

A New Twist on Empirically Supported Treatments

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ABSTRACT. This paper reports preliminary findings of an experiment study that was designed to develop and pilot test an integrative form of psychological intervention. Prescriptive Psychotherapy draws procedures from a set of cross-cutting guiding principles. It focuses on the fit of treatment procedure to patient characteristics and postulates that this fit will add predictive power to the contributions of initial patient factors, classes of treatment procedure, and the therapeutic alliance. A pilot test on 40 depressed, stimulant dependent patients confirmed that the fit of patient to the intervention added substantially to the effectiveness of treatment, especially during a six-month follow-up period. The findings suggest that patient factors alter the patient's prognosis, that interventions contribute a modest influence on outcome, and the therapeutic alliance adds additional predictive power. However, the fit of treatment to patient appears to be more powerful than any of the other classes of variables, particularly in influencing depression and sense of well-being.

KEYWORDS. Psychotherapy. Prescriptive Therapy. Integration. Chemical Abuse. Alcohol. Experimental study.

RESUMEN. Este artículo presenta los resultados preliminares de un estudio experimental diseñado para desarrollar y validar un modelo integrador de intervenciones psicológicas. La psicoterapia prescriptiva basa sus procedimientos en principios de cambios meta-teóricos. Este enfoque enfatiza la adecuación o correspondencia de las intervenciones psicológicas a las características del paciente, planteando que esta correspondencia incrementa el poder predictivo

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de las contribuciones iniciales de los factores del paciente, tipos de intervención y alianza terapéutica de cara al resultado terapéutico. Este estudio piloto, en una muestra de 40 pacientes con trastornos del estado de ánimo y consumo excesivo de sustancias, confirmó que la correspondencia entre las características del paciente y las intervenciones psicológicas beneficia sustancialmente la eficacia del tratamiento, especialmente a los seis meses de finalizar el tratamiento. Los resultados sugieren que las características del paciente influyen en su pronóstico, que las intervenciones como tal influyen de forma modesta y que la alianza terapéutica incrementa el poder predictivo. Con todo, la adecuación de las intervenciones al paciente parece tener un valor predictivo superior al resto de variables, en particular para la depresión y la sensación de bienestar.

PALABRAS CLAVE. Psicoterapia. Terapia prescriptiva. Integración. Consumo excesivo. Alcohol. Estudio experimental.

RESUMO. O presente artigo apresenta os resultados preliminares de um estudo piloto experimental planejado para desenvolver e testar um modelo integrativo de intervenções psicológicas. A Psicoterapia Prescritiva baseia os seus procedimentos em princípios de mudança meta-teóricos. Esta abordagem enfatiza a adequação ou correspondência das intervenções psicológicas às características do paciente, e postula que esta correspondência acrescenta ao poder preditivo das contribuições iniciais dos factores do paciente, classes de intervenções, e aliança terapêutica para o resultado terapêutico. Este teste piloto, em uma amostra de 40 pacientes com perturbações do humor e consumos excessivos, confirmou que a correspondência entre as características do paciente e as intervenções psicológicas beneficia substancialmente a eficácia do tratamento, especialmente após seis meses do final da intervenção. Os resultados sugerem que as características do paciente influenciam o seu prognóstico, que as intervenções propriamente ditas influenciam os resultados de uma forma modesta, e que a aliança terapêutica acrescenta ao poder preditivo. Contudo, a adequação das intervenções ao paciente parece ter um valor preditivo superior aos restantes grupos de variáveis, em particular para a depressão e o sentido de bem-estar.

PALAVRAS CHAVE. Psicoterapia. Terapia Prescritiva. Integração. Consumos Excessivos. Alcool. Estudo Experimental.

Introduction

In 1999, the US Government, Department of Agriculture, closed a meat packing plant when a new, sophisticated testing procedure revealed that the meat contained a life threatening bacteria. The Department of Agriculture demanded that the plant change their procedures for handling, testing, and processing meat in order to remove the contamination. But, a Texas court ruled that the U.S. government could not close the plant, even though the food they were producing was contaminated. The court asserted that the newly developed method used to detect the contamination, while accurate, was unfair to use because it was higher than the general community standard. As in clinical practice, the test of whether the meat product was “good” was based on whether the procedures used to process it were consistent with those usually used and accepted in the community, not on whether that process produced meat that was healthy or poisonous.

In contemporary society, clinical practices are often held hostage to three standards that are used to evaluate the effectiveness of our work (Beutler, Bongar, and Shurkin, 1998), all of which are fundamentally tied to clinician belief and sincerity. Clinical opinion and sincerity have been operationalized in western society by three more specific criteria that, individually, have been used to define when a treatment is effective (Beutler, 2000). The first of these criteria are collected under the name of “Cost-Effectiveness”. This is a set of criteria used to determine the acceptability of treatment to third party payers and government agencies. It weighs the cost of services against “effectiveness”, but in this case “effectiveness” is defined as the number of people served. In this standard, the cost of service is assessed in time and dollars, but it ignores the amount of actual improvement experienced by the patient. The remaining two standards by which the effectiveness of services are assessed have been defined by the courts and are used to decide on cases of malpractice. In these latter cases, effectiveness is assumed to be present if malpractice is not. The most widely recognized legal standard is based on “Common and Usual Practice”. This standard bases decisions about the value of treatment on the acceptance of the treatment to the community of practitioners. This relegates the question of effectiveness to one of popularity. Under this principle, nothing new would ever be considered to be effective. The final standard of a treatment’s worth was designed by the courts to compensate for the problems of standards based on common practice. It defines the value or effectiveness of a treatment by its acceptance among a significant and respectable minority of practitioners. Under this rule, if there has been a standard of delivery articulated and “a significant minority” of professionals accept this standard, then the intervention must be effective. Again, there is no direct concern in this criterion with the actual effectiveness or improvement attributable to the treatment. This criterion was defined by the U.S. courts in a case of a medical treatment that was known to be dangerous and ineffective, but which had earned the regard of six individual practitioners whose rights were protected by this definition of effectiveness. Of these various criteria by which a treatment’s usefulness is based, none directly rely on a determination of whether the patient actually gets better. That, too, is left to clinical judgment and clinician sincerity. None of the various standards directly answer this question in a way that is scientifically and politically credible. They, like the rules governing meat packing procedures, are more concerned with how treatment is conducted—the process—rather than with its actual effects. Treatment guidelines developed by the American Psychiatric Association (1993) and other groups (e.g., Berman and Jobes, 1992; Rush *et al.*, 1993) represent variations on the latter three criteria of worth. They capitalize on the popularity of the treatment as represented by consensus panels and on minority views, as represented by recognized “authorities”. In one way or another, these guidelines seem to represent more of political statements than an objective set of guidelines. Few in either academic institutions or clinical practices are satisfied with these standards of effectiveness. A new standard is needed and politicians, health care administrators, and clinicians have all begun to look to science to provide that standard. Clinicians approach the task of assessing the worth of treatment from the viewpoint that what the therapist does, to whom, and when she does it matters—it affects how a patient feels and acts. In scientific terms, this viewpoint holds that there is an interaction effect between patient behavior and therapy procedures that is significant

in enhancing outcomes. However attractive this proposition, it is not one on which scientists have a uniform opinion. Scientists fall into two major camps with regard to this clinical assumption.

On one hand, many scientists have asserted that there are certain treatments that have proven their worth through scientific investigation. It is this viewpoint that has underwritten the movement to define “Empirically Supported Treatments” or ESTs. The EST movement in American psychology and psychiatry has held that only treatments that have been shown to be effective in head-to-head comparisons with control and no-treatment groups, should be practiced. From this movement, we have lists of “Treatments that work” for patients with different diagnoses. These ESTs are defined by long lists of brand-name therapies and reference manuals, all indexed to a particular diagnostic group (e.g., Nathan and Gorman, 1998). Indeed, in this perspective, all treatments should be clearly defined and prescribed through the use of manuals that allow more or less precise assessment of when therapists are complying with the treatment recipes. Some authors (Hamilton & Dobson, 2001) have even proposed international or world-wide dissemination of ESTs in culturally sensitive and researched ways. While these latter scientists believe that what the therapist does matters, their view of this question differs from that of most clinicians. While clinicians look for change in the individual fit of procedures to specific patients and moments in treatment, EST scientists look at a larger grained analysis. They look at the fit of a packaged model of treatment and the patient’s diagnosis. From this perspective, an effective treatment is defined without reference to a particular therapist, patient, or therapy relationship. That is, the EST perspective holds that some models and theories are better than others, irrespective of either the therapist who practices them, or the patient, as long as the patient’s diagnosis is appropriate to the treatment model. This perspective is quite different than that adopted by the usual clinician.

On the other hand, there is another group of scientists who take even a more dim view of the clinician’s belief in the value of fitting their specific interventions to patients. This group of scientists take the view that there are few effects of specific interventions, or even treatment models. They assert that to the degree that any treatment or intervention works, it is probably because it shares certain qualities with all other effective treatments and interventions. Principally, these scientists take the view that it is the relationship between patient and therapist that works, not the techniques or the brand name of treatment that is provided. It is not what the therapist does, but who the therapist is and how she is perceived by the patient that matters. In this perspective, all therapeutic acts are considered to be interchangeable, as long as they enhance the quality of the therapeutic alliance or relationship. Scientists in this latter perspective (e.g., Lambert and Bergin, 1994; Strupp, 1986) have concluded that all therapies are equivalent as long as a good enough therapeutic alliance is present. Some even (e.g., Andrews, 2000) have asserted that as much as 80% of the variance in outcome is associated with “non-specific” factors, those that occur naturally and virtually independently of therapy interventions. The do-do bird verdict implies that it doesn’t much matter what one does as long as one cares.

Thus, in today’s world we as practicing clinicians find ourselves in a bind. On one hand, clinical judgment has proven to be fallible and our clinical impressions are not

accepted as being a sufficient basis for building evidence of a treatment's worth. On the other hand, the standards that have evolved in health care and political agencies for assessing the value and worth of treatments say little about whether these treatments really make a difference or even if they are safe. Still further, the scientific community is divided between those who believe that all practitioners should learn to follow certain manualized and researched treatments and those who believe that almost anything a therapist does is acceptable, as long as one is sincere, caring, and good willed. But, there is a small group of scientists whose viewpoints are much more similar to those of most clinicians. These "Prescriptive" or "Eclectic" theorists oppose both the do-do view and the rigid EST perspective. They hold to the positions that, (1) some treatment procedures fit certain patients better than do others, (2) the patient's personality and non-pathological qualities determine at least as much about whether or not a treatment works as the patient's diagnosis, and (3) good interventions often draw from multiple theories and perspectives. But, subjecting these beliefs to scientific test is difficult. Kazdin and Bass (1989) have opined that a test of such propositions would involve such a large number of participants that it would be virtually out of reach of most investigators. Without a clear articulation of what such a therapy would look like, and without evidence that once defined, it could be trained and practiced in a reliable way, a large budget and a multi-site study could not readily be expected to be funded by a federal agency.

Nonetheless, these research scholars have remained convinced that what the therapist does matters—it is not enough to do "anything"; sometimes a specific "something" is required to improve the chances of benefit. Some of us also believe that the "something" required is not always contained or embodied in one specific theory, nor is its use dependent on something as indefinite as the patient's diagnosis—sometimes it can come from cognitive theory and sometimes from experiential or psychodynamic theory, even at different times when working with a given patient. These "Eclectics" believe that a maximally effective treatment will not be one that constrains the use of an effective procedure simply because it was spawned from a theory that is not embraced by one or another clinician. This paper will review some of the preliminary findings of a randomized clinical trial investigation of such a Prescriptive Therapy (PT). The current report is preliminary in that it is not based on a complete follow-up and end point assessment, which is still underway. A detailed description and report of the final findings of this study is currently being prepared. Nevertheless, the current experimental study (Montero and Leon, 2002) does follow the structure of the guidelines proposed by Bobenrieth (2002). Our research has been concerned with developing a new empirically supported treatment. This one would specifically be a treatment that cuts across theoretical boundaries, integrates a wide array of techniques, and can be applied to a cross-section of patients with different diagnoses. This treatment is governed by principles that can be applied from within any viable treatment model. Within it, the patient's diagnosis is of limited value for planning treatment and is used instead as a measure of change in order to evaluate the effectiveness of treatment. Specifically, this brief review of the project will address the hypothesis that certain, empirically defined patient, treatment, relationship, and matching variables each add independent variance to the prediction of outcome.

Method

Participants

- Therapists. Forty-nine full-time professional practitioners from the Santa Barbara (California) community responded to our advertisements and volunteered to be trained in one of three therapies and to participate (for a fee) in the treatment of patients who were defined as being chemically dependent with co-morbid, mild to moderate depression. Thirty-four (34) experienced therapists actually completed 16 hours of training in one of the three conditions, Cognitive Therapy (CT; n = 11), Narrative Cognitive Therapy (NT—our rendition of a supportive, self-directed, intervention; n = 12), and Prescriptive Therapy (PT; n = 11). Selection of the final cohort of therapists for this treatment development study was based on a final role playing exercise. Role plays were based on one of four, randomly selected vignettes portraying various aspects of depression, disturbance, and chemical abuse. Videotapes of these role playing exercises were rated by the experts in the specific modality and these experts rank-ordered the performance of the therapists within each group. The top three therapists in each training condition were invited to participate as therapists and the fourth ranked therapist in each condition was invited to serve as a back up therapist and to attend supervision sessions. Of the 13 therapists who were selected as therapists, 11 (5 male and 6 female) were assigned patients and two acted as back-up therapists, attending supervision sessions but not seeing patients. Therapist experience ranged from two (2) to 27 years. Ten of the 13 initially selected therapists held a Ph.D., two of the therapists held an MFCC, and one held a Master's in nursing. The academic credentials of all groups were balanced. After patients were assigned, therapists in each condition met for group supervision once per week. During this time, cases were supervised and adherence to the treatment protocol was assessed by the supervisor for at least one of every five sessions using standard compliance forms developed for each treatment.
- Patients. Our target population was co-morbid patients who were both stimulant dependent and depressed. They were required to meet DSM-IV criteria for either cocaine or methamphetamine dependence and one of the depressive spectra disorders. Most patients in our final sample used a variety of drugs, and many were dependent on heroin, methamphetamine, marijuana, and cocaine, at once. Eighteen (18) were identified as primarily cocaine dependent, 12 were primarily methamphetamine dependent, and a primary drug could not be determined on 10. Only 30.5% (n=12) used cocaine but not meth, only 22.2% (n=9) used methamphetamine and not cocaine. All patients reported abuse of at least one additional drug, usually marijuana (69.4%), alcohol (50%), or heroin (25%). These percentages were much higher than in the community sample of general drug abusers.

Treatments

The three therapies selected for study were identified because, conceptually, they encouraged quite contrasting styles of interacting with patients on the four dimensions

that defined patient and therapist fit in Prescriptive Therapy: Intensity, Focus, Directiveness, and Affective Regulation.

- Cognitive Therapy was based on the theories of A.T. Beck, and followed the manual for treating chemical abuse authored by Beck, Wright, Newman, and Liese (1993). It was conducted by four therapists, all of whom were in compliance with CT criteria developed by Dobson, Shaw, and Vallins (1993). The therapy was supervised by a clinician who was trained in the use of CT by Delores Gallagher-Thompson, and Larry Thompson. The Thompsons participated in the supervision and cross-checked compliance.
- Narrative Therapy was based on the theories of Goncalves (1995) and Mahoney (1991) and on efficacy research on depression by our research group (Beutler *et al.*, 1991; Scogin, Hamblin, and Beutler, 1987). It was conducted by four therapists using materials and criteria developed by O. Goncalves. These therapists were supervised by a senior clinician (PhD) who was trained in and helped develop the manual and procedures. This form of treatment focuses on episodes (narrative material) drawn from the past and present life of the patient. Elaboration of these stories are stimulated by videotapes, books, stories, and poetry to facilitate discussion about how drugs have affected one's life and to help patients understand what roles drugs have played in their lives. The therapist remained reflective and questioning, avoided interpretations and demands, except to suggest that the patient may benefit from becoming involved with outside groups (such as AA and NA)—Most patients were involved in a 12 step-program as part of treatment.
- Prescriptive Therapy adapted the interventions to fit key patient dimensions that have been found in previous research to be effective mediators of treatment outcome (Beutler, Clarkin, and Bongar, 2000; Beutler *et al.*, 1991). It was conducted by three trained therapists and was supervised by the P-I (Beutler).

PT maintains that four critical patient qualities, four correlary families of interventions, and four matching variables will exert independent variance to the prediction of benefit and that the matching variables will exceed the contributions attributable to the therapeutic alliance. Thus, in PT, each of the four treatment qualities were assigned individually as a function of assessed patient variables.

Patients whose intake GAF was less than 60 and who had few family/social support were identified as having high levels of Functional Impairment. Accordingly, they were scheduled for bi-weekly sessions until a noticeable decrease in drug use was noted. Those with scores that were above 60 were seen on a weekly basis. This procedure was used to differentially address the needs for varying intensity of treatment. Patient's whose MMPI-2 suggested a preponderance of self-inspection (D), emotional constriction (Pt), and social isolating (Si) behaviors (Internalizers) were encouraged, within the first few sessions of treatment, to begin focusing on the meaning of drug use and the genesis of their unhappiness and to seek the answers to these questions in past relationships and experiences. In contrast, externalizing patients (those with elevations on Pd, Pa, and Ma subscales of the MMPI-2) received a symptom focused, here-and-now therapy using the materials and behavioral interventions employed in the CT condition. A focus on impediments to goals (motivational interviewing), social activation, identifying problems,

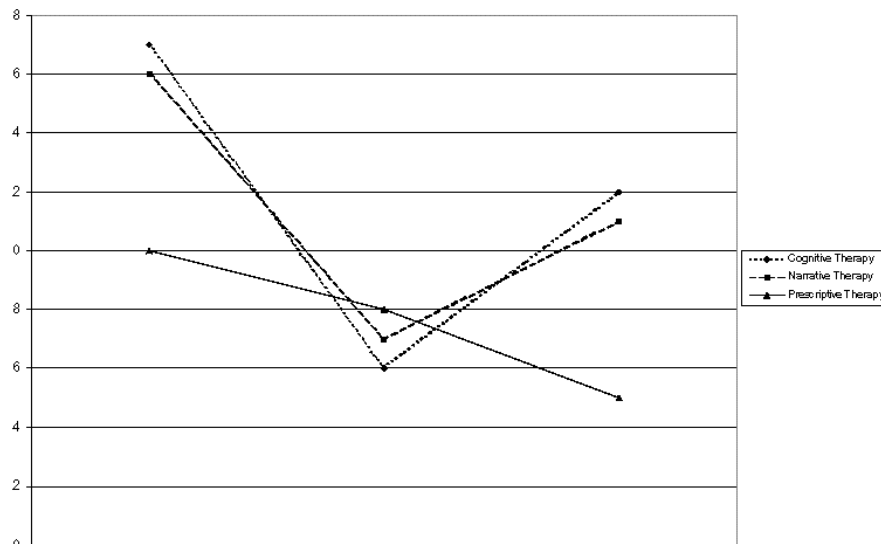
contingency contracting, self-monitoring, and cognitive analysis were used to facilitate skill development and behavioral change. Patients who scored above the normative (patient) mean on the Dowd Therapeutic Reactance Scale (Dowd, Wallbrown, Sanders, and Yesenosky, 1994) were provided with a patient-directed regimen, using some of the general procedures employed by NT. Reflection, observations, and permissiveness were emphasized in the treatment. Homework assignments consisted of “suggestions”, with both passive and active options. For those low on this dimension, homework assignments were more directive, specific, and typical of those used in CT. The State Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, Lushene, Vagg, and Jacobs, 1983) was used to identify weekly level of distress. Scores above the patient mean were provided with a supportive intervention while those at or below the mean were provided with confrontation and experiential methods designed to increase arousal level and problem focus.

Results

As noted earlier, the findings presented here are preliminary. They are subject to some change as a more nearly complete set of data is obtained during continuing follow-up assessments.

Comparison of Treatments

FIGURE 1. HRSD Mean Scores per Treatment Group.



Because of the small samples and associated limited statistical power, we relied on visual inspection of individual growth curves to highlight differences among the three treatments. Figure 1 compares the three treatments across time on the Hamilton Rating Scale for Depression (HRSD), a measure of depression. Follow up assessment took place one month at three and six months post-treatment. Visual inspection suggests an apparent treatment effect at the end of treatment, favoring CT over NT and PT. These differences reversed during follow-up when CT patients experienced a high level of relapse. This latter finding should be considered to be very tentative as it is based on an attrited sample of 15 subjects.

FIGURE 2. UA Mean Scores per Treatment Group.

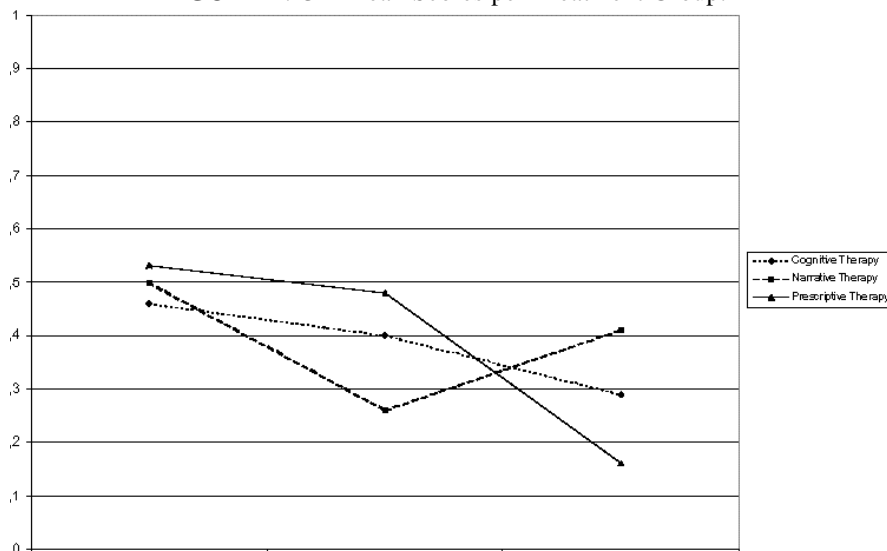


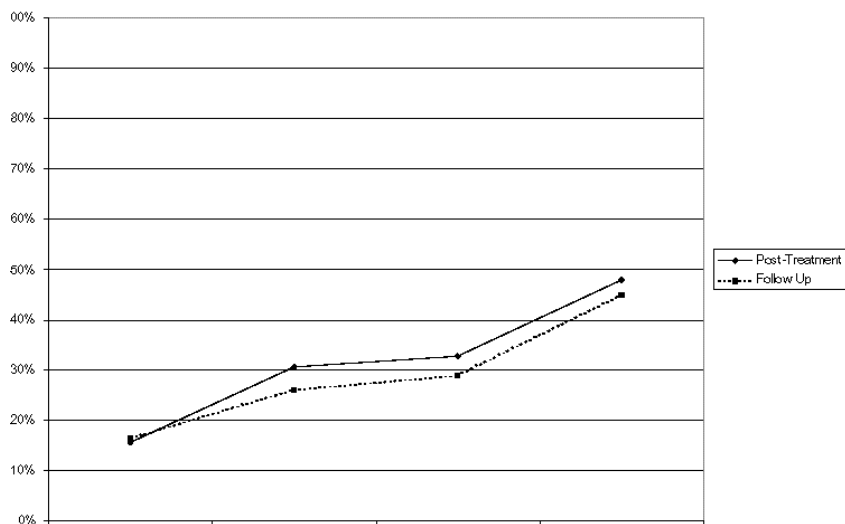
Figure 2 depicts evidence of stimulant substrates in patient urine. Here we see some very interesting effects. There was a general decline in positive urine data over treatment and continuing through follow-up, but the wave-to-wave stability was much greater in PT than in either of the other treatments. The difference between CT and NT at wave three, about 12 sessions into the 20-week course of treatment, was particularly large. By that point, CT was showing the strongest effects, but most CT patients had relapsed by the end of treatment and had surpassed the initial entry baseline. Positive urine findings continued gradually and predictably to decline in PT, with the other treatments showing a variable pattern of improvement and relapse.

Main Analysis—Fit of Therapy to Patients

A question that we considered to be more important than the horse race among therapies, was what are the relative contributions of patient, therapy, relationship, and treatment matching variables to outcome? Thus, the principle analysis was designed to

determine the relationship between compliance with PT principles and outcomes. We conducted a hierarchical analysis in which the four patient variables were entered as a first block, followed sequentially by the four treatment variables, and then by patient ratings of the therapeutic alliance taken within the first five treatment sessions. The HAq-Patient version was used for this purpose. As a last step in the analysis, we entered a score that indexed the fit between the four patient variables and the four treatment qualities. This allowed us to use the entire sample and enhanced statistical power.

FIGURE 3. Variance of BDI accounted for in Hierarchical Multiple Regression.



In Figure 3, we see that each of the variable sets, except the now included therapeutic alliance rating at the third step, added independent variance to both the end of treatment and six-month follow-up ratings of depression, based on the BDI. After initial patient and intervention variables were entered, therapeutic alliance contributed little to the prediction of outcome, whereas the addition of a good fit of patient and treatment significantly boosted the predictive power. This was a modest contribution at the end of treatment, but a very large one by the end of the six-month follow-up period. This pattern was repeated with even more striking results for other measures, both of depression change and change in drug use.

FIGURE 4. Variance of HRSD accounted for in Hierarchical Multiple Regression.

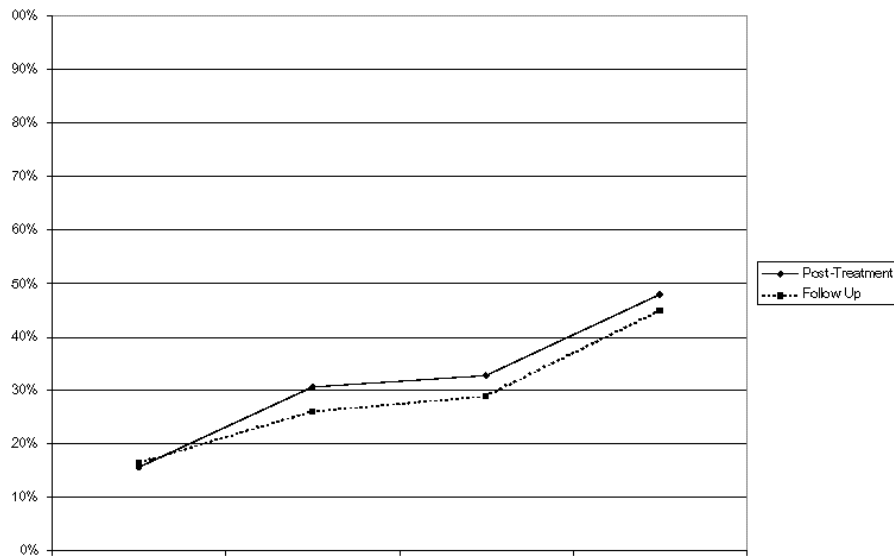
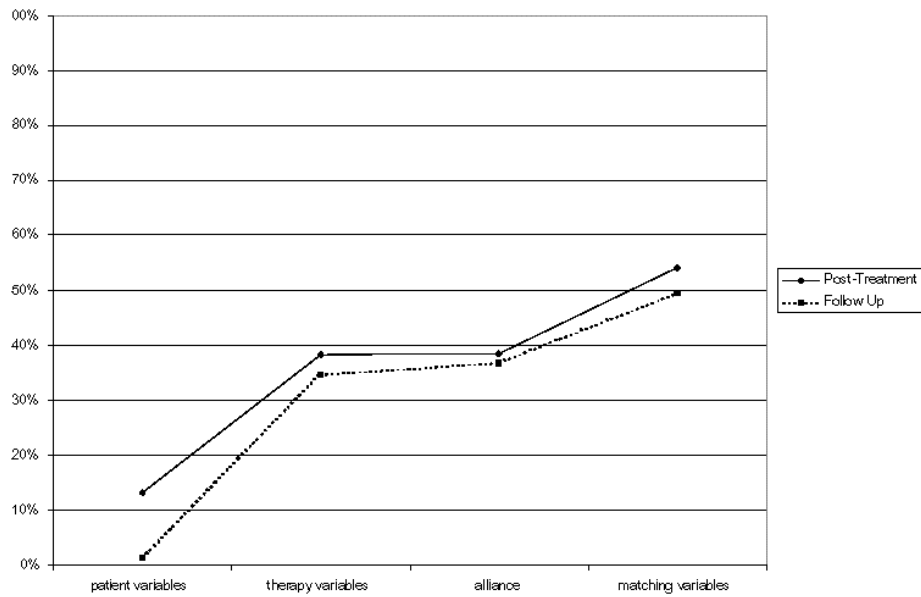


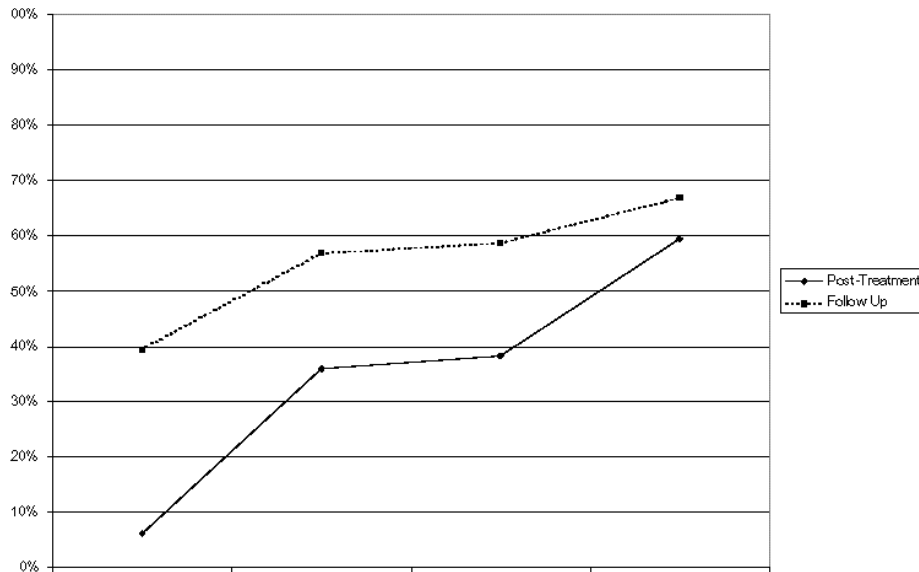
Figure 4 reveals essentially the same pattern when the outcome variable is the HRSD. In this case, therapeutic alliance appears to make a contribution beyond that attributed to patient and treatment. The matching dimensions added only a modest additional predictive power at treatment end, but lifted the entire equation to over 90% predictive efficiency at six month follow-up.

FIGURE 5. Variance of ASI Alcohol accounted for in Hierarchical Multiple Regression.



As noted in Figure 5, the ASI alcohol abuse index showed a remarkably strong contribution from therapy procedures, increasing the proportion of variance accounted for from about 3% to 23% during treatment. This measure again showed a modest contribution of the Therapeutic Alliance, strongest at follow-up, but a substantial additional contribution of matching therapy and patient, especially during the follow-up period.

FIGURE 6. Variance of ASI Drug accounted for in Hierarchical Multiple Regression.



The foregoing pattern again persisted when drug abuse changes were the dependent measure. In Figure 6, visual inspection again suggests that the overall contribution of all variables, patient characteristics, treatment interventions, therapeutic alliance, and patient-treatment fit boosted the prediction at follow up compared to during the active treatment phase.

Discussion

The current results add to an increasing body of research that suggests that what the therapist does matters. Some procedures are stronger and more powerful than others. The therapeutic alliance also matters as we all know. But, interestingly, a large portion of the variance attributable to this variable is captured when we know the contributions of patient resistance, coping style, distress/motivation, and severity, and when we know what interventions the therapist has used. Additionally, we found that symptom focused interventions that are designed to raise emotional intensity, contribute to good alliances. But, beyond these effects of patient, intervention, and alliance, the fit of patient and therapy makes a difference. Good fits predict good outcomes across outcome dimensions and among very complex, co-morbid patient groups. The promise of building a therapy and training therapists to adapt their procedures to these principles is still equivocal, however. We still do not know if it is best to train therapists anew or if they can learn to apply

their own procedures from within different theoretical models. Our findings indicate that, following training in Prescriptive Therapy, therapists believe that they are adapting their approach to patient indicators, judge that doing so improves their therapy work, and think that this approach is compatible with both their own and their colleagues beliefs and practices. But, they probably are not doing as much of this as they believe they are. Clinician sincerity and strong belief are, indeed, fickle measuring rods. We continue to be impressed, nonetheless, with the degree to which adjusting the therapeutic intervention to fit the patient actually makes a difference, especially in the months following the actual treatment. From this, we hope to eventually find ways for therapists to use the knowledge that they have to build novel treatments for each patient. Then, we may see the science and art of psychotherapy in joint action.

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