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Participant Factors in Treating Dysphoric Disorders

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Separating those factors and qualities that are legitimately characteristic of participants from those that are related to the process of developing a therapeutic relationship, or even those that are characteristic of the treatment being offered is central to the work of the current Task Force. However, it is also a more arbitrary distinction than it would initially seem. For example, in each of the five editions of *The Handbook of Psychotherapy and Behavior Change* (Bergin & Garfield, 1971, 1994; Garfield & Bergin, 1978, 1986; Lambert, 2003), separate chapters are devoted to discussing therapist and patient/client (participant) characteristics, treatment processes (i.e., relationship) variables, and various treatment approaches.[1] Yet, at least 50% of the variables or qualities discussed in any one of these chapters are also discussed in at least one of the other three. Almost any given variable has, at one time or another, been attributed to one of the participants, the treatment relationship or therapeutic alliance, or to an inherent aspect of some treatment model.

To illustrate this complexity, consider whether you, the reader, consider therapist "warmth," "self-disclosure," and "persuasiveness" to be aspects of the therapeutic relationship, qualities of therapist skillfulness, or ingredients of treatment? They have been included in each of these domains by various authors. Even such supposedly therapist offered conditions as those described by Rogers (1957) have long been known to confound aspects of both the therapist and patient (Gurman, 1977).

Following the guidelines applied to the authors of this volume, we have identified "Participant Factors" as those qualities that (1) exist within the person of the therapist or patient, and (2) that are identifiable outside of what takes place within psychotherapy itself. That is, participant factors are enduring and relatively stable traits that are brought into treatment by the patient or therapist who is involved in the process.

In the current chapter, we have separately considered those variables that are *inferred* to be present by extrapolating from observations made by the patient of the treatment process, and those that are objectively measured or *observed* by other

people. This distinction gives order to our presentation and is borrowed from that suggested in previous reviews of this literature (e.g., Beutler, Machado, & Neufeldt, 1994; Beutler, Malik, Alimohamed, Harwood, Talebi, Noble, & Wong, 2003). Thus, drawing from the topics discussed by the Division 29 Task Force on Relationships, sex, ethnicity, resistance to others, coping style, and personality disorder are measurable from behavioral observations of participants, independent of self-reports, while religious belief, expectations, preferences, assimilation of problematic experience, and stages of change, are participant qualities that can only be inferred from some aspect of participant's report.

In a comprehensive meta-analysis of therapist factors, spanning the last decade of the twentieth century, Beutler, Malik, et al. (2003) observed that the independent effects of therapist variables were weak. The strongest effects were observed when either patient and therapist or patient and treatment factors were considered together. That is, participant factors moderate the effects of specific treatment in the same way that treatment procedures sometimes moderate the effects of patient and therapist qualities (Garfield, 1994).

The complex interactions among patient and therapist characteristics were taken into account by the Division 29 Task Force on the "Empirically Supported Therapeutic Relationship" by including patient characteristics that served to moderate treatment effects, leading different types of patients to benefit selectively from various treatment approaches. To ensure that the current chapter retained this perspective, we confined our review of participant variables to the factors that were defined by the Division 29 Task Force. Wherever feasible, we considered the role of shared factors in all dimensions reviewed.

Little research has looked specifically at the effects of patient and therapist variables as predictors of some measurable outcome of treatment. The paucity of this research was noted by the Task Force on the Empirically Supported Relationship (Norcross, 2002), but this latter Task Force, like other scholars in this area, gave little consideration to specific problems and conditions. Our review of participant effects attempted to address this failure to consider the potential impact of different types of patient problem by comparing the conclusions reached by the Division 29 Task Force with the findings that are revealed when only those studies that employed depressed samples are considered. When inadequate literature was present, we accepted the conclusions of the Division 29 Task Force as likely applicable to depression. However, when literature on depression was present, we sought to confirm or refute validity of the Division 29 conclusions.

To extend, where possible, the body of literature reviewed and considered in testing the generalization of the Division 29 conclusions, we added references and findings from other reviews, especially chapters on participant variables from the most recent edition of the *Handbook of Psychotherapy and Behavior Change* (Lambert, 2003) and other meta-analytic reviews of recent research. In all cases, principles of treatment were only defined as "empirically supported" when (1) a critical mass of literature was available and (2) the "preponderance of evidence" obtained from it favored the identified finding.

OBJECTIVE TRAITS SHARED BY PATIENT AND THERAPIST

Patient and Therapist Sex

General Effects

Sue and Lam (2002), writing for the Division of Psychotherapy (29) Task Force on the Empirically Supported Relationship, examined available research evidence for differences in treatment effects as a function of: (1) women versus men, (2) minority versus nonminority individuals, and (3) bisexuals versus heterosexuals across problem areas. They inspected these comparisons as applied to patient characteristics and then addressed the issue of whether these same qualities when matched with similar qualities in the therapist altered the findings. In most domains, they concluded that research was inadequate to determine whether patient demographic qualities or the similarity of patient and therapist on these dimensions enhanced outcomes of psychotherapy in a meaningful way.

They found a small number of studies ($N = 3$) that suggested the presence of a sex difference among patients. Whenever such differences were

observed, women uniformly were more responsive to treatment than men. Similarly, they inspected the effects of same versus different sex matching among patients and therapists. In the three studies in which differences were observed, female–female pairs were associated with more favorable outcomes than were the other dyads.

In a more comprehensive review of 58 studies, Bowman, Scogin, Floyd, and McKendree-Smith (2001) also summarized the effects of therapist sex on treatment outcome using meta-analytic procedures. The authors found a significant but small effect size favoring female therapists (d = .04; $p < .05$), thus, lending support to the observations of Sue and Lam. However, no significant differences were obtained as a function of patient sex.

Similarly, Beutler, Malik, et al. (2003) conducted a meta-analysis of sex effects, based on 10 studies published since 1990. They found a significant but small main effect of therapist sex on outcome (*ES1(r)* = .12), once again favoring females. Only one study (Sue, Fujino, Hu, Takeuchi, & Zane, 1991) found a significant relationship between patient–therapist sex matching and outcomes. These results favored similar sex pairs in predicting treatment outcome.

Overall, the results from these three reviews are consistent and suggest that a statistically significant but small effect favors female therapists over male therapists in treating a variety of largely mixed outpatient populations. The small number of studies detracts from but does not overshadow the strength of this conclusion. However, the results are less persuasive when applied either to effects associated with patient sex or to those associated with the sex match of patients and therapists. There is no convincing evidence, from these reviews, that sex matching of patients and therapists contributes appreciably to treatment benefit.

Extending the concepts derived from sex matching to more general aspects of gender, Sue and Lam (2002), reporting for the Division 29 Task Force, revisited the findings of Dunkle (1994), who reviewed six studies of patient gay/lesbian/bisexual (GLB) status on therapy change. Unfortunately, only two of the studies measured actual changes in clinical conditions. Sue and Lam identified seven additional outcome studies on this topic, however, and concluded that the preponderance of evidence indicated that GLB patients make significant changes during psychotherapy programs and tend to be reasonably well satisfied with their progress.

Conclusions about patient–therapist match on sexual attitudes are still weak, however. The weak findings may be attributed to design weaknesses in most of the studies. The infrequent use of control groups and a tendency to confound GLB status with such patient characteristics as ethnicity (e.g., Choi et al., 1996; Peterson et al., 1996) reduce the viability of the conclusions. Taking a broader view and employing meta-analytic procedures, Beutler, Malik, et al. (2003) explored the role of therapist–patient matching in the treatment of patients who varied in their gender-related attitudes. They found positive but weak support for the hypothesis that therapists who identify themselves as "feminist" in orientation may be better able to establish a good working relationship than nonfeminist therapists, regardless of the gender preferences of the patient (Cantor, 1991). While outcome is even more weakly affected, whatever the advantage that accrues to therapists who hold nontraditional views of sexual roles, it appears to be most pronounced among female clients, at least when compared to those therapists who hold traditional gender views (e.g., Banikiotes & Merluzzi, 1981; Hart, 1981).

Principles for Treating Depressed Patients

We extracted from the reviews by Sue and Lam (2002) and by Beutler, Malik, et al. (2003) those studies that focused on patient samples that were characterized by clinical depression. A review of these studies (Table 2.1) reveals a pattern that is generally consistent with the overall trend. Unfortunately, the number of studies of depressed samples who were GLB was too small and the effect sizes too weak to reach conclusions about the role of therapist and patient gender-based attitudes. A more substantial and consistent body of studies was available on patient and therapist sex. This sample of studies was comprised of five from the meta-analysis by Beutler, Malik, et al. (2003) and eight from the report by Sue and Lam (2002). Five of the resulting 13 studies found an effect favoring female therapists and five found evidence of pa-

Table 2.1
Sex and Gender

Study	N	Diagnosis	Outcome effects
		Therapist sex	
From Beutler et al., 2003			
Krippner & Hutchinson, 1990	288	Mixed depression/anxiety (clients with homicidal/suicidal ideation excluded)	Significant effect of female therapist gender on State-Trait Anxiety (STAI) scores No significant effect of gender match on STAI scores
Orme & Boswell, 1991	721	Dysphoric	No significant effect of gender on attendance at intake No significant effect of gender match on intake attendance
Sue, Fujino, Hu, Takeuchi, & Zane, 1991	13,439	Dysphoric	Positive effect of gender match on lack of dropout (dropout = failure to return after first session) Positive effect of gender match on length of treatment Positive effect of gender match on Global Assessment Scale (GAS) outcomes
Talley, 1992	72	Dysphoric	No significant effect of gender on multivariate outcome (Beck Depression Inventory, Zung Self-Rating Depression Scale, Zung Self-Rating Anxiety Scale)
Zlotnick, Elkin, & Shea, 1998	203	Major Depressive Disorder	No significant effect of therapist gender on Hamilton Rating Scale for Depression scores (HRSD) No significant effect of gender match on HRSD scores
From Sue & Lam, 2002			
Craig & Huffine, 1976	140 mostly African American	Dysphoric	Non-significant effect of therapist gender on premature termination
Fujino, Okazaki, & Young, 1994	1,132	Dysphoric	Significant effect of gender match on dropout, treatment duration, and functioning level for Asian American women and men, and White American women (match reduced premature termination, increased treatment duration, and predicted higher initial functioning, particularly for Asian American women) No significant effect of gender match on initial diagnosis or posttreatment functioning
Heisler, Beck, Fraps, & McReynolds, 1982	200	Dysphoric (community mental health center)	No significant correlation of client's gender and therapy attendance

Study	N	Diagnosis	Outcome effects
		Therapist sex	
Jones, Krupnick, & Kerig, 1987	60 female	DSM-III PTSD or adjustment disorder, most with anxiety or affective disorders (excluded: those with psychiatric hospitalization, severe character problems, lifestyle of trauma life events)	Effect of therapist gender on symptomatic improvement and client satisfaction (more improvement and satisfaction with female therapists) Significant effect of therapist gender on levels of client intrusive symptomology (lower levels with female therapists) Initial symptomology, client age, and therapist gender account for .22, .13, & .08 of variance in outcome in that order
Jones & Zoppel, 1982	160	Neurotic and personality disorders, depression, and adjustment reactions (psychosis, schizophrenia, and psychotic trends excluded)	Study 1: therapist ratings No effect of client gender on ratings of improvement, but female therapists rate themselves as more successful with female clients, report better alliances, and describe clients in more positive ways than male therapists Study 2: client ratings Significance effect of therapist gender on client ratings of effectiveness of therapeutic alliance (both male and female clients found female therapists more effective in forming therapeutic alliance) No significant effect of gender match on therapy outcome Significant effect of gender match on length of treatment (same sex dyads had longer treatment duration but possible effect of nonrandom assignment of clients to therapists)
Kirshner, Genack, & Hauser, 1978	189; 47% female (university health service; includes faculty)	Dysphoric	Significant effect of therapist gender on patient satisfaction and self-rated improvement (greater satisfaction and improvement with female therapists)
Orlinsky & Howard, 1976	118 women with 78 male & 40 female therapists	Depression, anxiety, and personality disturbance	Significant effect of therapist gender on client therapy experience (clients with male therapists feel more involved, uncomfortable, and self-critical, and less supported) Significant effect of depressive conditions on sensitivity to therapist sex (those with depressive reaction [vs. anxiety reaction and personality disturbance] more sensitive to male therapists) No significant effect of therapist gender on levels of mastery, insight, overall outcome

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Table 2.1
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Study	N	Diagnosis	Outcome effects
		Therapist sex	
Weitz, 1982	73 females	Feminist consciousness raising group participation	Significant positive effect of group participation on helplessness and self-esteem Significant positive relationship between self-esteem and helplessness, and depression scores
Bowman, Scogin, Floyd, & McKendree-Smith, 2001	Review of 58 studies	Dysphoric	Modest effect of therapist sex on treatment outcome
		Client sex	
From Sue & Lam, 2002			
Jones & Zoppel, 1982	160	Neurotic and personality disorders, depression, and adjustment reactions (psychosis, schizophrenia, and psychotic trends excluded)	No effect of client gender on ratings of improvement (both male and female clients reported significant improvement) No significant effect of gender match on therapy outcome Significant effect of gender match on length of treatment (same sex dyads had longer treatment duration but possible effect of nonrandom assignment of clients to therapists)
Kirshner, Genack, & Hauser, 1978	189; 47% female (university health service; includes faculty)	Dysphoric	Significant effect of client gender on response to therapy (female patients are more responsive
Talley, Butcher, Maguire, & Pinkerton, 1992	N/A	Dysphoric Disorder	Significant effect of client gender on dysphoria scores (females show greater symptom reduction)
Thase et al., 1994	84	Research Diagnostic Criteria for Major Depression (nonpsychotic, nonbipolar type)	Significant effect of pretreatment depression scores on outcome (higher initial depression scores related to poorer outcomes, particularly for women) No significant interaction effect of gender and time on depression scores
Zlotnick et al., 1996	188	Major Depressive Disorder	No significant main or interaction effects of patient gender (with treatment type, dysfunctional attitudes, life events, or social support) on severity of depressive symptoms

tient–therapist sex similarity as a correlate of positive effects.

While female sex and sexual similarity are relatively consistent correlates of outcome, the percentage of positive findings failed to meet the criteria of a "preponderance of evidence." Thus, we accepted the Division 29 conclusion that:

1. Research on gender effects is insufficient for a clear judgment of effects on the treatment of depressed patients to be made.

This latter conclusion has been reiterated by others with respect to the effects of specific therapies on the treatment of panic disorder (Huppert et al., 2001).

Patient and Therapist Ethnicity and Socioeconomic Status

General Effects of Ethnicity

In the analysis of ethnic status and patient–therapist ethnic similarity, Beutler, Malik, et al. (2003) concluded that there is insufficient research to systematically compare outcomes as a direct effect of therapist race or ethnicity, independently of that of the patient. Most research is relational in nature and assumes that outcome is or may be improved when therapist and patient share certain ethnic experiences and background. These shared perspectives can be assumed to derive from either systematic training to enhance cultural sensitivity (Valdez, 2000) or from the presence of similar cultural backgrounds.

The review of this literature for the Division 29 Task Force shows similarly weak effects of ethnicity on outcome. Reviewing literature on this latter literature, Sue and Lam (2002) separately inspected the effects of treatment that were associated with patient and therapist samples of African Americans, Native Americans, Asian Americans, and Latinos. They noted that among African Americans, a small but proportionately large number of studies (N = 3 of 6) found that African Americans do more poorly in psychotherapy than other ethnic groups. The other three studies obtained nonsignificant findings and no study, to our knowledge, has reported a superior response to psychotherapy among African-American clients, compared to white or Asian-American samples.

According to Sue and Lam, studies of Native Americans are too sparse to use in any investigation of principles of change (N = 1), and these authors found only two studies conducted on Asian-American samples. These latter studies demonstrated lower satisfaction rates among Asian Americans than among other groups, and both of these studies also demonstrated that patient–therapist ethnic similarity was associated with lower dropout rates. Three studies indicated that directive interventions were preferred and (perhaps) more effective among Asian Americans than among majority groups. These latter conclusions are based upon too little evidence to draw reasonable conclusions at this point, however.

Sue and Lam concluded that improvement among Latinos is comparable to that observed among non-Latino samples. However, they cite three studies that found that matching patient–therapist ethnic similarity enhances the likelihood of improved outcomes. The authors suggest that language commonality may account for these latter findings—sharing a primary language was associated with low dropout rates. They also noted that family involvement in therapy may enhance response to treatment among Latino adolescents.

In their inspection of patient–therapist ethnic similarity, Beutler, Malik, et al. (2003) identified five studies that assessed change over treatment (Hosch et al., 1995; Ricker, Nystul, & Waldo 1999; Snowden, Hu, & Jerrell 1995; Sue et al., 1991; Yeh, Eastman, & Cheung, 1994) and three more that used treatment dropout as an outcome variable (Sterling, Gottheil, Weinstein, & Serota, 1998; Sue et al., 1991; Yeh et al., 1994).

Collectively, the studies cited in these two reviews confirm the hypothesis that, across problem types, patient–therapist ethnic similarity is a factor that contributes to reduced dropout rates. Ethnic match, particularly among Asian Americans (Snowden et al., 1995) and Mexican Americans (Sue et al., 1991), seems to be conducive to improvement, but the effect sizes are small, ranging from 0 to .28. In the Beutler, Malik, et al. (2003) review, the mean (weighted) effect size (r) was only .02 ($p < .05$).

General Effects of Socioeconomic Status

Because socioeconomic status (SES) is often confounded with ethnicity, Sue and Lam (2002) analyzed its potential influence on the foregoing relationships, separately. They conclude that low-income clients are more likely to drop out of treatment prematurely than middle- and high-income clients. They also conclude that there is not a strong or meaningful relationship between social class and direct therapy outcome.

Principles for Treating Depressed Patients

To test the specificity of the foregoing findings to depressed samples, a collected group of 14 studies of samples represented by dysphoria and clinical depression were extracted from the reviews by Beutler, Malik, et al. (2003) and Sue and Lam (2002). Table 2.2 reveals the results of these studies, separately listed by those attending to therapist ethnicity and patient ethnicity. Seven studies (50%) revealed that similar patient–therapist ethnic pairs were associated with better outcomes or lower dropout rates than ethnic-different pairs. Three additional studies reported advantages of adjusting the treatment to the special needs and considerations of ethnic patients, and only one indicated advantages accrued to ethnically mismatched pairs. Another study indicated that language similarity reduced mental health usage of emergency rooms.

The general results of the foregoing studies of depression appear to be somewhat stronger than that noted in the general psychotherapy literature using mixed diagnostic samples of patients. The results confirm the value of ethnic similarity, with a consistent majority of the studies on depressed samples favoring the importance of patient–therapist ethnic similarity in fostering positive response to psychotherapy or reducing dropout. These studies support the following treatment planning principles as applied to the treatment of patients with dysphoria and depression.

1. Patients representing underserved ethnic or racial groups achieve fewer benefits from conventional psychotherapy than patients from Anglo-American groups.
2. If patients and therapists come from the same or similar racial/ethnic backgrounds, dropout rates are positively affected and improvement is enhanced.

We also inspected the conclusions of Sue and Lam (2002) with respect to socioeconomic status (SES) in order to see if these relationships transferred to aspects of social economic status in the treatment of depression. The conclusions of Sue and Lam regarding socioeconomic status were largely based on two prior reviews of empirical literature (Lorion, 1973; Luborsky, Chandler, Auerbach, Cohen, & Bachrach, 1971) and so we inspected these reviews to identify studies that addressed depression. Unfortunately, none of the studies that addressed the role of SES on treatment outcome were conducted on homogeneously diagnosed depressed groups of patients. Three studies, however, used samples that consisted of a mix of depression and other disorders (Brill & Storrow, 1960; Rosenbaum, Friedlander, & Kaplan, 1956; Rosenthal & Frank, 1958), but only one of these (Rosenbaum et al., 1956) found any association between social class and outcome.

Sue and Lam (2002) also inspected social status as a moderator of treatment type. In spite of general claims in the literature, they found only suggestive evidence to support the belief that time-limited and directive therapies are more effective than insight-oriented treatment for low-SES clients. From the studies cited in the Sue and Lam review, only one addressed the role of time-limited therapy as a function of patient SES, using a dominantly depressed sample (Koegler & Brill, 1967). This latter study found no relationship between socioeconomic class and type of treatment.

From among the three studies cited by Sue and Lam (2002) that addressed the question of whether the use of behaviorally oriented, therapist-directed therapy might be better for low-SES clients than more insight-oriented therapy, two employed depressed samples (Organista, Munoz, & Gonzales, 1994; Satterfield, 1998). Unfortunately, neither of these studies employed a comparison group, and the results are ambiguous. In a study of this question that was missed in Sue and Lam's review, however, Sloane, Staples, Cristol, Yorkston, & Whipple (1975) found that "patients with higher incomes and less pathology did better than their opposites in analytically oriented ther-

Table 2.2
Ethnicity/Race

Study	N	Diagnosis	Outcome effects
		Therapist race	
From Beutler et al. 2003			
Ricker, Nystul, & Waldo, 1999	51	Dysphoric	Significant effect of ethnic match on SCL-90 Global Severity Index (GSI) scores
Snowden, Hu, & Jerrell, 1995	26,943	Schizophrenia, Adjustment Reaction	Significant effect of ethnic match on decreased use of emergency room Significant effect of language match on decreased use of emergency room
Sue, Fujino, Hu, Takeuchi, & Zane, 1991	13,439	Dysphoric	Effect of ethnic match on Global Assessment Scale (GAS) outcomes Effect of ethnic match on dropout (dropout = failure to return after first session) Significant effect of ethnic match on treatment length
Yeh, Eastman, & Cheung, 1994	4,616	Dysphoric	Effect of ethnic match on GAS outcomes Significant effect of ethnic match on dropout for adolescents (dropout = failure to return after first session) Effect of ethnic match on dropout
From Sue & Lam, 2002			
Brown, Schulberg, Sacco, Perel, & Houck, 1999	160, mostly female	DSM-III R Major Depressive Disorder	No significant effect of race or treatment (interpersonal or pharmacotherapy) on depression outcome scores for intent-to-treat cohorts African Americans more likely to be unemployed, unmarried, and to experience more stressful life events in 6 months pretherapy
Craig & Huffine, 1976	140 mostly African American	Dysphoric	No significant effect of patient or therapist race on continuation in therapy
Flaskerud & Hu, 1994	273 (66% female)	Major Depression	Significant effect of ethnic match and setting on number of sessions but not GAS outcome scores (same sex dyads and treatment in Asian-specific clinic resulted in greater number of sessions) Use of medication positively related to number of sessions and improvement on GAS scores
Fujino, Okazaki, & Young, 1994	1,132	Dysphoric	Ethnic match significantly associated with reduced premature termination increased treatment duration, higher initial functioning No significant effect of ethnic match on initial diagnosis or client functioning at discharge
Gamst, Dana, Der-Karabetian, & Kramer, 2000	4,554	Dysphoric	Significant differential effect of ethnic match on initial and termination GAF scores (matched Latino and Asian clients have higher scores than African American and White clients; African Americans in schizophrenia classification have higher scores, those with mood disorders have lower (scores) Significant differential effect of ethnic match on change in GAF scores (higher for matched Latino and White than for African American clients)

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Table 2.2
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Study	N	Diagnosis	Outcome effects
		Therapist race	
			Significant differential effects of ethnic match on visits to mental health center (fewer for Latino and African American, higher for White. Higher levels for Asian clients regardless of match)
Rosenheck, Fontana, & Cottrol, 1995	4,726 African American and White male clients and 315 therapists	Dysphoric	Significance effect of unmatched dyads on dropout and number of sessions (African American clients matched with White therapists have higher rates of termination and fewer number of sessions)
Takeuchi, Sue, & Yeh, 1985	4,710 African, Asian, and Mexican Americans	Dysphoric	Better outcomes for clients in ethnic-specific programs and longer stay in treatment (vs. those in mainstream service) No effect of treatment on GAS scores for Mexican Americans (authors suggest GAS is insensitive measure of treatment outcome
		Client race	
From Sue & Lam, 2002			
Markowitz, Spielman, Sullivan, & Fishman, 2000	101 African American, Hispanic, & White HIV-positive	Depression	Significant interaction effect of ethnicity and treatment (CBT, interpersonal, supportive, or drug + supportive) on depression scores (African Americans in CBT group had significantly poorer outcomes than other Ss)
In Rosenthal, 2000	Review		
Gomez, Ruiz, & Laval, 1982	12 bilingual Hispanic	Dysthymia and anxiety	Positive effect of treatment (brief psychodynamic therapy) on outcome scores No significant effect of language in therapy on depression, anxiety, or psychoticism scores (no control comparison group)
Szapocznik, Santisteban, Kurtines, Hervis, & Spencer, 1982	100 Cuban Americans elders	Depression	Significant effect of treatment (life enhancement counseling and medication) on depression outcome; no effect of client variables on treatment success
Takeuchi, Sue, & Yeh, 1985	4,710 African, Asian, and Mexican Americans	Dysphoric	Better outcomes for clients in ethnic-specific programs and longer stay in treatment (vs. those in mainstream service) No effect of treatment on GAS scores for Mexican Americans (authors suggest GAS is insensitive measure of treatment outcome)

apy, whereas such differences were not noted in the behavioral group."

As a result of the relative paucity and inconsistency of this research, no conclusions were reached about social class in the Division 29 review (Norcross, 2002). Our own review suggests the following principle:

1. Insufficient research has been conducted on SES to determine if it is a contributor to treatment outcome for depressed patients.

Personality Disorders

General Effects

Research on psychological treatments for patients with personality disorders is still in its infancy. The Division 29 Task Force report (Norcross, 2002) concluded that insufficient research had been done to make a clear judgment about the general role that personality disorders may play in moderating treatment effects. Benjamin and Karpiak (2002) reviewed both the effectiveness of treating those with personality disorders and the role that personality disorders played as moderators of treatment for the Division 29 Task Force on "Relationships that Work." They concluded that "There are effective psychotherapy treatments for personality disorders and they come from a variety of theoretical and practical perspectives" (p. 433). While interesting and important, these data are outside of the scope of the current chapter. Here, our task is to determine if the presence of a co-morbid personality disorder moderates the effectiveness of treating patients with depression. About this latter question, Benjamin and Karpiak are relatively silent. Hence, we reinspected the studies reported in their review with an eye toward discovering principles that may bear on this important question.

Principles for Treating Depressed Patients

In order to inspect the role of personality disorder as a moderator of treatments for depression, we extracted from the chapter by Benjamin and Karpiak (2002) those studies of treatment effectiveness that had been conduced on patients with co-morbid depression and personality disorder. We added to these studies, several additional studies published in reviews by Reich (2003) and Mulder (2002).

Table 2.3 summarizes the results of 20 studies that inspected the level of treatment effect among patients with co-morbid depression and anxiety. Only five of these studies (Kuyken, Kurzer, Debubeis, Beck, & Brown, 2001; Shahar, Blatt, Zuroff, & Pilkonis, 2003; Stuart, Simons, Thase, & Pilkonis, 1992; Taylor & McLean, 1993) failed to conclude that the presence of a personality disorder attenuated the effects of psychosocial treatment. Fifteen studies (Table 2.3) found significant or strong evidence that the presence of a personality disorder tends to reduce treatment effects. Thus, this literature tends to support the following principle:

1. Co-morbid personality disorders are negative prognostic indicators in the psychological treatment of depressed patients.

The results of available studies of depressed samples are not strong enough to draw conclusions about differential effectiveness of different treatments. Nor are the findings consistent enough to warrant drawing conclusions about the relative attenuation of effects as a function of different personality or clusters of personality disorders. However, Table 2.3 reveals several studies that suggest that dependent and unstable personality types tend to suffer worse outcomes than other dispositional patterns (e.g., Alnaes & Torgersen, 1997; Hoffart & Martinsen, 1993; Ilardi & Craighead, 1999; Shahar et al., 2003).

Patient Age

General Effects

Among other potential factors on which patient and therapist might contribute to improvement, age effects have been the most frequently studied in general samples. These studies consistently support the conclusion that the age of adult patients is inversely related to the quality of outcome achieved. Indeed, Jones, Krupnick, and Kerig (1987) report that patient age accounted for twice the amount of outcome variance as patient gender, on measures of symptomatic change and satisfac-

Table 2.3
The Role of Personality Disorder in the Treatment of Depression

Study	N	Diagnosis	Treatment used	Outcome effects
Alnaes & Torgersen, 1997	298	Depressed outpatients with co-morbid personality disorder	Naturalistic study	Borderline and dependency traits predicted relapse; avoidant personality disorder and borderline personality disorder predicted new cases
Andreoli et al., 1993	31	Depressed outpatients with co-morbid personality disorder	Naturalistic study; psychotherapy and clomipramine monitored by blood levels (if required)	Worse long-term outcome seen in patients with co-morbid personality disorders
Diguer, Barber, & Luborsky, 1993	25	Depressed outpatients with co-morbid personality disorder	Psychodynamic psychotherapy	Patients with co-morbid personality disorder had worse outcome, although decreased in Beck inventory scores similar
Frank, Kupfer, Jacob, & Jarrett, 1987	68	Depressed outpatients with co-morbid personality disorder	Imipramine; interpersonal psychotherapy	Slow response group (>8 months to recovery) had higher rates of personality disorders
Hardy et al., 1995	114	Depressed outpatients stratified by severity with co-morbid personality disorder	Eight or 16 sessions of cognitive behavior therapy or psychodynamic interpersonal therapy	In PI therapy, PD clients maintained more severe symptomatology than NPD. Among clients in CBT, no significant differences were found between PD and NPD. PD clients with severe depression showed less improvement than both PD and NPD clients with less severe depression
Hoffart & Martinsen, 1993	77	Panic with agoraphobia, major depression, or a combination in impatients	Psychodynamic psychotherapy	Worse outcome at posttreatment seen in patients with dependent and paranoia personality disorders; avoidant personality disorder predicted worse 1 year follow-up
Ilardi & Craighead, 1999	40	Formally depression patients	Cognitive behavior therapy	General personality pathology factor associated with dysfunctional cognitions, though a more specific association between Axis II Cluster C pathology and dysfunctional attitudes was observed
Kuyken et al., 2001	162	Depressed patients with and without a personality disorder	Naturalistic study following cognitive therapy	Maladaptive avoidant and paranoid beliefs, and not personality disorder predicted variance in outcome
Miller, Norman, & Keitner, 1990	69	Depressed outpatients with co-morbid personality disorder impatients	Tricyclic antidepressants; psychotherapy	No difference between "high" and "low" cognitive dysfunction groups

Study	N	Diagnosis	Treatment used	Outcome effects
Patience, McGuire, Scott, & Freeman, 1995	113	Major depression with co-morbid personality disorder	Primary care counseling and amitriptaline as needed	After treatment the personality disorder group had more depression and poorer social functioning, but they caught up with the no-PD group by 18 months
Pilkonis & Frank, 1988	119	Depressed outpatients with co-morbid personality disorder impatients	Imipramine; interpersonal psychotherapy	Those who took more than 8 months to recover had higher rates of personality disorders
Seivewright, Tyrer, & Johnson, 1994	181	Generalized anxiety disorder, panic disorder, or dysthymia	Drug treatment; psychotherapy (cognitive) or self-help	Logistic regression indicated presence of personality disorder was a negative prognostic indicator at 5 years
Shahar et al., 2003	153	Major depression in outpatients with co-morbid personality disorder and perfectionism	Brief treatment for depression	Poor therapeutic outcomes for patients with elevated levels of perfectionism and odd-eccentric and depressive PD features. Patients' contribution to therapeutic alliance was predicted by perfectionism but not by PD
Shea et al., 1990	239	Depressed outpatients with co-morbid personality disorder	Imipramine; cognitive behavior therapy; interpersonal psychotherapy	Patients with any co-morbid personality disorders less likely to recover across all treatment groups and had significantly worse social functioning. Patients with elevated odd-eccentric PD features had elevated depressive symptoms
Stuart et al., 1992	53	Depressed outpatients with co-morbid personality disorder	Cognitive behavior therapy	No difference in response; rates of personality disorder dropped in a limited number of patients
Taylor & McLean, 1993	155	Depressed outpatients with co-morbid personality disorder	Psychotherapy; amitriptyline; behavior therapy; relaxation	High neuroticism scores predicted worse 12-week outcome regardless of treatment
Tyrer, Seivewright, Ferguson, Murphy, & Johnson, 1993	181	Generalized anxiety disorder, panic disorder, or dysthymic outpatients	Dithiepin; diazepam; cognitive behavior therapy	Psychological treatment methods, particularly self-help, were more effective in patients without personality disorder, patients with personality disorders responded better to drug treatment
Viinamaki et al., 2002	117	Major depression with co-morbid personality disorder	Naturalistic follow up	Logistic regression indicated an association between lack of recovery and Cluster C personality disorder
Zuroff & Blatt, 2002	162	Major depressive disorder in outpatients	Interpersonal psychotherapy, CBT, active medication, and placebo	Stress reactivity was predicted by depressive personality at intake

Table 2.4
Age

Study	N	Diagnosis	Outcome effects
		Client age	
From Beutler, Harwood, et al., 2002			
Craig & Huffine, 1976	140 mostly African American	Dysphoric	Significance effect of age and diagnosis on duration in therapy (longer duration for those > age 30 and with psychosis or personality disorders)
Garvey & Schaffer, 1994	177	Depressive illness	Differential effects of age on depressive and anxious symptoms (Ss < 40 years of age more likely to suffer hypersomnia, increased appetite and weight gain, decreased libido, headaches, lower p.m. mood and sad vs. anxious mood. Ss > 40 years of age more likely to have terminal insomnia, lower a.m. mood, endogenous, incapacitated, or agitated mood)
Mazure, Nelson, & Jatlow, 1990	52	DSM III-R nonpsychotic unipolar Major Depression	Inverse relationship between age and likelihood of response to treatment (1 week of hospitalization without antidepressants)
From other sources			
Heisler, Beck, Fraps, & McReynolds, 1982	200	Dysphoric	Significant correlation of client's gender and therapy attendance (early dropouts tend to be younger, less well educated, less likely to be employed, more likely to be diagnosed with personality disorders)
Jones, Krupnick, & Kerig, 1987	60 females	DSM-III PTSD or adjustment disorder. Most with anxiety or affective disorders (excluded: those with psychiatric hospitalization, severe character problems, lifestyle of trauma life events)	2 studies: Study 1: Patient age accounted for twice the outcome variance contributed by gender to symptomatic improvement and patient satisfaction with treatment; both were exceeded by initial symptomology as contributors of variance in outcome Study 2: 2 female therapists found to arouse less negative affect in female patients, and fewer interpersonal difficulties
Orlinsky & Howard, 1976	118 women with 78 male & 40 female therapists	Depression, anxiety, and personality disturbance	Significant effect of client age on sensitivity to therapist sex (younger single and single women more sensitive to male therapists)
Barber & Muenz, 1996	84	Major Depression with avoidant or obsessive personality	No effect of age or age-similarity on outcome
Beck, 1988	1,500 patients, 250 therapists	Dysphoric	Significant effect of therapist age on treatment outcome (clients whose therapists are > 10 years younger have poorest outcomes)
Dembo, Ikle, & Ciarlo, 1983	2,898	Dysphoric	Significant effect of therapist age on treatment outcome (client–therapist dyads whose age difference is 10 or less years have most positive outcomes for distress and social isolation at posttreatment)

tion. Patient age also appears to moderate the effects of variables such as gender, directly. For example, among males, early dropouts tend to be younger, less well educated, and more likely to be diagnosed with personality disorders (Heisler, Beck, Fraps, & McReynolds, 1982).

Therapist, as compared to patient, age is even a more complex variable, partly because it is confounded by so many other, therapy-relevant factors (e.g., experience). Because of the complexity of moderating effects, however, little can be clearly concluded about the degree to which therapist age or patient–therapist age similarity contributes to outcome. For example, Barber and Muenz (1996) failed to find a significant effect of patient–therapist age similarity on outcome. On the other hand, both Dembo, Ikle, and Ciarlo (1983) and Beck (1988), observed that therapists who are more than 10 years younger than their adult patients tend to produce lower overall outcomes than those who are 10 years or closer to the client's age. Unfortunately, therapist age and experience are confounded in such findings and this precludes strong conclusions.

Principles for Treating Depressed Patients

Nine studies on depressed or largely depressed samples were extracted from the review by Beutler, Malik, et al. (2003) and by Sue and Lam (2002). Table 2.4 summarizes these studies and confirms the conclusion of Sue and Lam as applied to depressed patients. Specifically, older depressed patients experienced fewer gains than younger depressed patients in psychotherapy. The results suggest the validity of the following principle:

1. Age is a negative predictor of a patient's response to general psychotherapy.

INFERRED TRAITS THAT MODERATE TREATMENT EFFECTS

Client Expectations and Preferences

General Effects

Arnkoff, Glass, and Shapiro (2002) have summarized the results of research on client expectancies and preferences for the Division 29 Task Force, largely restricting their review to the role of patient perceptions. They identified 24 studies that addressed the role of client expectations, 37 that addressed the effects of patient and therapist shared role expectancies, and 13 that addressed patient preferences for either therapy styles (roles) or type of therapy. They found an insufficient number of studies that addressed the effects of either confirming or disconfirming a patient's preferences for a therapist of a given ethnicity or sex. Hence, neither we nor they reviewed these latter studies.

Among the studies of various types of psychopathology, Arnkoff and colleagues found that the preponderance (N = 12 of 24) of those that addressed the impact of outcome expectancies revealed a positive relationship between the level of outcome expected by patients and that obtained. Seven studies on this topic found no relationship between outcome expectancy and benefit and seven found a complex relationship in which mediating variables played a role between expectation and outcome.

Likewise, among the 37 studies identified by Arnkoff and colleagues (2002) that addressed the effect of role expectations—the degree to which there is similarity between the actual and expected roles of patient and therapist in a given treatment—on treatment outcome, the majority (N = 21) found a positive relationship. The more patients and therapists agreed on the roles to be played by each during psychotherapy, the stronger the benefit achieved. The authors concluded that agreement in expected roles was a contributor to outcome.

Arnkoff and colleagues (2002) undertook a separate analysis of client preferences. They identified 16 studies that addressed either role preferences or preferences for the type of therapy used. Most of these studies failed to demonstrate a significant relationship between either of these types of preference and treatment outcomes.

Principles for Treating Depressed Patients

From the Arnkoff et al. (2002) review, we extracted those that had focused explicitly on patients with depression and reanalyzed the three types of expectancies on which they based their conclusions.

Among the 24 studies of outcome expectations identified by Arnkoff et al., only three were conducted on homogeneous samples of depressed patients. To broaden our review, we compared these three studies to nine that used a general outpatient sample in which depression was expected to be pervasive. Seven of the latter nine samples (Friedman, 1963; Goldstein & Shipman, 1961; Heine, 1962; Lipkin, 1954; Martin, Friedmeyer, Moore, & Claveaux, 1977; Tollinton, 1973; Uhlenhuth & Duncan, 1968) produced a significantly positive relationship between patient expectations of outcome and the level of benefit achieved using a variety of outcome measures. Interestingly, this result was not replicated in the depressed samples. Two of these latter studies (Hardy et al., 1995; Morrison & Shapiro, 1987) obtained indications of the presence of a moderating variable and one (Piper & Wogan, 1970) found nonsignificant results. Collectively, therefore, we were unable to confirm the promising findings of the Division 29 Task Force and conclude that outcome expectations do not consistently contribute to the treatment of clinically depressed patients to the degree that they appear to do so among other dysphoric groups.

To explore the effect of Role Expectations, we identified 13 studies from the original 37 reported by Arnkoff et al. (2002) that assessed the effects of Role Expectations on outcomes among depressed patients. Once again we failed to support the conclusions of Arnkoff et al., and there was no evidence that role expectations meaningfully affected the treatment of depressed samples. Only five of the 13 studies of depression found some positive results (Heine & Trosman, 1960; Kamin & Caughlan, 1963; Heine, 1962; Isard & Sherwood, 1964; Schonfield, Stone, Hoehn-Saric, Imber, & Pande, 1969). Four of the studies found largely nonsignificant findings (Brennan, 1990; Silverberg, 1982; Rosen & Wish, 1980; Volsky, Magoon, Norman, & Hoyt, 1965) and four found a moderating variable that differentially affected the results (Gaston, Marmar, Gallagher, & Thompson, 1989; Heppner & Heesacker, 1983; Martin, Sterne, & Hunter, 1976; Severinsen, 1966).

In a third analysis, we extracted from the 16 papers on preferences reviewed by Arnkoff et al. (2002), four studies that focused on clinically depressed samples. Only two of the latter studies (Elkin et al., 1999; Chilvers et al., 2001) found that patient preferences contributed to benefit. The other two studies in this series (Addis & Jacobson, 1996; Hardy et al., 1995) found evidence of additional moderators that affected outcome.

Collectively, the foregoing applications to depressed populations failed to support the Division 29 conclusion in the specific case of depression and, instead, indicate that:

1. Principles related to preference and expectance are not sufficiently well defined to be applied to the clinical treatment of depressed patients.

Stages of Change

General Effects

Prochaska and Norcross (2002), reviewing the literature for the Division 29 Task Force, concluded that "different processes of change are differentially effective in certain stages of change" (p. 308). They support this conclusion with a variety of research studies, including a meta-analysis (Rosen, 2000) of 47 of these studies. The samples in these studies range from substance abuse, where the concept of "stages of change" has been used extensively and quite successfully, to "exercise, diet, and psychotherapy" (p. 308). They conclude that effect sizes are relatively large when the construct of stages of change are considered to be differential moderators of treatment effects, and cite a large number of impressive research studies to support this contention.

The Division 29 Task Force, following the lead of Prochaska and Norcross, conclude that consideration of the patient's stage of change in assigning behaviorally or insight-oriented treatments is a promising and probably effective means of enhancing the fit of treatment and patient.

Principles for Treating Depressed Patients

Although a large number of studies are cited by Prochaska and Norcross (2002) in support of patient level or stage of change and the fit of various treatments, this literature has not addressed the role of these factors in treating depression. Only three studies have addressed mental health, non-

substance abusing populations, who might be considered to be rather dysphoric and anxious (Brogan, Prochaska, & Prochaska, 1999; McConnaughy, Prochaska, & Velicer, 1983; McConnaughy, DiClemente, Prochaska, & Velicer, 1989), and none of these studies inspected subsamples of depressed patients. The absence of appropriate studies and associated findings render it impossible to adequately evaluate the role of stages of change in treating depression. However, in concert with our default position, in such cases, we find no reason to refute the Division 29 conclusion that a patient's stage of change is a predictor of how well various kinds of psychotherapy might work. Thus, we offer the following working principle:

1. Patient stage of change is a promising (but not proven) variable for fitting patient and treatment and for predicting the level of intervention in which to engage the patient.

Assimilation of Problematic Experiences

General Effects

The assimilation model is a framework to understand change in psychotherapy in terms of particular problematic experiences, instead of changes in a person as a whole. The model suggests that clients will progress through a particular continuum of stages in successful psychotherapy. The eight levels of the model are summarized in the Assimilation of Problematic Experiences Scale (APES; Stiles et al., 1991), labeled 0 to 7: (0) warded off/dissociated; (1) unwanted thoughts/active avoidance; (2) vague awareness/emergence; (3) problem statement/clarification; (4) understanding/insight; (5) application/working through; (6) resourcefulness/problem solution; and (7) integration/mastery. The levels are not considered to be discrete entities, but rather markers along a continuum of change.

Stiles (2002) described a number of studies that have provided support to the assimilation model. As a result, the assimilation of problematic experiences as been retained as a "promising and probably effective" means of customizing therapy by the Division 29 Task Force (Norcross, 2002). As noted by Stiles (2002), the "assimilation model has been most intensively studied with respect to time-limited (8–20 session) psychotherapy for depression" (p. 360). A first set of empirical investigations (interpretative studies) described by Stiles involves several case studies, which together suggest that the assimilation of problematic experiences follow a pattern that is consistent with the APES.

Principles for Treating Depressed Patients

Of the examples reviewed by Stiles (2002), two reports that describe three case studies involved samples of clinically depressed clients (Field, Barkham, Shapiro, & Stiles, 1994; Honos-Webb, Stiles, Greenberg, & Goldman, 1998) and four case studies (from three reports) involved mixed anxiety and depressed clients (Stiles, Morrison, Haw, Harper, et al., 1991; Stiles, Shapiro, & Harper, 1994; Stiles, Shapiro, Harper, & Morrison, 1995). Based on a second set of studies (hypothesis-testing studies), Stiles (2002) also suggested that clients' APES level of their presenting problem may have an impact on their aptitude for benefiting from one form of treatment as opposed to another (e.g., a client who comes early in therapy with a clear statement of a problem improves more in cognitive behavior therapy than in psychodynamic-interpersonal therapy). The two studies cited in this second set of examples were conducted with purely depressed samples (Stiles, Barkham, Shapiro, & Firth-Cozens, 1992; Stiles, Shankland, Wright, & Field, 1997).

Taken together, the nine empirical studies reviewed above suggest the following principle of change:

1. Benefit may be enhanced when the interventions selected are responsive to and consistent with the patient's level of problem assimilation.

Patient and Therapist Religion and Spirituality

General Effects

The wide interest expressed by scholars in the role of religious and spiritual values and beliefs on the therapy relationship and process has not translated to a large number of research studies applying

these concepts to psychotherapy outcome. Most studies of religion have investigated its role in psychopathology and mental health (e.g., Gartner, Larson, & Allen, 1991). Indeed, the Division 29 Task Force on relationships concluded that insufficient research had been conducted on this topic to draw clear conclusions. The review of literature by Worthington and Sandage (2002) for that Task Force provided few additional references over that undertaken nearly a decade earlier (Worthington, Kurusu, McCullough, & Sandage, 1996). Given these conclusions, we will devote the current section of this chapter to a consideration of studies that have addressed religion in various ways, among depressed and dysphoric samples of patients. Specifically, we will concentrate on shared aspects of client–therapist religion and spirituality as related to (a) beliefs and values and (b) efforts to incorporate client religious values in religion accommodative therapy among these dysphoric and depressed samples.

While the terms "religious" and "spiritual" are often used interchangeably, it is useful to distinguish them from one another (Richards & Bergin, 2000). Following the logic of Worthington et al. (1996), "religious" is used in the current context to refer to the degree of commitment or acceptance of a particular faith or organized religious dogma. In contrast, "spiritual" is used to refer to one's subjective sense of personal faith and subjugation to a higher power. Thus, religious people may be said to hold religious beliefs and value religion.

While a significant number of therapists and counselors indicate they are religiously and/or spiritually oriented, and even religiously active (Kelly, 1995), they are often reluctant to examine client presenting issues in spiritual or religious contexts, often considering such themes as inappropriate topics for psychotherapy (Beutler, Machado, & Neufeldt, 1994; Worthington & Sandage, 2002). This viewpoint presents an interesting contrast if not an ethical conundrum in view of the observations that the vast majority (90+%) of Americans consider themselves religious and/or spiritual (Richards & Bergin, 2000). Most of these individuals (79+%), in contrast to their therapists, consider religious values as important topics in therapy (Quackenbos, Privette, & Klentz, 1985).

The methodology of studies examining the impact of religious and spiritual values, value convergence, and client–therapist values similarity on psychotherapy are usually analogue in nature, and infrequently include an assessment of treatment outcomes. They largely examine the influence of client religious values on perceptions of therapists and therapy, and the ramifications of these preferences and expectations for therapy outcome. Only a very small number of studies address client–therapist spirituality and none focus on non-Judeo-Christian values and beliefs.

Principles for Treating Depressed Patients

Our review of studies in the area of values and beliefs that affect treatment outcome is limited to those studies that address (a) value convergence and (b) patient–therapist similarity of religious values. Those studies, as applied to the treatment of depressed samples, are reported in Table 2.5.

Value Convergence

Psychotherapy is far from value free (e.g., Bergin, 1980, 1991; Beutler, Machado, & Neufeldt, 1994; Gibson & Herron, 1990), and patient values tend to converge with those of their therapists in successful treatment (Beutler, Crago, & Arizmendi, 1986; Beutler, Machado, & Neufeldt, 1994; Worthington & Sandage, 2002). However, compared to personal and mental health values, religious values are among the least susceptible to this type of convergence and generally resist change during psychotherapy (Beutler, Machado, & Neufeldt, 1994; Kelly & Strupp, 1992).

Client–Therapist Match

Two studies (see Table 2.5) have examined the effects of client–therapist matching on religious values among depressed samples and have found that a pattern of both similarity and dissimilarity among various values may contribute to improvement (Propst, 1980; Propst et al., 1992). Generally, depressed religious clients receiving religiously congruent cognitive therapy fared better with nonreligious therapists trained to deliver religious therapy than those with therapists who were committed to similar religious beliefs.

Table 2.5
Religion and Spirituality

Study	N	Diagnosis	Outcome effects
		1. Client values: client–therapist match	
Propst, 1980	44	Mild depression	Ss receiving therapy from nonreligious therapists were more improved in religious CBT and religious placebo treatment groups than in standard CBT and wait-list groups
Propst et al., 1992	59	Nonpsychotic, nonbipolar depressive disorder	Religious content CBT and pastoral counseling groups improved in depression and adjustment scores more than those in standard CBT and wait-list conditions; CBT success based on performance of nonreligious therapists with religious Ss
		2. Religious-accommodative studies	
Christian accommodative			
Pecheur & Edwards, 1984	21	Research Diagnostic Criteria for depression	Significant effect of treatment on depression scores at posttreatment and 1-year follow-up (no significant differences between secular and religious versions of CBT; both groups outperform wait-list condition)
Propst, 1980	44	Mild depression	Significant positive effect of treatment on depression scores (religious CBT outperformed self-monitoring and secular CBT treatment groups)
Propst et al., 1992	59	Nonpsychotic, nonbipolar depressive disorder	Significant positive effect of treatment on depression and adjustment scores at posttreatment and follow-up at 3 months and 2 years (religious content CBT and pastoral counseling outperformed standard CBT and wait-list conditions)
Johnson & Ridley, 1992	10	Depression	Significant effect of treatment on depression, automatic negative thought, and depressive irrational beliefs (both religious and secular rational emotive therapy (RET) groups improved on depression and negative thoughts scores, only religious RET group improved on irrational thought measure)
Johnson, DeVries, Ridley, Pettorini & Peterson, 1994	32	Depression	No significant differential effect of treatment on depression and depression-related measures (both religious and secular versions of RET equally improve client depression, automatic negative and irrational thinking, and general pathology)
McCullough, 1999 Meta-analysis of 5 studies noted above	166	Depression	No significant differential effect of treatment on depression and depression-related measures (both standard and religious accommodative versions are equally effective)
Muslim accommodative			
Azhar & Varma, 1995a	30	Major Depressive Disorder (bereavement)	Significant differential effect of treatment on depression scores (patients receiving supportive psychotherapy and medication were less improved than those who also received religious psychotherapy)

(continued)

Table 2.5
(continued)

Study	N	Diagnosis	Outcome effects
		2. Religious-accommodative studies	
Azhar & Varma, 1995b	64	DSM-III R Dysthymic Disorder	Significant differential effect of treatment on depression scores (patients receiving supportive psychotherapy and medication were less improved than those who also received religious psychotherapy. At six months, group differences were nonsignificantly)
Christian group accommodative			
Hawkins, Tan, & Turk, 1999	29	Depression	Significant positive relationship between reduction in depression and spiritual well-being (SWB) No significant differential effect of treatment on reduction in depression scores (both Christian and secular CBT performed equally well) Significant differential effect of treatment on SWB scores (clients in Christian CBT scored higher than those in secular CBT)
Richards, Owen, & Stein, 1993	15	Perfectionistic and depressed	Significant positive effect of religiously oriented treatment on depression and perfectionistic scores (no control or comparison group)
Rye, 1999	58	Women hurt in romantic relationships	Significant differential effect of treatment on measures of depression, anger, hurt, and avoidance of hope (students in secular forgiveness group improved more in these areas than those in religiously integrated forgiveness group or nontreatment control)

Note. From Worthington & Sandage, 2002.

Religion-Accommodative Approaches

Accommodative therapies insert religious themes into interpretations and directly address religious beliefs and values, frequently offering religion-based solutions for the patient's problems (e.g., recommending prayer). Religiously oriented therapies have compared well to a variety of alternative treatments for various problems (e.g., lay counseling [Toh & Tan, 1997]; pastoral counseling [Propst et al., 1992]; and 12-step approaches to substance abuse [Humphreys, 1999]). However, these accommodative studies often neglect the effects of the therapeutic alliance and several suffer from serious methodological limitations (Worthington & Sandage, 2002).

Christian-accommodative individual therapies. Worthington and Sandage (2002) report the results of a meta-analysis of five treatment outcome studies of cognitive therapy for depression. These studies are cited in Table 2.5. All five studies integrated client religious beliefs into treatment strategies through the use of such procedures as religious imagery, prayer, and religiously based challenges of irrational beliefs. Three of the five studies compared standard and Christian accommodative versions of cognitive-behavioral therapy (CT) and two compared standard and accommodative versions of rational emotive therapy (RET).

Of those studies that adapted CT to accommodate religious beliefs, one (Pecheur & Edwards, 1984) found nonsignificant differences among religious, CT, and wait-list control groups. Two other controlled studies revealed significant advantages favoring both CT and religious placebo conditions over secular therapy. The first of these, using student volunteers and nonreligious therapists found

that both religious CT and religious placebo groups outperformed the standard CT and wait-list groups. The second, and later, study found not only that patients in the religious CT and pastoral counseling groups were more improved than the secular counseling groups on depression and social adjustment scores at post-treatment, but that these group differences were attributable to the superior performance of nonreligious therapists in the religious CT group. Additionally, religious counselors had greater success with standard than with religiously constructed CT, and religious subjects in the secular CT/nonreligious therapists group were the least improved. The interaction between therapist religiousness and type of CT indicated that clients improved the most when there was intermediate, rather than low or high levels of similarity to the values of the therapist or correspondence with the orientation of the therapy itself.

Of the two outcome studies reviewed by Worthington and Sandage (2002) in which comparisons were made between standard and Christian-adapted versions of RET, neither found significant differences in outcome among the treatments. However, standard and Christian-modified RET reduced depression and negative thought in both studies. Thus, the weight of evidence fails to confirm the advantages of Christian-modified and adapted treatments over standard interventions. This general conclusion is illustrated by the meta-analysis reported by Worthington and Sandage who found a nonsignificant difference in mean effect size ($d = .18$) between the standard and modified versions.

Muslim-accommodative individual therapies. Worthington and Sandage (2002) found only three studies that compared a religiously based therapy and an alternative treatment among devout Muslim patients. Two studies compared religious therapy with supportive psychotherapy and medication among depressed samples (see Table 2.5). In both studies, clients who received religiously based therapy had significantly better outcomes than those whose therapy did not include a focus on religious beliefs. The significant gains were maintained at follow-up.

Based on only a sample of two studies, we do not believe that conclusions about the efficacy of accommodative therapy among Muslim patients can be reached, though this is a promising area of research.

Christian-accommodative group therapy. Three therapy studies have addressed Christian-accommodative treatments (see Table 2.5). Hawkins, Tan, and Turk (1999) assessed depression as well as spiritual and religious well-being and found significant improvement in depression at post-test, as well as a significant indirect relationship between depression and spiritual well-being. The observed changes in spiritual well-being, favoring those in the religious CT group, may have been a reflection of their high initial preference for religious therapy.

Richards, Owen, and Stein (1993) investigated an integrative Christian therapy based on the CT model, among Mormon undergraduate students who were attending a Mormon institution and who were deemed to be perfectionistic and depressed. Subjects improved significantly on both outcome measures, but the absence of a control group limited the available interpretation.

Finally, Rye (1999) investigated dysphoric college women who were recovering from being hurt in intimate relationships; participants were randomly assigned to a secular or religiously integrated forgiveness group, or a no-treatment control group. Both treatment groups were involved in activities, discussions, and homework assignments designed to foster forgiveness. Neither treatment group demonstrated differential treatment effects: both were equally efficacious on measures of forgiveness, hope, and existential as well as religious well-being and surpassed the control group at post-test and six-week follow-up. Additionally, while the secular forgiveness group improved significantly more on anger, hurt, and avoidance of hope measures, participants in both groups were found to use religiously based forgiveness strategies.

Conclusions

In summary, while the methodology in empirical research has become increasingly more sophisticated in its use of standardized measures, control

procedures, and methods of quantitative analyses, there is little quantitative research in the area of religion and spirituality that is not analogue in nature, naturalistic in design, or based on case studies. As currently constituted, nonetheless, the empirical literature on religion and values provides tentative support for two principles:

1. If patients have a preference for religiously oriented psychotherapy, treatment benefit is enhanced if therapists accommodate this preference.
2. If psychotherapists are open, informed, and tolerant of various religious views, treatment effects are likely to be enhanced.

Attachment Style

General Effects

The interpersonal history of patient and therapist has an impact on the therapeutic process and its outcome. Various enduring and persistent ways of attaching to others—secure, anxious-ambivalent, dismissive-avoidant, and disorganized—are all potentially expressed in the therapeutic relationship (Bowlby, 1988). The clinical applications of attachment theory have recently begun to be explored through theory development (Bowlby, 1988; Blatt & Levy, in press; Diamond, Clarkin, Levine, Levy, et al., 1999; Farber, Lippert, & Nevas, 1995; Gunderson, 1996; Holmes, 1996; Levy & Blatt, 1999; Mackie, 1981; Sable, 1992; Shane & Shane, 2001; Slade, 1999; Szajnberg & Crittenden, 1997) and through empirical methods (Dozier, 1990; Dozier, Cue, & Barnett, 1994; Fonagy et al., 1996; Mallinckrodt, Gantt, & Coble, 1995; Tyrell et al., 1999). From this work, authors have begun to delineate how attachment classifications and dimensions contribute to understanding the quality and nature of psychotherapy process as well as psychotherapy outcome (e.g., Blatt, Shahar, & Zuroff, 2002). Research has suggested that patient attachment patterns are both a prognostic indicator of outcome and useful as a vehicle for understanding aspects of the psychotherapeutic process. Complicating the integration of findings to date is that the various studies have used different attachment measures with different patient groups in different types of therapy.

Psychotherapy Outcome as a Function of Attachment Status

From the literature reviewed for the Division 29 Task Force (Meyer & Pilkonis, 2002), there are seven studies that examined psychotherapy outcome as a function of attachment (Cyranowski et al., 2001; Dozier et al., 1994; Fonagy et al., 1996; Kilmann et al., 1999; Meyer et al., 2001; Mosheim et al., 2000; Tyrell et al., 1999). The results converge on four main findings: (a) securely attached patients tend to function better than other patients at both admission and discharge, (b) patients with preoccupied or unresolved attachment status tend to respond more poorly than patients with other attachment patterns and (c) securely attached patients appear to benefit more than other patients from brief treatment whereas dismissively attached, more severely impaired, patients appear to do better in long-term intensive treatment (Fonagy et al., 1996; see also Blatt, 1992; Blatt & Ford, 1994).

Meyer and Pilkonis (2002) speculate that patients with "dismissing attachment may require more concentrated . . . interventions, helping them overcome their characteristic detachment. Once they do connect emotionally with a therapist, however, improvement might be all the more dramatic."

Psychotherapy Process as a Function of Attachment

A series of studies have considered the attachment styles of therapists and their impact on the therapeutic process (Dozier et al., 1994; Hardy et al., 1998; Hardy et al., 2001; Kanninen et al., 2000; Rubino, Barker, Roth, & Fearon, 2000; Tyrell et al., 1999). Generally the findings have suggested that therapists with anxious-attachment styles tended to respond with less empathy, especially to patients with secure and dismissive attachment.

Relatedly, Eames and Roth (2000) found that securely attached patients tended to form an effective alliance whereas fearful avoidant patients tended to rate their alliance as weaker. Interestingly, some evidence also suggested that both preoccupied and dismissive attachment styles were both associated with more positive alliance ratings, but for different reasons. "Patients who yearn for

intimacy and fear abandonment might strive with particular persistence to establish a close alliance, given their concerns about a possible rejection. In contrast, patients with dismissive styles might defensively deny problems in the alliance or establish only a superficial relationship while remaining reluctant to connect and self-disclose on a more genuine, personal level" (Eames & Roth, 2000). Consistent with this interpretation, preoccupied attachment was associated with more ruptures and dismissing attachment with fewer ruptures.

Dozier (1990) found that dismissing patients are often resistant to treatment and have difficulty asking for help and retreat from help when it is offered. Dismissing individuals often become more distressed and confused when confronted with emotional issues in therapy (Dozier, Lomax, Tyrell, & Lee, 2001). This observation led Dozier and colleagues to identify patterns of relationship that were likely to occur between patient and therapists with different attachment styles using the Adult Attachment Interview (AAI).

Patients in treatment with therapists who were dissimilar to them on the hyperactivating/deactivating (preoccupied to dismissing) dimension of attachment on the AAI proved to produce better therapeutic outcomes and stronger therapeutic alliances than their counterparts (Dozier et al., 1994; Tyrell et al., 1999). Clinicians classified as secure/autonomous on the AAI tended to challenge the patient's interpersonal style (whether deactivating or hyperactivating), whereas clinicians classified as insecure on the AAI were more likely to compliment the patients' interpersonal style (Dozier et al., 1994; Tyrell et al., 1999). Patients had the best outcome if treated by securely attached clinicians (defined on the AAI) or when the clinician was at the opposite side of the secure/autonomous continuum from the patient's AAI classification (e.g., patient rated preoccupied on AAI and therapist rated at the dismissing end of the autonomous category; Dozier et al., 1994). Consistent with prior research on client–clinician match (e.g., Beutler et al., 1991), the dissimilarities between patients and therapists interpersonal style appears to be advantageous, indicating that patients benefit from interventions that counteract their problematic style of relating to others. Overly emotional patients may require emotion-containing interventions whereas emotionally detached patients may need interventions that facilitate their affective expression and connection (cf. Hardy et al., 1999; Stiles et al., 1998).

Different interpersonal or attachment styles of patients pull for different types of interventions from the therapist. While preoccupied patients pull for emotional-experiential interventions, they appear to benefit from a more cognitive-behavioral strategy that helps them modulate overwhelming feelings (Hardy et al., 1998, 1999). Likewise, avoidant patients pull for rational-cognitive interventions, but appear to benefit from strategies that facilitate emotional engagement (Hardy et al., 1999). Therapists need to recognize how a patient's attachment style influences their response to the patient and their ability to establish a therapeutic alliance.

Diamond and colleagues (Diamond et al., 1999) reported that two patients with borderline personality disorder, treated with Kernberg's Transference Focused Psychotherapy (TFP; Clarkin, Yeomans, & Kernberg, 1999) by the same therapist, progressed from insecure to secure attachment after one year of treatment. Consistent with previous research (e.g., Eames & Roth, 2000; Dolan et al., 1993; Dozier et al., 1994; Mallinckrodt et al., 1995; Tyrell et al., 1999), Diamond et al. noted, however, that each patient interacted with and affected the therapist in a very different way, and that the therapist responds very differently to each patient. The therapist was engaged and active in the treatment of the client initially classified as preoccupied, whereas, the same therapist was much less engaged, often felt dismissed and developed a much weaker therapeutic bond, with the patient initially classified as dismissive on the AAI.

Attachment as a Psychotherapy Outcome Measure

Three studies that employed attachment constructs as an outcome measure (Fonagy et al., 1995; Levy et al., 2004; Travis et al., 2001), Levy and colleagues (Levy, 2002; Levy & Clarkin, 2002; Levy, Clarkin, & Diamond, 2002) used the AAI to assess change in attachment status and reflective function in 25 patients over the course of a one-year long-term randomized clinical trial or in patients diagnosed with borderline personality dis-

order. Levy and colleagues found that all but two patients were initially rated as insecure with the majority having a primary AAI classification of unresolved for trauma and/or loss. The majority of patients showed a change in attachment after one year of treatment—some patients shifted from unresolved and insecure to secure, others to cannot classify or to a mixed attachment. In addition, they found a significant increase in patients' reflective function. Fonagy and colleagues (Fonagy et al., 1996) reported on changes in attachment status on the AAI for 35 nonpsychotic inpatients following one year of intensive psychodynamic psychotherapy. Although all 35 inpatients were classified as insecure during their initial Adult Attachment Interview, 14 or 40% of the 35 inpatients showed a shift to a secure classification upon discharge. Travis et al. (2001) examined change in attachment patterns over the course of time-limited dynamic psychotherapy in 84 patients and found that a significant number of clients changed from an insecure to a secure attachment pattern. Additionally, significant relationships were also found among changes in attachment, GAS scores, and symptom levels.

Principles for Treating Depressed Patients

From the list of studies on general psychiatric patients, cited in the foregoing, we were able to identify only six studies that employed a dysphoric or clinically depressed sample (see Table 2.6). This

Table 2.6
Attachment Styles

Type of study	N	Treatment	Disorder	Attachment measure	Findings
Outcome					
Cyranowski et al., 2002	162	IPT	Major Depression	RQ	½ women = fearful, no attachment difference in recovery rate, but fearful avoidance was related to delayed remittance
Meyer, Pilkonis, et al., 2001	149	University medical school clinic TAU	Depression, anxiety, substance abuse	Pilkonis prototypes	Security of attachment greater relative improvement
Hardy et al., 2001	24	Time-limited CBT	Depression	IIP	Highly avoidant subjects showed less improvement
Process studies					
Hardy et al., 1998	114	ST PI and ST CB	Depression	IIP	Therapist used more affective and relationship-oriented interventions with overinvolved clients and more cognitive treatments with underinvolved cases
Eames & Roth, 2000	30 of 43	24 CBT, 3 PDT, 1 CAT, 2 ecclectic TAU	General outpatients	RSQ	Fearful with lower alliance, secure with higher alliance, preoccupied & dismissing associated with increased alliance, preoccupied associated with more ruptures and dismissing less (gender differences?)
Attachment as outcome					
Travis et al., 2001	84	Time-limited dynamic therapy	Dysphoric outpatients	Bartholomew Attachment Rating Scale	Significant changes from insecure to attached

was not a sufficiently large sample to address the issue of whether attachment lent itself to do the three tasks described in the foregoing review: (1) predict outcomes, (2) predict process, or (3) serve as an outcome measure.

Three studies (Cyranowski et al., 2002; Hardy et al., 2001; Meyer, Pilkonis, et al., 2001) attempted to predict outcome on the basis of attachment, and all suggested that secure attachments were more predictive of improvement than insecure attachments. Beyond this tentative conclusion, however, little could be determined from the available research on depression.

Two studies (Hardy et al., 2001; Hardy et al., 1998) investigated the use of attachment to predict differential responses or other aspects of therapy process. These studies suggested that attachment may be a moderator of treatment, with affective and relationship-oriented interventions being selected by therapists for overinvolved clients and more cognitively oriented therapies for underinvolved patients. The rate of success, however, was not consistently associated with this selection of treatment strategy.

Another study in this set (Eames & Roth, 2000) found that one's attachment style was predictive of the type and strength of the alliance that developed. Fearful attachment styles were associated with low alliance scores, while secure attachments were associated with the development of higher therapeutic alliances. Preoccupied attachment styles tended to be associated with ruptures in the therapeutic alliance.

Finally, one study (Travis et al., 2001), using a general outpatient sample of dysphoric patients, found that treatment tended to evoke movement toward more stable and secure attachments.

While the preponderance of available studies address aspects of therapy process rather than outcomes, we find sufficient evidence in the foregoing to offer a tentative principle:

1. A secure attachment pattern in both patient and therapist appears to facilitate the treatment process.

Beyond this, the findings do not permit a clear conclusion about the role of attachment as a moderator or contributor to psychotherapy. This remains, as defined by the Division 29 Task Force, a promising variable in the study and prediction of response to psychotherapy.

Resistance

General Effects

Patient resistance, particularly when defined as a trait-like quality of the patient's response to the therapy, has received a good deal of research attention in recent years. Summarizing the results of 11 studies on resistance-like traits on eventual treatment outcome, Beutler, Moleiro, and Talebi (2002) indicate that 82% found clear and negative relationships with various indices of therapeutic output. Similar findings are observed when the sample is restricted to those studies that involved depressed samples.

Principles for Treating Depressed Patients

Table 2.7 presents 18 studies that were originally identified by Beutler, Moleiro, and Talebi (2002) and by Beutler, Malik, et al. (2003), that involved the treatment of depressed samples. The seven studies (Addis & Jacobson, 2000; Beutler, Clarkin, & Bongar, 2000; Beutler, Mohr, Grawe, Engle, & McDonald, 1991; Joyce, Ogrodniczuk, Piper, & McCallum, 2000; Last, Thase, Hersen, Bellack, & Himmelhoch, 1984; Neimeyer & Feixas, 1990; Persons, Burns, & Perloff, 1988) among these that investigated the direct effect of patient resistance-like qualities on treatment outcome all found a negative relationship between resistance and outcome. It should be noted that four of these studies used, as an indicator of resistance, the degree to which patients complied with homework assignments (Addis & Jacobson, 2000; Neimeyer & Feixas, 1990; Last et al., 1984; Persons, Burns, & Perloff, 1988). This narrow view of "resistance" may temper the results, but their consistency with the other studies in this set suggest that there is a relatively robust but negative relationship between level of trait-like resistance and treatment outcome. Since resistance in these studies is represented, frequently, as an ongoing process, the findings also suggest that interventions that avoid inducing resistance are likely to be most effective with most patients.

A related question relates to how one can best

Table 2.7
Resistance and Directiveness

Study	N	Diagnosis	Outcome effects
		Patient resistance	
From Beutler, Moleiro, & Talebi, 2002			
Addis & Jacobson, 2000	150	Major Depressive Disorder	Positive effect of acceptance of treatment rational and homework compliance on within-treatment change and treatment outcome for depression, with homework compliance contributing to additional change
Beutler, Clarkin, & Bongar, 2000	284	Depression, dysthymia	Patients with high interpersonal resistance respond better with minimal structure, self-directed interventions, nondirective procedures or paradoxical directives; those with low interpersonal resistance, to directive interventions and clinician guidance
Beutler, Engle, Mohr, et al., 1991	63	DSM-III Major Depressive Disorder	Differential effect of patient defensiveness (resistance potential) on depression scores at posttreatment: Low resistance Ss improve more in group cognitive behavior & focused expressive (authoritative) therapies; high resistance Ss in supportive/self-directed therapy
Beutler, Machado, Engle, & Mohr, 1993	49	Major Depressive Disorder	Differential effect of patient resistance potential on depression scores at posttreatment maintained at 1-year-follow-up: greater improvement of high resistance Ss in supportive/self-directed therapy & low-resistance Ss in group cognitive-behavior and focused expressive psychotherapies. Number asymptomatic Ss at follow-up match number at treatment-end
Beutler & Mitchell, 1981	40	Nonpsychotic, nonmedicated, impulsive externalizers and depressive internalizers (MMPI)	Positive effect of treatment on outcome (experiential treatment procedures have positive effect overall; analytic treatments most effective with depressive anxious, and least effective with impulsive externalizing patients)
Beutler, Mohr, Grawe, et al., 1991	60	Moderate & Major Depression (nonpsychotic)	Interactive effects of treatment and level of reactance potential (for cognitive and focused-expressive therapy, high reactance potential negatively related to treatment benefit; for supportive/self-directed therapy nonauthoritative positive relationships are shown)
Greenberg & Watson, 1998	34	Major Depression	No significant differential effect of treatment on depression scores at posttreatment and 6-month follow-up (both process experiential and client-centered groups improve equally). Superior effects of experiential therapy at mid-treatment on depression and at posttreatment on symptoms, self-esteem, and interpersonal problems

Study	N	Diagnosis	Outcome effects
		Patient resistance	
Joyce, Ogrodniczuk, Piper, & McCallum, 2000	144	Axis 1: Major depression (49%), dysthymia (26%), and personality disorders. 47% comorbid	Significant interaction effect of patient qualities and treatment on mid-treatment outcome (for interpretive therapy at mid-treatment high psychologically minded Ss had better outcomes on well-being and current symptoms, high reactance patients had poorer outcomes on current life dysfunction)
Joyce & Piper, 1996	60	Axis 1: adjustment (28%), affective (22%); Axis II: dependent (13%) & 15% are co-morbid with depression	Transference-oriented approach: Significant effect of use of transference interpretation on outcome (for high quality of object-relations [QOR] patients, transference focus + patient work is inversely related to posttherapy outcome for depression and symptom distress) Pretreatment anxiety/symptom distress related to work performance (significant degree of pretherapy anxiety and distress among high QOR Ss can promote work with transference oriented approach)
Last, Thase, Hersen, Bellack, & Himmelhoch, 1984	120	Unipolar depression	No significant differential effect of treatment (skills training, psychotherapy, or drug therapy) on solicited and unsolicited Ss on depression, assertiveness, and social adjustment scores (groups improve equally; no differences in level of attrition)
Neimeyer & Feixas, 1990	63	Research Diagnostic Criteria: unipolar depression	Significant positive effect of homework compliance on positive change in depression symptoms at posttreatment (pretreatment depression scores controlled) Significant positive effect of homework compliance on positive change in depression symptoms at follow-up (pretreatment depression not controlled)
Persons, Burns, & Perloff, 1988	70	Major Depressive, Dysthymic, Bipolar, & Cyclothymic Disorders	Significant effect of initial depression scores, endogenous symptoms, homework compliance on posttreatment depression scores. The effect of homework substantially larger for Ss with high initial depression. Homework compliers improved three times as much as noncompliers Homework compliance: Patients not completing homework more likely to drop out. Dropout possible expression of resistance. Completers average 65.5% reduction in depression scores

(continued)

Table 2.7
(continued)

Study	N	Diagnosis	Outcome effects
		Patient resistance	
Piper, Joyce, McCallum, & Azim, 1998	144	DSM-III-R Major Depressive Disorder, Dysthymic Disorder, & personality disorders; 73% with previous psychiatric treatment	Positive effect of symptom-focused supportive therapy on change in depression scores and global symptomatic distress at posttreatment (supportive vs. interpretive therapy)
Klausner et al., 1998	13	Major Depressive Disorder; residual depressive symptoms	Significant positive effect of directiveness on positive change in depressed mood at post-treatment (Goal Focused group vs. reminiscence therapy)
McLean & Hakstian, 1990	121	Major Depression	Negative effect of directiveness on positive change in depression scores at 2¼ year follow-up (Behavior, Relaxation vs. Nondirective therapy) Significant positive effect of homework compliance on positive change in depression symptoms at follow-up (pretreatment depression not controlled)
Shapiro et al., 1995	104	DSM-III Major Depressive Episode	Positive effect of directiveness on maintenance of gains at 12-month follow-up (cognitive-behavioral vs. psychodynamic-interpersonal)
Shaw et al., 1999	36	Research Diagnostic Criteria: Major Depression	Significant positive effect of directiveness (as session structure in CBT) on positive change in depression scores at posttreatment (pretreatment depression severity and adherence controlled) No effect of therapist directiveness (as session structure) on psychiatric symptom distress scores at posttreatment (pretreatment depression severity and adherence controlled)
Stiles & Shapiro, 1994	39	Present State Examination Index of Definition Category System: depression (77%), anxiety disorders	Positive effect of directiveness on rate of change in depression scores at end-point (cognitive behavioral questions, General Advisement vs. psychodynamic-interpersonal interpretation, exploratory reflections) Positive effect of directiveness on rate of change in global symptom distress scores at end-point (CB questions, General Advisement vs. PI interpretation, exploratory reflections)

deal with resistance when it is present or when the patient embodies a trait-like quality of resistance at the outset of therapy. This question bears on the degree to which patient resistance traits determine what treatments will be effective. In addressing this question, Beutler, Moleiro, and Talebi identified 20 studies that had inspected the differential effects of directive and nondirective treatments as a function of patient resistance traits. Sixteen of these studies (80%) found a significant interaction effect, all of which indicated that (1) high resistant patients did poorly when treated with directive interventions, (2) that low resistant patients did quite well with directive interventions, (3) high

resistant patients did best when treated with evocative and nondirective interventions, and (4) low resistant patients did best with highly structured and directed therapies

Of the 20 studies identified by Beutler, Moleiro, and Talebi, 16 were conduced on a depressed sample and are reported in Table 2.7. The results are consistent with the overall finding, with all but two of the studies revealing at least a partial moderating effect of patient resistance traits on the effectiveness of either directive or nondirective treatment, or both. Collectively, the results suggest the validity of the following principles:

1. The most effective treatments are likely to be those that do not induce patient resistance.
2. In dealing with the resistant patient, the therapist's use of directive therapeutic interventions should be planned to inversely correspond with the patient's manifest level of resistant traits and states.

Functional Impairment

General Effects

Beutler, Harwood, Alimohamed, and Malik (2002) reviewed the relationship between the severity of the patient's problems, as expressed in level of social functioning, and the effectiveness of different aspects of psychotherapy procedures. They identified a cluster of variables that seemed to constitute level of functioning. This cluster was comprised of low levels of social support, high levels of social alienation, and multiple areas of reduced functioning, as comprising "Impairment." Collectively, they concluded with Sperry, Brill, Howard, and Grissom (1996), that impairment was best reflected in reduced functioning at work, within intimate and nonintimate relationships, in self-care activities, and in levels of social responsibility assumed. Among these, the level of social support felt by the patient was among the most highly related (inversely) to general estimates of functional impairment levels.

Beutler, Harwood, Alimohamed, and Malik (2002) found a consistent but inverse relationship between initial level of functional impairment and eventual outcome. Seventy-seven percent of the 42 studies reviewed supported this conclusion. Table 2.8 reports the results of the 39 studies from this latter review that addressed the specific problem of depression. These studies demonstrate the consistency of the relationship between level of functioning (or, inversely, functional impairment) and subsequent outcome. High initial levels of impairment were associated with lessened likelihoods and magnitudes of benefit following treatment in nearly 80% of the studies. Notably, however, two studies (Ackerman, Greenland, & Bystritsky, 1994; Lueger, 1996) found that level of impairment actually enhanced the level of improvement achieved and nine of the 11 studies that inspected differential effects found that impairment level moderated the effects of different treatments. High levels of impairment retarded the effects of emotionally focused therapy among inpatients (Beutler, Frank, Scheiber, Calvert, & Gaines, 1984), but low levels of impairment were associated with improved functioning following emotion-focused therapy among outpatients (Beutler, Kim, Davison, Karno, & Fisher, 1996); lengthening treatment or increasing its intensity seemed to overcome some of the negative effects of high impairment levels (Hoglend, 1993; Moos, 1990), an effect that may be especially noted among the interpretive or insight-focused therapies (Joyce, Ogrodniczuk, et al., 2000); and impairment level was positively associated with the likelihood of receiving beneficial effects of pharmacotherapy (Elkin et al., 1995; Ravindran et al., 1999).

Principles for Treating Depressed Patients

Collectively, the available studies on depression (Table 2.8) fail to reveal a single treatment that is better, overall, than others for the treatment of patients with high levels of functional impairment. Two conclusions are warranted, however, and can be extracted as principles of treatment application:

1. Patients who enter treatment with high levels of functional impairment tend to do poorly relative to other patients.
2. Patients with high levels of initial impairment respond better when they are offered long-term, intensive treatment, than when

Table 2.8
Functional Impairment

Study	N	Diagnosis	Outcome effects
From Beutler, Harwood, Alimohamed, & Malik, 2002			
Ackerman, Greenland, & Bystritsky, 1994	520	Obsessive-Compulsive Disorder	Significant relationship between response and baseline depression scores. Higher initial scores more predictive of good response
Andrew, Hawton, Fagg, & Westbrook, 1993	59	Major Depressive Disorder	Negative effect of low self-esteem on depression scores for suicidal women
Barkham, Rees, et al., 1996	212	Most with Major Depressive Disorder	Significant effect of length of treatment on outcome (at treatment end Ss in 8-session group improve more than those at mid-treatment in 16-session group on most measures, i.e., diminished returns from longer treatment) More Ss improve on depression measures than on interpersonal patterns; among depressive symptoms, faster change for those related to acute distress, slower change for those that were characterological
Beutler, Clarkin, & Bongar, 2000	284	Depression, dysthymia	Significant inverse relationship of functional impairment and treatment outcome (high levels indicate poor prognosis, may indicate longer term and intensive treatment)
Beutler, Frank, Scheiber, Calvert, & Gaines, 1984	176	Dysphoric including Major Depressive Disorder	Differential treatment effects on outcome: systematic deterioration among patients in expressive experiential group; best results in interactive process-oriented group which maintained gains at 13-month follow-up
Beutler, Kim, Davison, Karno, & Fisher, 1996	63	Major Depression	Initial distress inversely related to therapy efficacy For low distress patients, clinicians rate cognitive therapy more effective than focused expressive psychotherapy
Burvill, Hall, Stampfer, & Emmerson, 1991	103	Major Depression	No clear effect of chronic physical illness, severity of depression, or severe life events on outcome at 12-month follow-up
Dadds & McHugh, 1992	22	Single parents of conduct problem children	No significant differential effect of treatment (child management training with/without ally support training) on outcome: both groups improve equally on measures of parent depression, social support and behavior, and child deviance Responders more likely than nonresponders to report high levels of social support
Elkin et al., 1995	239	Major Depressive Disorder	Significant interaction effects of initial severity of depression and functional impairment and treatment type on treatment outcome For low initial severity, no effect of treatment type on outcome (all treatments equally effective; CBT = IPT = IMI-CM = PLA-CM)

Study	N	Diagnosis	Outcome effects
			For high initial severity, significant effect of treatment type on outcome (IMI-CM superior to CBT, IPT, and PLA-CM for more severely ill; IPT superior to CBT for more severely depressed) No differences among treatment at 18-month follow-up
Ellicott, Hammen, Gitlin, Brown, & Jamison, 1990	61	Bipolar Disorder	Significant effect of life events and levels of stress on likelihood of relapse: Ss with high stress levels showed greater likelihood of relapse or recurrence; those with low or average stress showed risk of relapse equal to those who stayed well
Fountoulakis, Tsolaki, & Kazis, 2000	50 elderly	DSM-IV Major Depression, Dysthymia	Significant positive effect of pharmacotherapy (fluvoxamine) on depressive thought content and daily functioning at three months
Gitlin, Swendsen, & Heller, 1995	82	Bipolar Disorder	73% risk of relapse into mania or depression after 5 years of maintenance pharmacotherapy; high affective morbidity for those who do not relapse Cumulative affective morbidity stronger correlate of psychosocial functioning than # of relapses Poor psychosocial functioning predicts shorter time to relapse Depression related most strongly to family and social dysfunction
Hardy, Barkham, Shapiro, et al., 1995	114	Depression, Personality Disorders, Non-Personality Disordered	Significant effect of initial symptomology and treatment type on treatment outcome (depression and personality disorder: higher levels initially correlate with higher levels at posttreatment and 1-year follow-up; Ss with severe depression less improved posttreatment than those with less severe depression or non-personality disordered Ss)
Hoencamp, Haffmans, Duivenvoorden Knegtering, & Dijken, 1994	88	Major Depressive Disorder	Differential effects of initial depression, personality disorder, and social functioning: Ss with somatization and passive aggressive personality show poorer response to pharmacotherapy than those with obsessive-compulsive personality and/or high initial level of depression
Hoglend, 1993	45	DSM-III personality disorders, Dysthymia, Major Depression, adjustment, anxiety disorders	Significant positive effect of treatment length on positive dynamic change at 4-year-follow-up (≥ 30 sessions of dynamic psychotherapy show improved problem-solving capacity, self-esteem, interpersonal functioning)
Imber et al., 1990	250	Research Diagnostic Criteria:Major Depression	Positive effect of symptom-focus on improvement in global symptoms at posttreatment (cognitive-behavioral vs. interpersonal therapy) Improved need for social approval CBT>IPT, IMI-CM, placebo

(continued)

Table 2.8
(continued)

Study	N	Diagnosis	Outcome effects
Joyce, Ogrodniczuk, Piper, & McCallum, 2000	144	Axis 1: Major depression (49%), dysthymia (26%), and personality disorders. 47% comorbid.	Significant interaction effect of patient qualities and treatment on mid-treatment outcome (for interpretive therapy at mid-treatment, high psychologically minded Ss had better outcomes on well-being and current symptoms, high reactance patients had poorer outcomes on current life dysfunction)
Keijsers, Hoogduin, & Schaap, 1994	40	Obsessive Compulsive Disorder	Negative effect of depression on treatment outcome. High severity of agoraphobic complaints is strongest predictor
Lueger, 1996	243	Distress, anxiety, depression, anger, problems with romantic partner or spouse, reacting too emotionally to events	Feedback on problem severity, early response to therapy, symptom remediation, and improvement in life functioning predict treatment success Higher severity results in more improvement on average
Maling, Gurtman, & Howard, 1995	307	Axis I or II diagnosis, interpersonal distress	Inverse relationship of salience and distressfulness of interpersonal problems and response to therapy: control issues found more responsive, self-effacing problems more intractable
Mazure, Nelson, & Jatlow, 1990	52	DSM III-R nonpsychotic unipolar Depressive Disorder	Negative association of initial depression severity, melancholia, and panic disorder with response to 1 week of hospitalization without antidepressants. About 50% of non-melancholic and non-panic disordered patients required hospitalization plus medication
McLean & Taylor, 1992	151	Unipolar Depressive Disorder	For severely depressed, nonsignificant effect of treatment on posttreatment depression scores (nondirective psychotherapy, behavior therapy, pharmacotherapy, and relaxation training are not differentially effective)
Mintz, Mintz, Arruda, & Hwang, 1992	Review of 10 studies	Depressive illness	2 studies indicate (a) Significant effect of treatment on work restoration: tricyclic antidepressants restored work more rapidly than psychotherapy (b) Significant effect of treatment duration on work restoration i.e. depressive symptoms improve more rapidly than outcome for work
Moos, 1990	265	Unipolar depression	Negative effect of family conflict and lack of social support on treatment outcome Significant effect of treatment length and level of support on outcome: Ss with high levels of social and family support improve with brief therapy; Ss with low levels of support have better outcome with longer treatment

Study	N	Diagnosis	Outcome effects
Ogles, Sawyer, & Lambert, 1995	162	Major Depressive Disorder.	No differences in clinical significance rates among treatment groups (cognitive-behavioral, interpersonal, pharmacotherapy + clinical management and placebo + clinical management) on measures of depressive symptoms
Prudic, Sackeim, Davanand, & Kiersky, 1993	100	Major Depressive Disorder, double depression	No differential effect of electro-convulsive treatment on depression scores at treatment end for Ss with MDD or double depression Ss with double depression had more residual symptoms posttreatment than Ss with MDD Double depressed also more likely to relapse in year following treatment
Ravindran et al., 1999	97	Primary Dysthymia	Significant differential effect of treatment on functional impairment of depression (improvement with sertraline with/without cognitive behavior therapy exceeded that of CBT alone; effects of CBT equaled those of placebo treatment)
Scogin, Bowman, Jamison, Beutler, & Machado, 1994	133	Mild, moderate, & major depression	Results failed to replicate previous findings of a poorer response to treatment for participants higher in dysfunctional thinking. Cognitive therapy may not be contraindicated for persons evidencing higher levels of dysfunctional thinking
Shapiro, Rees, et al., 1995	104	DSM-III Major Depressive Episode	Positive effect of directiveness on maintenance of gains at 12-month follow-up (CB vs. PI)
Shea et al., 1992	239	Research Diagnostic Criteria: Major Depression	Positive effect of symptom-focus on maintenance of gains (absence of relapse for treatment responders) at 18-month follow-up (cognitive behavioral vs. interpersonal therapy)
Sotsky et al., 1991	239	Major Depressive Disorder	Depression severity, social and cognitive dysfunction, expectation of improvement, endogenous depression, double depression, and current episode duration predicted outcome
Spangler, Simons, Thase, & Monroe, 1997	53	Depression	Significant positive effect of cognitive behavioral treatment on posttreatment depression scores No significant effect of pretreatment cognitive dysfunction or negative stressors on posttreatment outcome
Thase, Simons, Cahalane, McGeary, & Harden, 1991	59	Major Depression with endogenous features	No significant effect of depression severity on depression or global scores posttreatment (more or less severe groups improve equally and at comparable rates), however, more severely depressed tend to remit less completely
Vallejo, Gasto, Catalan, Bulbena, & Menchon, 1991	116	Major Depression with melancholic features	No significant effect of depression severity on pharmacotheraphy outcome. Social support is positively associated with favorable outcome

(continued)

Table 2.8
(continued)

Study	N	Diagnosis	Outcome effects
Veiel, Kuhner, Brill, & Ihle, 1992	190	Discharged depressed patients	No significant effect of stable personality traits on recovery, but for recovered patients severe long-term life difficulties and efforts to seek social support are less likely, while negative outlook and problem avoidance are more likely
Woody et al., 1984	110	Non-psychotic opiate addicts	Low-severity patients made equal progress with drug counseling alone or with psychotherapy Significant effect of added psychotherapy on depression and symptom distress outcome measure for Ss with more severe psychiatric symptoms
Zlotnick et al., 1996	188	Major Depressive Disorder	Correlational 6-month follow-up number of satisfying supports was significant predictor of depressive symptoms. Positive effect of social support on severity of depression posttreatment

they receive nonintensive and brief treatments, regardless of the particular model and type of treatment assigned. Patients with low impairment seem to do equally well in high and low intensive treatments.

Coping Style

General Effects

Coping style subsumes a number of specific concepts and assumptions, ranging from those that are derived from rational logic and theory to those that are descriptive and empirically derived. Rational definitions are extrapolated from observations and assume that patterns of behavior merely reflect the presence of some quality of inner life that characterizes and stabilizes one's behavior. In contrast, empirical definitions rely only on the correlated nature of behaviors to define common qualities or aspects of behavior (Beutler, Malik, et al., 2003). This review will reflect this diversity and will present findings on coping styles ranging from the general to the specific and including both descriptive and theoretical perspectives.

Coping Style as an Empirically Derived Concept

"[C]oping styles" are habitual and enduring patterns of behavior that characterize the individual when confronting new or problematic situations. Thus, coping styles are not discrete behaviors but are a cluster of related behaviors that are distinguished because they are repetitive, enduring, and observable when problems are being addressed. (Beutler, Harwood, et al., 2002, p. 147)

This definition of general coping styles emphasizes that coping styles are defined by the presence of recurring, related behaviors. The recurrence of similar patterns defines these behaviors as being trait-like, and places their measurement squarely within the context of personality variables. Thus, from this general perspective, one's coping style is not merely observed during times of stress, but transcend situational factors and describe one's usual way of being in the world of other people. This view asserts that coping styles are arranged on one or more continua, the most frequently described ranging from "externalizing" patterns in

Table 2.9
Patient Coping Style

Study	N	Diagnosis	Outcome/effects
Beutler, Harwood, et al., 2002			
Barber & Muenz, 1996	250	Major Depressive Disorder	Significant interaction effect of treatment and personality type on depression scores (avoidant patients improve more with cognitive therapy, obsessing clients with interpersonal therapy)
Beutler, Clarkin, & Bongar, 2000	284	Depression, dysthymia	Significant negative effect of functional impairment on likelihood of improvement (prognosis); improvement may be facilitated by high levels of social support Positive effect of long-term and intensive treatment on functional impairment
Beutler, Engle, Mohr, et al., 1991	63	Major Depressive Disorder	Significant interaction effect of treatment and coping style on depression scores (externalizing patients improve more with group cognitive therapy, internalizing with supportive self-directed therapy)
Beutler, Machado, Engle, & Mohr, 1993	49	Major Depressive Disorder	Significant interaction effect of treatment and coping style on depression scores (externalizing patients improve more with group cognitive therapy, internalizing with supportive self-directed therapy; improvement maintained at 1-year follow up)
Beutler & Mitchell, 1981	40	Dysphoric	Significant interaction effect of treatment and coping style on outcome (impulsive externalizers improve more with experiential therapy, depressive anxious with analytic therapy)
Beutler, Mohr, et al., 1991	131	Moderate depression	Significant effect of coping style and treatment on depression outcome (poorly controlled externalizers improve more with cognitive therapy, more controlled internalizing best with supportive self-directed therapy)
Calvert, Beutler, & Crago, 1988	108	Dysphoric (include Bipolar Affective Disorder, Major Depressive Disorder and Dysthymic Disorder)	Significant interaction of coping style and treatment on outcome (internalizing patients improved more in feelings and behavior with insight-awareness-oriented therapy, while externalizers improved in feelings with behavior-oriented therapy)

which one behaves impulsively, actively, and excessively, to "internalizing" in which one behaves more sedately, distantly, and cognitively. Externalizers deal with the processes of life in active, impulsive, undercontrolled, even gregarious ways. They seek stimulation and are not prone to reason their way through situations as they arise. In contrast, internalizers are prone to use rational and intellectual means for managing their relationships with other people. They are slow to decide, thoughtful, and even self-deprecatory and self-demanding.

In their Division 29 Task Force review, Beutler, Harwood, and colleagues (2002) identified 19 studies that had used some measure of coping style as a potential moderator of treatment efficacy. Fifteen (79%) of these found a clear, differential treatment effect. However, only seven studies have been conducted on groups of homogeneous, depressed patients (see Table 2.9). Nonetheless, all seven found interaction effects in which patients who presented with externalizing coping styles tended to be most receptive to treatments that emphasized skill building, direct behavior change,

cognitive management, and symptom reduction procedures. Similarly, those who were classified as internalizers have been prone to benefit the most from models of treatment that emphasized the quality of interpersonal relationships, insight as a method of overcoming problems, and self-understanding.

The consistency of these results suggests that coping style is a moderator of treatment and calls for the differential application of symptom and skill-focused treatments, on one hand, and insight or interpersonal and relationship-focused treatments, on the other. The significance of this finding and conclusion becomes even clearer when it is added to the results of research that addresses theoretical distinctions among coping responses.

Coping Style as a Rational Concept

Blatt and colleagues (e.g., Blatt, 1974, 1995; Blatt & Blass, 1996; Blatt & Shichman, 1983) proposed that personality develops along two fundamental developmental lines—(a) a relatedness (anaclitic) line that involves the development of the capacity to establish mature, mutually satisfying interpersonal relationships, and (b) a self-definitional (introjective) line that involves the development of a consolidated, realistic, essentially positive, differentiated, and integrated self-identity. These two developmental lines evolve throughout life in a dialectic transaction. An increasingly differentiated, integrated, and mature sense of self is contingent on establishing satisfying interpersonal relationships and, conversely, the development of mature and satisfying interpersonal relationships is contingent on the development of a mature self-identity.

Severe and repeated disruptions of this reciprocally balanced, interactive process, at various points in development, can lead to psychopathology. Individuals usually cope with severe developmental disruptions by placing extreme emphasis on one of a small number of fundamental strategies. Females tend to cope with developmental disruptions by becoming preoccupied with interpersonal relatedness while males tend to become preoccupied with issues of self-definition. Thus, various forms of psychopathology can be conceptualized as involving an over-emphasis and exaggeration of one of these developmental lines and the defensive avoidance of the other. This distorted over-emphasis defines two distinct configurations of psychopathology, each containing several types of disorders.

Anaclitic psychopathologies are disorders in which patients are primarily preoccupied with interpersonal issues of trust, caring, intimacy—from more dependent to more mature reciprocal relationships—and use primarily avoidant defenses (e.g., denial and repression). From more to less disturbed, anaclitic disorders include borderline personality disorder, infantile (or dependent) character disorder, anaclitic depression, and the hysterical personality disorder. In contrast, introjective psychopathologies includes disorders that are primarily concerned about establishing and maintaining a viable sense of self, ranging from a basic separateness, through concerns about autonomy and control, to more complex internalized issues of self-worth—and to use counteractive defenses (projection, rationalization, intellectualization, doing and undoing, reaction formation, overcompensation). Introjective patients are more ideational and concerned with establishing, protecting, and maintaining a viable self-concept. Anger and aggression, directed toward the self or others, are usually central to their difficulties. Introjective disorders, ranging from more to less severely disturbed, include the over-ideational borderline, paranoia, and obsessive-compulsive personality disorders; introjective (guilt-ridden) depression, and phallic narcissism (Blatt, 1974, 1995; Blatt & Shichman, 1983).

The distinction between anaclitic and introjective styles of relating has been particularly useful in defining subtypes of depressed patients (e.g., Blatt, 1974, 1998; Blatt, D'Afflitti, & Quinlan, 1976; Blatt et al., 1982). Investigators from different theoretical positions have discussed two major types of depressive experiences: (a) disruptions of gratifying interpersonal relationships (e.g., object loss), and (b) disruptions of an effective and essentially positive sense of self (e.g., guilt, failure). Depressed patients, primarily responsive to one or the other of these two types of experiences, have been characterized by psychoanalytic investigators as anaclitic and introjective (e.g., Blatt, 1974, 1998; Blatt & Shichman, 1983) or dependent and self-critical (Blatt, D'Afflitti, & Quinlan, 1976; Blatt et al., 1982), as dominant other and dominant goal (Arieti & Bemporad, 1980), and anxiously at-

tached and compulsively self-reliant (Bowlby, 1980). In a more recent cognitive-behavioral formulation, Beck (1983), congruent with these psychoanalytic formulations, differentiated between a socially dependent (sociotropic) and an autonomous type of depression. In addition, Blatt (Blatt et al., 1976) and Beck (1983), and their respective colleagues, have developed instruments to assess dependency (sociotopy) and self-criticism (autonomy). Also experienced clinical judges achieved substantial inter-rater agreement about this distinction based on initial case reports (Blatt, 1992; Blatt & Ford, 1994). This anaclitic/introjective distinction was used in three studies of the therapeutic process.

In the *Riggs-Yale Project Research Review* (Blatt & Ford, 1994), therapeutic change was studied in 90 seriously disturbed, treatment-resistant patients who sought long-term, intensive, psychoanalytically oriented, inpatient treatment, including at least four times weekly psychoanalytically-oriented psychotherapy. Introjective patients generally had indications of greater therapeutic progress after, on average, 15 months of treatment, as assessed across a wide range of measures. In addition, systematic differences between anaclitic and introjective patients were found in independent measures of therapeutic change. Introjective patients expressed their change primarily in the intensity of clinical symptoms, as assessed from case reports, and in cognitive functioning, as reliably assessed on psychological tests administered at the beginning and toward the end of treatment (thought disorder on the Rorschach and measures of intelligence). Therapeutic change in anaclitic patients was expressed primarily in changes in their interpersonal relationships, as rated from case reports, and in representations of the human figure on the Rorschach. Thus, anaclitic and introjective patients changed primarily in the modalities of their basic concerns and preoccupations.

The *Menninger Psychotherapy Research Project (MPRP)* undertook analyses of data from the MPRP, comparing the outcome of anaclitic and introjective outpatients treated in psychoanalysis or in long-term supportive-expressive psychotherapy (Blatt, 1992). These analyses indicated that anaclitic and introjective patients were differentially responsive to psychotherapy and psychoanalysis. Based on the evaluation of object representation (Urist, 1973) on Rorschach protocols at the beginning and end of treatment, anaclitic patients had significantly greater positive change in psychotherapy than in psychoanalysis, while introjective patients had significantly greater positive change in psychoanalysis than in psychotherapy. It seemed consistent that more dependent, interpersonally oriented, anaclitic patients would respond more effectively in a therapeutic context in which there is more direct interaction with the therapist. It also seems consistent that more ideational introjective patients, who stress separation, autonomy, and independence, would respond more effectively in psychoanalysis. This statistically significant ($p < .001$) patient-by-treatment interaction indicates that a congruence between patients' character style and aspects of the therapeutic situation facilitated treatment outcome.

Depressed patients were the focus in the *Treatment of Depression Collaborative Research Program (TDCRP)*. The NIMH sponsored TDCRP (e.g., Elkin et al., 1989) compared three forms of treatment for depression: interpersonal therapy (IPT), cognitive behavioral therapy (CBT), and imipramine plus clinical management (IMI-CM), with a double-blind placebo plus clinical management (PLA-CM). In the primary analyses of their data, the TDCRP investigators found "no evidence of greater effectiveness of one of the psychotherapies as compared with the other and no evidence that either of the psychotherapies was significantly less effective than . . . imipramine plus clinical management" (Elkin, 1994, p. 971). IPT and IMI-CM, however, were more effective than CBT with severely depressed and functionally impaired patients.

Further analyses of data from the TDCRP, however, indicate the importance of the anaclitic and introjective distinction. These dimensions were introduced into analyses of the TDCRP data by patients' pretreatment scores on the two subscales of the Dysfunctional Attitude Scale (DAS; Weissman & Beck, 1978); Need for Approval (NFA) and Perfectionism (PFT). Previous studies have shown links between these two DAS scales and the anaclitic (dependent) and introjective (self-critical) personality configurations, respectively (e.g., Blaney & Kutcher, 1991).

While NFA tended to facilitate treatment outcome, results failed to reach statistical significance.

Consistent significant effects, however, were found with PFT. Patients' PFT predicted poorer outcome at termination (i.e., after 16 weeks of treatment), as well as at a follow-up 18 months after termination of treatment (Blatt et al., 1995; Blatt et al., 1998). Further analyses revealed that PFT significantly impeded therapeutic progress in two-thirds of the sample, primarily in the latter half of treatment (Blatt et al., 1998) by disrupting patients' interpersonal relations both in treatment and in social relationships outside of treatment (Shahar et al., 2001; Zuroff et al. 2000). Even further, patients with higher pretreatment PFT were more vulnerable to stressful life events during follow-up, leading to increased depression, because they failed at termination to develop a capacity to cope with stressful life events (Zuroff et al., 2001).

Studies of self-critical perfectionism (e.g., Blatt et al., 1979; Mongrain, 1998; Zuroff & Duncan, 1999) suggest that perfectionistic (introjective) individuals have malevolent, harsh, and punitive representations of significant others that interfere with interpersonal relations. In the course of therapy, introjective patients appear to project these negative representations onto the therapist, thus disrupting the therapeutic alliance. Therapists need to be aware of how they are perceived by perfectionist patients early in the course of treatment and how these negative representations limit the capacity of patients to participate in the therapeutic alliance. Thus, treatment with perfectionist patients takes time and patience, and therapists need to be sensitive to the interpersonal processes, within the patient and themselves, that limit the ability of these patients to gain from brief treatment. Data (Blatt, Stayner, Auerbach, & Behrends, 1996) suggest that patients at moderate levels of PFT are able to gain from brief treatment if early in the treatment process they perceive the therapist as empathic, open, and available.

In addition, therapists should be alert to ways in which perfectionistic patients generate a negative social environment outside of treatment. PFT not only interferes with the therapeutic alliance, but it also interferes with patients' establishing and maintaining supportive social relations (Shahar et al., 2001).

Anaclitic and introjective patients come to treatment with different types of problems, different character styles, different needs, and are responsive in different ways to different types of therapeutic intervention. Specifically, perfectionistic patients need to feel early on that the therapeutic relationship is accepting and nonjudgmental—helping them perceive themselves and others in less critical ways—thus facilitating their entering actively into the therapeutic process and understanding more fully how their negative anticipation of self and others impairs their capacity to establish satisfying relationships.

Principles for Treating Depressed Patients

There are obvious similarities between the rational and empirical descriptions of coping styles. For purposes of summary, it is easy to assume that the anaclitic and externalizing descriptions identify the same group of patients and correspondingly, that the introjective and internalizing descriptors apply to similar patterns of behavior. With this consolidation, it is apparent that introjective/internalizing patients and anaclitic/externalizing patients come to treatment with different types of problems, different character styles, different needs, and are responsive in different ways to different types of therapeutic intervention. The identification of patients' personality organization from a theoretical stance can enhance therapists' understanding of their patients' responses to the treatment process and to stressful events that occur in their lives.

Collectively, the current results support the development of two related principles, as follows:

1. Patients whose personalities are characterized by impulsivity, social gregariousness, and external blame for problems benefit more from direct behavioral change and symptom reduction efforts, including building new skills and managing impulses, than they do from procedures that are designed to facilitate insight and self-awareness.
2. Patients whose personalities are characterized by low levels of impulsivity, indecisiveness, self-inspection, and over control tend to benefit more from procedures that foster self-understanding, insight, interpersonal attachments, and self-esteem, than they do from procedures that aim at directly altering symptoms and building new social skills.

DEFINITION AND CONSOLIDATION OF PRINCIPLES

The current review reveals 18 principles that we believe can be reliably extracted from clinical research literature and applied to treating depressed patients. Four of these principles simply state that evidence is unavailable to support the role of a given variable in the improvement of depressed patients.

1. Research on gender effects is insufficient for a clear judgment of effects on the treatment of depressed patients to be made.
2. Principles related to preference and expectance are not sufficiently well defined to be applied to the clinical treatment of depressed patients.
3. Insufficient research has been conducted on SES to determine if it is a contributor to treatment outcome for depressed patients.
4. Patient stage of change is a promising (but not proven) variable for fitting patient and treatment and for predicting the level of intervention in which to engage the patient.

Thus, effectively 14 principles identify a quality and characteristic of the patient or therapist that can be used in predicting and planning treatment programs. Of these, eight identify variables that relate to patient prognosis and likelihood of change, without regard to the type of treatment employed.

1. Patients representing underserved ethnic or racial groups achieve fewer benefits from conventional psychotherapy than patients from Anglo-American groups.
2. If patients and therapists come from the same or similar racial/ethnic backgrounds, dropout rates are positively affected and improvement is enhanced.
3. If psychotherapists are open, informed, and tolerant of various religious views, treatment effects are likely to be enhanced.
4. Co-morbid personality disorders are negative prognostic indicators in the psychological treatment of depressed patients.
5. Age is a negative predictor of a patient's response to general psychotherapy.
6. Patients who enter treatment with high levels of functional impairment tend to do poorly relative to other patients.
7. A secure attachment pattern in both patient and therapist appears to facilitate the treatment process.
8. The most effective treatments are likely to be those that do not induce patient resistance.

These eight principles can help a therapist determine the degree to which services may be useful and can, therefore, help one set priorities and make referrals.

The remaining six principles relate to ways to fit and match the therapy to particular characteristics of the patient.

1. Benefit may be enhanced when the interventions selected are responsive to and consistent with the patient's level of problem assimilation.
2. If patients have a preference for religiously oriented psychotherapy, treatment benefit is enhanced if therapists accommodate this preference.
3. In dealing with the resistant patient, the therapist's use of directive therapeutic interventions should be planned to inversely correspond with the patient's manifest level of resistant traits and states.
4. Patients with high levels of initial impairment respond better when they are offered long-term, intensive treatment, than when they receive nonintensive and brief treatments, regardless of the particular model and type of treatment assigned. Patients with low impairment seem to do equally well in high and low intensive treatments.
5. Patients whose personalities are characterized by impulsivity, social gregariousness, and external blame for problems benefit more from direct behavioral change and symptom reduction efforts, including building new skills and managing impulses, than they do from procedures that are designed to facilitate insight and self-awareness.
6. Patients whose personalities are characterized by low levels of impulsivity, indecisiveness, self-inspection, and over control tend

to benefit more from procedures that foster self-understanding, insight, interpersonal attachments, and self-esteem, than they do from procedures that aim at directly altering symptoms and building new social skills.

These six principles reflect broadly on both objective traits that can be used for matching with a class of therapists and moderating characteristics that can be used to fit treatments to patient needs. Demographic factors, for example, bear on the advisability of matching patient and therapist background characteristics, while personality and developed attributes bear on the question of fitting and selecting.

These principles collectively bring focus on another, broader issue and associated principle that we believe is important both to advancing research on treatment and advancing the effectiveness of our treatments. In the beginning of this chapter we drew attention to the difficulty of differentiating among factors that are "owned" by the patient, therapist, relationship, and treatment. The magnitude of this difficulty only appears to be greater as we review the foregoing principles of change. Virtually all variables that contribute to outcome involve some interaction among participant, treatment, and relationship factors, to such a degree that distinguishing among them is only possible in an abstract way. The pervasiveness of this interaction suggests that therapists and researchers alike would benefit from reconsidering the unit of analysis in discussing and understanding psychological treatment. Norcross (2002), in summarizing the Division 29 Task Force on the empirically supported therapeutic relationship, concluded that the unit of analysis should be the therapeutic dyad. We would add that even this emphasis may be too simple.

The unit of observation in psychotherapy must encompass the totality of participants, relationships, and treatment events. The balance and priority among these contributors is not entirely known, and at this point, teasing apart of these dimensions in order to assign such priorities and to apportion percentages of variance to attributed constructs is arbitrary and misleading. There can be no treatment without all being involved and they are involved within a pattern of intercorrelations. One can view any treatment as a cloud, comprised of particles and dewdrops, no one of which will give one an understanding of the nature of treatment. This is a true case of the whole being greater than the sum of its parts and we believe that a principle of good conceptualization is one that views the whole as a pattern, not the particles and individual and independent parts.

The latter overarching principle, as well as the 15 specific ones from which it derives, suggests the need for a high level of understanding, flexibility, and skill and for the possession of a wide range of therapeutic skills, on the part of the therapist. Therapists who can appreciate and adapt to patient differences, are aware of cultural factors and beliefs, and who are able to apply insight, behavioral, directive, and nondirective treatments within both a short-term and long-term or intensive format, will likely be maximally or optimally effective in facilitating change among depressed patients.

Editors' Note

1. A. E. Bergin and S. L. Garfield, alternating the senior position, edited the first four editions of this handbook. M. J. Lambert is the Editor of the 5th edition. In the 5th edition, the single process chapter is replaced by several, more specific chapters on aspects of therapeutic processes.

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