What Works for Whom: Tailoring Psychotherapy to the Person

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This article introduces the issue of the *Journal of Clinical Psychology: In Session* devoted to evidence-based means of adapting psychotherapy to the patient's (transdiagnostic) characteristics. Practitioners have long realized that treatment should be tailored to the individuality of the patient and the singularity of his or her context, but only recently has sufficient empirical research emerged to reliably guide practice. This article reviews the work of an interdivisional task force and its dual aims of identifying elements of effective therapy relationships (what works in general) and identifying effective methods of adapting treatment to the individual patient (what works in particular). The task force judged four patient characteristics (reactance/resistance, preferences, culture, religion/spirituality) to be demonstrably effective in adapting psychotherapy and another two (stages of change, coping style) as probably effective. Two more patient facets (expectations, attachment style) were related to psychotherapy outcome but possessed insufficient research as a means of adaptation. This special issue provides research-supported methods of individualizing psychotherapy to the person, in addition to his or her diagnosis. © 2010 Wiley Periodicals, Inc. J Clin Psychol: In Session 67:127–132, 2011.

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Since the earliest days of modern psychotherapy, practitioners have realized that treatment should be tailored to the individuality of the patient and the singularity of his or her context. As early as 1919, Freud introduced psychoanalytic psychotherapy as an alternative to classical analysis on the recognition that the more rarified approach lacked universal applicability (Wolitzky, 2011). The mandate for individualizing psychotherapy was embodied in Gordon Paul's (1967) iconic question: "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under which set of circumstances?" Every psychotherapist recognizes that what works for one person may not work for another; we seek "different strokes for different folks."

To many, the means of such matching was to tailor the psychotherapy to the patient's disorder or presenting problem—that is, to find the best treatment for a particular disorder. The research suggests that it is certainly useful for select disorders; some psychotherapies make better marriages with some mental health disorders (Barlow, 2007; Nathan & Gorman, 2007; Roth & Fonagy, 2004). Indeed, the overwhelming majority of randomized clinical trials in psychotherapy compare the efficacy of specific treatments for specific disorders (Lambert, 2011).

However, only matching psychotherapy to a disorder is incomplete and not always effective (Wampold, 2001). Particularly absent from much of the research has been the person of the patient, beyond his or her disorder. 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 accumulating research demonstrates that it is indeed frequently effective to tailor psychotherapy to the entire person (Norcross, 2011b).

The process of creating the optimal match in psychotherapy has been accorded multiple names: adaptation, responsiveness, attunement, matchmaking, customizing, prescriptionism, treatment selection, specificity factor, differential therapeutics, tailoring, treatment fit, and individualizing. By whatever name, the goal is to enhance treatment effectiveness by tailoring it to the individual and his or her singular situation. In other words, psychotherapists endeavor to create a new therapy for each patient.

This article introduces the special issue of the *Journal of Clinical Psychology: In Session* devoted to evidence-based means of adapting psychotherapy to the patient's transdiagnostic characteristics. We begin by summarizing the aims and work of an interdivisional task force that produced the following articles. Thereafter, we consider the challenge of determining what works in adapting psychotherapy. The article concludes by featuring the eight subsequent articles.

Interdivisional Task Force

The American Psychological Association's Division of Clinical Psychology and Division of Psychotherapy created a Task Force to update the findings and recommendations of an earlier task force (Norcross, 2002). The Task Force's dual aims were to, first, identify elements of effective therapy relationships and, second, identify effective methods of adapting therapy on the basis of characteristics of the patient (other than diagnosis). In other words, we were interested in both what works in general and what works for particular patients. This special issue addresses the second purpose; another special journal issue addresses the first (Norcross, 2011a).

The aims of the original and the current task force remained the same, but our name, methodology, and scope did not. First, we retitled the task force *evidence-based psychotherapy relationships* instead of *empirically supported* (*therapy*) *relationships* to parallel the contemporary movement to the newer terminology. This title change, in addition, properly emphasizes the confluence of the best research, clinical expertise, and patient characteristics to form an effective therapeutic relationship (see APA Task Force on Evidence-Based Practice, 2006). Second, we expanded the breadth of coverage. New reviews were commissioned on patient preferences, culture, and attachment style. Third, we decided to utilize meta-analyses for the research reviews to ensure the conclusions reflected a synthesis of all available research. These original meta-analyses enable direct estimates of the magnitude of association and the ability to search for moderators. However, as a consequence, several adaptation strategies appearing in the first task force report (functional impairment, anaclitic vs. introjective styles, assimilation of problematic experiences, and personality disorders) were excluded in this report because of their insufficient number of studies. Fourth, we improved the process for determining whether a particular treatment adaptation—say, the amount of therapist directiveness to the patient's reactance level—could be classified as Demonstrably Effective, Probably Effective, or Promising but Insufficient Research to Judge. We compiled expert panels to establish a consensus on the evidentiary strength of the empirical research for the adaptation method. Experts independently reviewed and rated the meta-analyses on several criteria: the number of supportive studies, consistency of the research results, magnitude of the positive relationship between the element and outcome, directness of the link between the element and outcome, experimental rigor of the studies, and external validity of the research base.

Presuming that psychotherapists desire to develop a repertoire of relational styles that fit the client, the question becomes what patient transdiagnostic dimensions can reliably guide practitioners in adapting psychotherapy to different clients or with the same client at different points in time. More than 200 client variables have been proposed as potential matchmaking markers, and at least 100 of these have been subjected to some research scrutiny (Clarkin & Levy, 2004). To narrow the potential list, we canvassed the research literature, consulted with experts, and conferred with authors of research reviews of the earlier task force. In the end, we commissioned original meta-analyses on the research linking treatment outcome to eight patient characteristics: reactance/resistance level, stages of change, preferences, culture, coping style, expectations, attachment style, and religion/spirituality.

The expert panel judged four of these patient characteristics (reactance/resistance, preferences, culture, religion/spirituality) to be demonstrably effective in adapting psychotherapy and another two (stages of change, coping style) as probably effective. Two more patient facets (expectations, attachment style) were promising but possessed insufficient research as a means of adaptation.

The task force reaffirmed and, in several instances, updated the findings and conclusions of its predecessor (Norcross, 2002) regarding treatment adaptation or responsiveness. Specifically, the interdivisional task force concluded that adapting or tailoring the therapy relationship to specific patient characteristics (in addition to diagnosis) enhances the effectiveness of treatment (see Norcross, 2011b, for details). It advanced a series of recommendations directed toward practice, training, research, and advocacy. Those related to treatment adaptation stated:

- We recommend that the results and conclusions of this second Task Force be widely disseminated to enhance awareness and use of what "works" in the therapy relationship.
- Readers are encouraged to interpret these findings in the context of the acknowledged limitations of the Task Force's work.
- We recommend that future Task Forces be established periodically to review these findings, include new elements of the relationship, incorporate the results of non-English language publications (where practical), and update these conclusions.
- Practitioners are encouraged to adapt or tailor psychotherapy to those specific patient characteristics in ways found to be demonstrably and probably effective.
- Concurrent use of evidence-based therapy relationships *and* evidence-based treatments adapted to the patient's disorder and characteristics is likely to generate the best outcomes.
- Training and continuing education programs are encouraged to provide competency-based training in adapting psychotherapy to the individual patient in ways that demonstrably and probably enhance treatment success.
- APA's Division of Psychotherapy, Division of Clinical Psychology, and other practice divisions are encouraged to educate its members regarding the benefits of evidence-based therapy relationships.
- Mental health organizations as a whole are encouraged to educate their members about the improved outcomes associated with using evidence-based therapy relationships, as they frequently now do about evidence-based treatments.
- We recommend that the American Psychological Association and other mental health organizations advocate for the research-substantiated benefits of a nurturing and responsive human relationship in psychotherapy.
- Finally, administrators of mental health services are encouraged to attend to the relational features of those services. Attempts to improve the quality of care should account for treatment relationships and adaptations.

This Issue

The following articles offer cutting-edge clinical examples, research summaries, and therapeutic practices on adapting the treatment and the relationship to the individual patient in psychotherapy. Each article uses the same section headings and follows a consistent structure, as follows:

- Introduction (untitled). Several paragraphs to introduce the patient characteristic and its historical context.
- Definitions and Measures. Define in theoretically neutral language the patient quality being reviewed. Identify any highly similar or equivalent constructs from diverse theoretical traditions. Review the popular measures used in the research and included in the ensuing meta-analysis.
- Clinical Examples. Provide concrete examples of the patient matching being reviewed.
- Meta-Analytic Review. Systematically compile all available empirical studies linking the patient characteristic to treatment outcome in the English language. Use the Meta-Analysis

Reporting Standards (MARS) as a general guide for the information included and report the effect size as *d*.

- Moderators. Summarize the significant moderators of the association between matching the patient characteristic and treatment outcome.
- Patient Contribution. The meta-analyses pertain largely to the psychotherapists' contribution—how the therapist tailors or customizes the treatment to the patient. By contrast, this section should address the patient's contribution to that relationship and the distinctive perspective he or she brings to the interaction.
- Limitations of the Research. A brief section pointing to the major limitations of both the meta-analysis and the available studies.
- Therapeutic Practices. The emphasis here should be placed squarely on what works. Bullet the practice implications from the foregoing research, primarily in terms of the therapist's contribution and secondarily in terms of the patient's perspective.
- Selected References and Recommended Readings.

The meta-analyses reported herein all employed the weighted *d* as the effect size (ES). This decision improved the consistency among the meta-analyses, enhanced their interpretability among the readers, and enabled direct comparisons of the meta-analytic results to one another as well as to the value of *d* when comparing the relative effects of two treatments. By convention (Cohen, 1988), a *d* of .20 in the behavioral sciences is considered a small effect, .50 a medium effect, and .80 a large effect.

Table 1 offers several practical ways to translate the effect size of *d* into clinical practice. As a point of comparison, it might prove helpful to consider the typical meta-analysis benchmarks in psychotherapy outcome research. The *d* between psychotherapy and no

Table 1
Practical Interpretation of d Values

d	Cohen's benchmark	Type of effect	Percentile of treated patients[a]	Success rate of treated patients[b]	Number needed to treat[c]
1.00		Beneficial	84	72%	2.2
.90		Beneficial	82	70%	2.4
.80	Large	Beneficial	79	69%	2.7
.70		Beneficial	76	66%	3.0
.60		Beneficial	73	64%	3.5
.50	Medium	Beneficial	69	62%	4.1
.40		Beneficial	66	60%	5.1
.30		Beneficial	62	57%	6.7
.20	Small	Beneficial	58	55%	10.0
.10		No effect	54	52%	20.0
.00		No effect	50	50%	
−.10		No effect	46	48%	
−.20		Detrimental	42	45%	
−.30		Detrimental	38	43%	

Adapted from "Statistical Power Analysis for the Behavioral Sciences, 2nd Edition," by J. Cohen, 1988, Hillsdale, NJ: Erlbaum. "The Great Psychotherapy Debate: Models, Methods, and Findings," by B.E. Wampold, 2001, Mahwah, NJ: Erlbaum.
[a]Each ES can be conceptualized as reflecting a corresponding percentile value; in this case, the percentile standing of the average treated patient after psychotherapy relative to untreated patients.
[b]Each ES can also be translated into a success rate of treated patients relative to untreated patients; a *d* of .70, for example, would translate into approximately 66% of patients being treated successfully compared to 50% of untreated patients.
[c]Number needed to treat (NNT) refers to the number of patients who need to receive the experimental treatment vis-à-vis the comparison to achieve one success. An effect size of .70 approximates an NNT of 3: three patients need to receive psychotherapy to achieve a success relative to untreated patients (Wampold, 2001).

treatment averages .80. The typical difference between one treatment and another treatment, when there is a genuine difference not attributable to researcher allegiance or bogus comparison, is a *d* of .10 or .20 (Wampold, 2001).

Given the large number of factors contributing to treatment outcome and the inherent complexity of psychotherapy, we do not expect large, overpowering effects of any single facet. Instead, we expect to find a number of helpful facets. And that is exactly what we find in the following articles—beneficial, small to medium-sized effects of adapting psychotherapy.

Six of the eight articles provide demonstrably or probably effective means of adapting psychotherapy to the patient. The remaining two articles present compelling research that patient expectations and attachment style predict treatment outcomes, but not enough research has been conducted yet to determine that adapting treatment to them renders patient benefit.

Adapting Psychotherapy to the Person

As the field of psychotherapy has matured, the identical psychosocial treatment for all patients is now recognized as inappropriate and, in select cases, perhaps even unethical. We will not progress, and our patients will not benefit, by imposing a Procrustean bed onto unwitting consumers of psychological services. In his Foreword to *Differential Therapeutics in Psychiatry*, Robert Michels (1984, p. xiii) summed it as follows:

> The easiest way to practice psychiatry is to view all patients and problems as basically the same, and to apply one standard therapy or mix of therapies for their treatment. Although some may still employ this model, everything we have learned in recent decades tells us that it is wrong—wrong for our patients in that it deprives them of the most effective treatment, and wrong for everyone else in that it wastes scarce resources.

Decades of research now scientifically support what psychotherapists have long known: different types of clients require different treatments and relationships. And the research has now identified specific patient characteristics and optimal matches by which to tailor or adapt psychotherapy. In the tradition of evidence-based practice, psychotherapists can create a new, responsive psychotherapy for each distinctive patient and his or her singular situation, in addition to his or her disorder.

In our presentations and workshops, we are frequently asked: What should we do if we are unable or unwilling to adapt our therapy to the patient in the manner that research indicates is likely to enhance psychotherapy outcome? We answer that four possible avenues spring to mind. First, address the matter forthrightly with the patient as part of the evolving therapeutic contract and the creation of respective tasks, in much the same way one would with patients requesting a form of therapy or a type of medication that research has indicated would fit particularly well in their case but which is not in your repertoire. Second, treatment decisions are the result of multiple, interacting, and recursive considerations on the part of the patient, the therapist, and the context. A single evidence-based guideline should be seriously considered, but only as one of many determinants of treatment itself. Third, an alternative to the one-therapist-fits-most-patients perspective is practice limits. Without a willingness and ability to engage in a range of interpersonal stances, the therapist may limit his or her practice to clients who fit that practice. Psychotherapists need not offer all services to all patients. Fourth, consider a judicious referral to a colleague who can offer the relationship stance (or treatment method or medication) indicated in a particular case.

The effectiveness of psychotherapy can be improved by tailoring psychotherapy to one or more of the patient characteristics skillfully summarized in the following eight articles. Research now enables us, in the terms of the philosophy of science, to balance particularity and generality: adapt psychotherapy to the *particulars* of the individual patient but do so according to *generalities* identified by research. This special issue advances the field by providing research-supported methods of individualizing psychotherapy to the entire person and his or her singular situation.

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