should be seen twice a week in order to facilitate reduction of her depression and improve her functioning. Weekly sessions can be introduced as her depression decreases and she is able to take upon herself household duties. Duration of treatment is anticipated to be about a half year.

(Patient should be seen at least twice a week for long-term treatment.)

Medication

A psychiatric evaluation will determine the need of anti-depressive medication at the present time.

Adjunct services

Involvement in adult education courses may be beneficial in increasing the patient's self-image and in facilitating social intercourse once her depression is lifted.

(The above adjunct services should be introduced towards the conclusion of treatment.)

Prognosis

Prognosis for symptom reduction in major depression, single episode, is good. However, prognosis for significantly modifying patient's dependent personality traits is unlikely to result from relatively short-term therapy. Motivation for long-term therapy seems poor. (If patient persists in long-term dynamic therapy, prognosis for improvement is good both for amelioration of her symptoms and modification of her dependent personality traits.)

Using a "decision tree" (whether Seligman's or others) to guide the trainee enables him to organize his thinking and deepen his understanding of the patient, his dynamics and pathology, so that he will be able to decide on the most effective treatment approach to utilize.

Presenting contrasting and opposing views and approaches, can on the one hand cause confusion and discomfit the trainee, while on the other hand, it can be a very stimulating, heuristic and eye-opening experience for him, especially if the two supervisors interact and relate to each other with openness and respect. The trainees are encouraged to actively participate in the deliberations, challenge and confront the supervisors freely during the meetings. The fact that a second follow-up meeting is held and further assessments are made and appropriate changes in the treatment plan are considered, should instill in the intern the value of flexibility and openness. In these supervisory meetings, the emphasis and focus is on the patient and reality factors and not on theoretical considerations. The "bed" is adjusted to the "guest" and not the other way around.

The idea of introducing two supervisors with contrasting views into the supervisory situation was borrowed from a therapeutic approach used by the author and his colleagues called "dialectical cotherapy" (Hoffman, et. al., 1994; Hoffman and Laub, 2004). Omer, (1991) views dialectical interventions as "treatment strategies that embody two antithetical moves in such a way that as the pendulum swings from one to another, change forces are mobilized and resistance is neutralized...Although sometimes the intervention aims at giving maximum power to one of the polar movements, at other times it aims at an emerging synthesis".

The last meeting of the training year is devoted to an open discussion by all the participants regarding this group supervision approach, where comments, feedback, criticism and recommendations are encouraged, in order to determine the effectiveness of this model in the training of potential therapists.

The author recently introduced the above idea into the training program at a clinic that he is working as a supervising psychologist in Bnei Brak and the initial reactions and responses by the

clinical psychology interns have been positive. It is recommended that supervisors from all disciplines that are involved in training students (psychiatrists, clinical psychologists and psychiatric social workers) in psychotherapy, experiment with the above model in their training programs.*

References

- Dimond, R. E., Havens, R. A. & Jones, A. C. (1978). A conceptual framework for the practice of prescriptive psychotherapy. *American Psychologist*, 33, 239-248.
- Frances, A., Clarkin, J., and Perry, S. (1984). *Differential Therapeutics in Psychiatry*. New York: Brunner/Mazel.
- Hoffman, S. (1992). Procrustean psychotherapy. *Journal of Integrative and Eclectic Psychotherapy*, 11, 5-7.
- Hoffman, S., Gafni, S. and Laub, B. (1994). *Co-therapy with Individuals, Families and Groups*. New York: Jason Aronson.
- Hoffman, S. and Laub, B. (2004). Dialectical co-therapy. *Israel Journal of Psychiatry*, 41, 3, 191-196.
- Maslow, A. H., (1966). *The Psychology of Science: A Reconnaissance*. New York: Harper and Row.
- Omer, H. (1991). Dialectical interventions and the structure of strategy. *Psychotherapy*, 28, 563-571.
- Perry, S., Frances, A. and Clarkin, J. (1985). *A DSM-3 Casebook of Differential Therapeutics*. New York: Brunner/Mazel.
- Seligman, L. (1990). *Selecting Effective Treatment*. San Francisco: Jossey-Bass.

Appendix:

Do A Client MAP - Differential Therapeutics

1. **Diagnosis**
 2. **Objectives of treatment**
 3. **Assessments needed**
 4. **Clinician characteristics viewed as therapeutic**
 5. **Location of treatment**
 6. **Interventions to be used**
 7. **Emphasis of treatment**
 8. **Nature of treatment**
 9. **Timing**
 10. **Medication needed**
 11. **Adjunct services**
 12. **Prognosis**
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- 1 Axis-1; Axis-2 (DSM-4). Psychodynamic Diagnostic Manual.
 - 2 Increase self-confidence, assertiveness; strengthen reality testing, decrease anxiety, depression; increase insight, self-control, modify distorted conceptions and perceptions, etc.
 - 3 Psychiatric/neurological evaluation, psychological testing, etc.
 - 4 Male/female, supportive, passive, active, confrontational, direct, indirect, etc.
 - 5 Mental health clinic, Day hospital program, Psychiatric hospitalization, etc.
 - 6 Psychodynamic, CBT, supportive, role-playing, play therapy, Animal Assisted Therapy, hypnosis, relaxation exercises, sex therapy, etc.
 - 7 Passive-aggressive, avoidance, hostile, suspicious, dependent, impulsive, avoidance, defensive behavior, etc.
 - 8 Format: Individual, couple, family, group therapy. Combination of treatment approaches.
 - 9 Twice weekly, weekly, monthly, long-term/brief therapy, etc.
 - 10 No medication, medication, increase/decrease/change medication, etc.
 - 11 Social services, coaching, bibliotherapy, social organizations, speech therapy, etc.
 - 12 Good, poor, guarded, in view of his pathology, distrust, motivation, guardedness, etc.