Depression

Alcohol Abuse

Pain Disorder

Panic Disorder

Trichotillomania

Social Phobia

Specific Phobia

Anxiety Disorder

Posttraumatic Stress Disorder

Obsessive-Compulsive Disorder

Sexual Dysfunction

Histrionic Personality Disorder

Insomnia

Somatization Disorder

Bulimia Nervosa

Exhibitionism

Borderline Personality Disorder

Pathological Gambling

Effective Brief Therapies

A Clinician's Guide

Edited by
Michel Hersen
Maryka Biaggio

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A Clinician's Guide

Edited by

Michel Hersen and Maryka Biaggio

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To Vicki

Michel Hersen

To Deb

Maryka Biaggio

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Contents

Preface xi

Contributors xiii

Part I

Introduction

Chapter 1
Overview of Assessment and Treatment Issues
James Lane 3

Part II

Treatment of Specific Disorders (DSM-IV Diagnoses)

Chapter 2
Major Depressive Episode
David O. Antonuccio, Peter M. Lewinsohn, Melissa Piasecki, and Robin Ferguson 19

Chapter 3
Alcohol Abuse
David C. Hodgins 41

Chapter 4
Panic Disorder
Jennie C. I. Tsao and Michelle G. Craske 63

Chapter 5
Specific Phobia
F. Dudley McGlynn and Steven R. Lawyer 79

Chapter 6
Social Phobia
Ronald A. Kleinknecht 99

Chapter 7
Obsessive–Compulsive Disorder
Ralph M. Turner, Belinda E. Barnett, and Kathryn E. Korslund 117

Chapter 8
Posttraumatic Stress Disorder
Terence M. Keane, Amy E. Street, and Holly K. Orcutt 139

Chapter 9
Generalized Anxiety Disorder
Michelle G. Newman 139

Chapter 10
Somatization Disorder
Ghazi Asaad 179

Chapter 11
Pain Disorder
Robin M. Masheb and Robert D. Kerns 191

Chapter 12
Sexual Dysfunction
Nathaniel McConaghy and M. Lowy 215

Chapter 13
Exhibitionism
Barry M. Maletzky 229

Chapter 14
Bulimia Nervosa
J. Scott Mizes and Deanna Zotter Bonifazi 257

Chapter 15
Primary Insomnia
Kenneth L. Lichstein and David L. Van Brunt 283

Chapter 16
Pathological Gambling
Robert Ladouceur, Carolyn Sylvain, and Claude Boutin 303

Chapter 17
Trichotillomania
Ruth M. T. Stemberger, Amanda McCombs-Thomas,
Sherry G. MacGlashan, and Charles S. Mansueto 319

Chapter 18
Borderline Personality Disorder
Soonie A. Kim and Brian C. Goff 335

Chapter 19
Histrionic Personality Disorder
William I. Dorfman 355

Part III

Special Issues

Chapter 20
Considerations for Gay and Lesbian Clients
Sandra J. Coffman and G. Dorsey Green 373

Chapter 21
Considerations for Clients with Marital Dysfunction
Gary R. Birchler and William Fals-Stewart 391

Chapter 22
Considerations for Ethnically Diverse Clients
Daniel S. McKitrick and Sandra Y. Jenkins 411

Chapter 23
Considerations for Older Adults
Barry A. Edelstein, Ronald R. Martin, and Jeffrey L. Goodie 433

Author Index 449

Subject Index 455

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Preface

Effective Brief Therapies: A Clinician's Guide emanates from our interactions with clinical students in practice, field placements, internships, and residencies over several decades. No matter how well prepared and trained in the theoretical aspects of our craft, nascent clinicians experience considerable anxiety in conceptualizing their cases and developing effective treatment regimens. Very often they are overwhelmed by clients who do not present as described in standard textbook fashion. Indeed, they find that inevitably there are concurrent diagnoses and treatments and numerous unanticipated treatment issues. Students also quickly learn in our era of accountability and managed care that time efficiency in dealing with clients is an imperative.

Our book, therefore, is devoted to facilitating clinicians' understanding of strategies for approaching cases, conducting viable assessments, and implementing contemporary therapies. The book is divided into three parts.

Part I (Introduction) includes one chapter that broadly considers assessment in effective brief therapy.

In Part II (Treatment of Specific Disorders) there are 18 chapters in which individuals with expertise for the specific disorders discuss the clinical approach to treatment. Most of the chapters in this part follow the following outline:

1. Case Description
2. Treatment Conceptualization
3. Assessment
4. Treatment Implementation
5. Concurrent Diagnoses and Treatment
6. Complications and Treatment Implications

7. Dealing with Managed Care and Accountability
8. Outcome and Follow-up
9. Dealing with Recidivism
10. Summary
11. References

In Part III (Special Issues), important issues frequently overlooked by some therapists are examined, including considerations for Gay and Lesbian Clients (Chapter 20), Clients with Marital Dysfunction (Chapter 21), Ethnically Diverse Clients (Chapter 22), and Older Adults (Chapter 23). Integral concern with diversity and cross-cultural issues should be a given in the contemporary clinician's daily activities. Chapters 20, 22, and 23 underscore these points.

Many individuals have contributed to the fruition of this book. First and foremost, we thank our eminent contributors for taking time out from their busy schedules to impart their erudite thinking about cases. Second, we thank Alexander Duncan, Carole L. Londerée, and Erika Qualls for their invaluable technical assistance. And, finally, but hardly least of all, we are most appreciative of Dr. George Zimmar's efforts as our editor at Academic Press. Indeed, when your editor is a psychologist himself you need to be on your toes. George's assistance, advice, and ideas have been of tremendous value to us.

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PART I

INTRODUCTION

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CHAPTER

Overview of Assessment and Treatment Issues

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Assessment in Brief Treatment
Assessment and Formulation
Assessment and Active Treatment
Empathy and Rapport
Feedback and Self-Understanding
Establishing Baselines and Monitoring Progress
Assessment and the Concluding Evaluation
Assessment and the Clinician's Guiding Conception
Future Directions: Empirically Supported Assessment
Summary
References

Effective Brief Therapies: A Clinician's Guide
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A basic principle of this Clinician's Guide is that assessment is an integral part of effective therapy, from diagnosis and treatment planning, through treatment implementation and monitoring progress toward treatment goals, to evaluation of outcomes. In keeping with this principle, subsequent chapters will include assessment considerations for specific disorders and special circumstances. This chapter considers general issues regarding the contribution of assessment to treatment planning, active intervention, and termination.

ASSESSMENT IN BRIEF TREATMENT

For pioneering developers of brief therapy interventions, formal assessment consisted largely of determining the suitability of clients for this approach (Vaillant, 1997). In the current climate of health care cost containment, brief interventions are the de facto treatments of choice for most clients. It would seem reasonable that the increased demand for efficiency and accountability in the provision of mental health services should lead to an increased emphasis on timely, effective assessment of clients as an integral aspect of treatment planning. However, two related trends contribute to decreased utilization of formal assessment in mental health treatment.

First, third-party payers are increasingly reluctant to pay for formal psychological assessment services. This is due, at least in part, to the historical development of assessment as a separate, and separately reimbursed, specialty service. A consultant or multidisciplinary team member not directly involved in treatment of the case often provide this service. Research documenting the cost-effectiveness of such formal assessment has lagged far behind research supporting the efficacy of interventions (Ollendick, 1999).

Second, current research and practices emphasize differential treatment selection based primarily on diagnosis. In current diagnostic practice, the clinician determines the presence or absence of facts that meet relatively explicit diagnostic criteria and then develops a descriptive, multiaxial diagnosis using the categories and language of the current diagnostic manual. Along with this straightforward, relatively noninferential diagnostic paradigm, the recent and long overdue emphasis on empirically supported interventions has contributed to overreliance on the clinical diagnosis for establishing treatment goals and selecting interventions. Assessment typically is limited to deriving a diagnosis, often without the aid of formal assessment techniques such as structured diagnostic interviews.

Diagnosis is an important step, but it is not sufficient for treatment planning. Meeting the criteria for a mental disorder documents that the client is experiencing significant distress or disability and justifies the clinician's intervention. For many disorders, the diagnosis also will direct the clinician to consider interventions with demonstrated efficacy. However, there are significant limitations to treatment selection based solely on matching diagnosis with empirically supported treatment.

Some limitations are practical. Empirically supported treatments have been documented for only a limited number of diagnoses. For many clients, an appropriate diagnosis will not have an associated treatment of established efficacy. In addition, the polythetic nature of some diagnoses means that there will be some heterogeneity of presentation in groups receiving the same diagnosis. For example, there are 105 combinations of symptoms that would meet the criteria for a major depressive episode in the current system (American Psychiatric Association, 1994). Unless we assume that these different presentations are due to the same underlying pathological process, a highly debatable assumption at best, then different presentations of the same disorder will require different treatment goals and interventions. Similarly, many clients seen in clinical practice are comorbid for two or more disorders. Such cases typically will require more complex treatment plans than those with uncomplicated disorders.

Other limitations are conceptual. Under our current diagnostic paradigm, the diagnosis of mental disorders, while potentially of high reliability, is of questionable validity for many specific diagnoses regarding their implications for etiology, course, and treatment response (Goodwin & Guze, 1996). It is troubling conceptually to select treatment based on a suspect criterion. In addition, the model of clinical practice that is implied by such a mechanical matching of treatment to diagnosis is one of a technician applying highly operationalized procedures. This model of practice as applied science (Peterson, 1991) is inconsistent with both the current development of our science and the actual practice of expert clinicians.

These comments are intended as an appeal for clinical practice to be as precise and scientific as our subject matter allows. In this regard, it can be useful to reframe the role of science in practice in a way that is consistent with contemporary developments in the philosophy of science. A positivist view of science interprets the empirically determined relationships between diagnoses and interventions as specific instances of more general basic principles, which it is science's role to discover. A more pragmatic, and more contemporary, view of our science would consider diagnoses and empirically supported treatments as potentially useful categories for

collecting, organizing, and accessing practices that have produced their intended results (Fishman, 1999). Such information becomes part of the empirical base upon which expert clinicians draw in planning treatment.

Polkinghorne (1992) noted that novice practitioners tend to follow rules and procedures in a rather mechanical manner, as implied by the positivist applied science model of practice, while experts more often modify procedures in a flexible manner based on the requirements of particular situations. More recent authors have described this conceptually informed, empirically based model of professional activity as reflective practice (Schön, 1987), disciplined inquiry (Peterson, 1991), the local clinical scientist model (Trierweiler & Stricker, 1998), and the pragmatic paradigm (Fishman, 1999).

This discussion implies that the call to be more scientific in our practice requires a more flexible and complex response than a simple insistence on following the rules and procedures delineated in empirically supported treatment manuals. Such manuals are crucial for the advancement of our science and practice. Not only do they ensure adherence to procedure and repeatability in research, they are effective tools for teaching novice clinicians and add to the expert's empirical basis for conceptualizing and planning treatment for a specific case. However, they cannot by themselves tell us how to treat every client with the relevant diagnosis or the client for whom no such manual exists.

In this vein, Sanderson (1997) argues that clinicians must consider interventions that address the client's full range of symptoms and advocates a symptom-focused, rather than disorder-based approach to treatment planning. Similarly, Horowitz (1998) argues that clinicians should not rely exclusively on diagnosis in treatment planning. A more comprehensive formulation, a conceptualization of the client in his or her life context, is needed for appropriate selection of treatment goals and specific interventions for those goals.

Formulation is a key component in Peterson's (1991) description of practice as disciplined inquiry, which provides a useful framework for describing the role of assessment in brief therapy.

Professional activity as disciplined inquiry begins with the client, which can be an individual, a group, or some larger social unit. The client's problems and goals for change shape the professional task. The first step in the process is the initial assessment, and it is at this point that disciplined inquiry begins to diverge from the applied science model. As noted above, the current incarnation of applied science views assessment chiefly in terms of noninferential determination of descriptive diagnosis. In disciplined inquiry, the assessment process is shaped by the clinician's "guiding

conception" of the phenomena under study (Peterson, 1991). This guiding conception includes the clinician's assumptions about epistemology, theory, and ethics, in addition to knowledge of relevant empirical research and personal knowledge of similar cases. The data collected by the assessment are then integrated into a formulation of the client's circumstances. The formulation represents the clinician's best understanding of this specific case, including the appropriate descriptive diagnosis in mental health practice, and may involve a reformulation of the client's initial presentation of problems and goals. The formulation points to a course of action, which is "either an intervention that offers the best available prospect of benefit to the client or a decision that will be useful to the client" (Peterson, 1991, p. 427). In many cases, this course of action will include an empirically supported intervention.

Clinician and client then evaluate the effectiveness of the action. If they agree that the changes or decisions are adequate to meet the client's goals or that further action is not likely to further those goals, the clinician completes the inquiry by conducting a concluding evaluation. However, if either party considers the outcome inadequate and both conclude that further action is likely to be beneficial, then "further cycles of reformulation, action, and evaluation may continue until an acceptable outcome is reached. Acceptable outcomes may include the decision by either or both parties that the attentions of the practitioner are of no use to the client" (Peterson, 1991, p. 427).

In an idealized applied science model, each case is an example of one or another general class, with class membership being the principal determinant of action. In contrast, in disciplined inquiry:

> Each case the practitioner studies adds to the store of knowledge he or she can bring to the next case. Usually the experience is assimilated within the body of comparable experiences the practitioner has accumulated previously. Occasionally, however, the outcomes or other characteristics of a case are so sharply inconsistent with the guiding conception the practitioner has followed until that time that an accommodating change in the conception is required. (Peterson, 1991, p. 427)

Each step of professional practice as disciplined inquiry is mediated by assessment data, either informal or standardized. Following are discussions of assessment in formulation and treatment planning, in monitoring evaluations, in the concluding evaluation, and in mediating change in the clinician's guiding conception.