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Leading Article

The Elegant Psychosocial Intervention: A Heuristic Conceptual Framework for Clinicians and Researchers

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Abstract. Controlled efficacy/effectiveness trials throughout the world have reached a high standard from a methodological stance, but what do we regard as the ideal or elegant intervention in clinical psychology? This paper presents six key points as the gold standards of psychosocial interventions by which treatment efficacy/effectiveness research with children, adolescents and adults might be evaluated: (1) Theoretical rationale and conceptualization of clinical dysfunction; (2) Clear problem identification and target client group; (3) Program features such as realistic goal setting, flexibility, and time limited interventions; (4) Manual based treatments; (5) Research support including clinically significant outcomes; and (6) Acceptability/social validation of clients and society. Sound case formulation and therapeutic alliance are crucial to assessment-treatment interface. Finally, we discuss the usefulness of such a framework for mental health professionals and clinical-researchers.

Keywords: Intervention, children, adolescents, adults.

Introduction

Recent years have witnessed many sophisticated randomized clinical trials conducted throughout the world, demonstrating the clinical effectiveness of psychosocial interventions for a range of serious mental health problems in children, adolescents and adults (Barrett and Ollendick, 2004; Graham, 2005; Kendall, 2006; Ollendick and March, 2004; Salkovskis, 2002). Notwithstanding debates about conceptual, design and sampling limitations (Norcoss, Beutler and Levant, 2006), investigatory teams have achieved a high level of methodological rigour and findings fill significant gaps in the literature about what works for various psychological disorders. However, we fail to see an overall conceptual framework that

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explicitly sets out the key features of psychosocial interventions. In a way, methodological rigour may have obscured our thinking about more fundamental considerations regarding the defining characteristics of ideal psychosocial interventions. The purpose of this brief commentary is to present a heuristic framework about psychosocial interventions that is aimed at therapists and researchers across various theoretical orientations. We propose that an ideal intervention would: 1) have a sound theoretical footing or rationale; 2) articulate clear problem identification and delineation of the client group; 3) possess salient program features such as clear goals and flexibility of implementation; 4) be set out in a sophisticated therapist manual format; 5) demonstrate research support for its efficacy under controlled conditions and in applied clinical settings; and 6) be acceptable to clients and society.

Theoretical rationale

Psychosocial interventions should have a clear theoretical rationale (Barlow, Hays and Nelson, 1984; Maxmen and Ward, 1995). Typically, the theoretical rationale of an intervention is assumed or taken to be self-evident on the basis of a superficial fit with an established school of psychotherapy such as psychodynamic therapy, cognitive-behaviour therapy, interpersonal therapy, or family therapy. However, we agree with others, such as Kazdin and Kendall (1998), on the need to go beyond the brand name in psychotherapy and use our understanding or conceptualization of the clinical dysfunction as a more appropriate rationale for psychosocial interventions. Conceptualization of the clinical dysfunction involves consideration of research on factors that lead or contribute to the pattern of functioning we wish to change, what processes are involved, and how these processes emerge or operate. Therefore, a conceptual model of the dysfunction encompasses concurrent correlates, causal/risk factors and protective factors (Kazdin and Kendall, 1998; King and Ollendick, 1998; 2000). The selection of a treatment intervention should be based on this conceptualization and the "goodness of fit" of the intervention to the problem areas addressed. Certain dysfunctions call for certain interventions that address the basic processes that underlie the dysfunction, and that can be predicted to work better for those dysfunctions (Barlow, 2001).

Understanding the treatment mechanism is a key issue for researchers and clinicians in all schools of psychotherapy, with much confusion in the literature over terminology. Recently, Kraemer and colleagues made an important distinction between mediators and moderators associated with change (Kraemer, Stice, Kazdin, Offord and Kupfer, 2001; Kraemer, Wilson, Fairburn and Agras, 2002). Conceptually, mediators such as self-efficacy or automatic thoughts identify why and how treatments supposedly work. Importantly, change in the mediator must show temporal precedence to change in the outcome variables. So, for example, change in cognitive distortions must occur before changes in depressed mood for changes in automatic thoughts to be viewed as a mediator of treatment outcome. Moderators, such as socio-demographic variables and other variables that exist prior to treatment such as family dysfunction or marital distress identify for whom and under what conditions treatments have their effects. The distinction between moderators and mediators should be helpful to scholars in all schools of psychotherapy seeking to develop a more sophisticated understanding of how psychosocial treatments work.

Clear problem identification and target client group

The ideal intervention has been developed for a problem that can be clearly defined and easily identified following specific diagnostic criteria such as those of *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV; American Psychiatric Association, 1994) (Maxmen and Ward, 1995) or *International Classification of Mental and Behavioural Diseases-10* (World Health Organization, 1992). For some readers such classification systems might be seen as embedded in the medical model and they might also have concerns about the possible negative impact of diagnostic labelling on the client/patient and family. A full discussion of the advantages and disadvantages of psychiatric classifications/diagnosis is beyond the scope of this paper (see for example, Jensen, Knapp and Mraazek, 2006; Rogers, 2001). However, this is not the only means by which it is possible to establish a clear problem operational definition. For example, problems such as poor assertion, shyness, relationship/marital discord can be assessed objectively through multi-method and multi-informant behavioural assessment strategies that yield clear operational behavioural definitions (Meier and Hope, 1998). The target client population should also be evident in terms of socio-demographic variables (age, sex, socio-economic level, and cultural/ethnicity factors), patient characteristics (co-occurrence with other disorders, history of psychopathology), and treatment setting (private practice, community health setting, hospital inpatient/outpatient setting). Presenting problems can be multi-faceted and involve complex diagnostic patterns in any treatment setting (Flannery-Shroeder, Suveg, Safford, Kendall and Webb, 2004; Tarrier, 2005). This takes us back to our most fundamental question in psychotherapy research: What works for whom, when, where, and why? (Hubble, Duncan and Miller, 1999; Ollendick and King, 2000, 2006; Paul, 1969).

Program features

First, interventions should have clear personally relevant goals for clients and their families and address what is known about risk factors, causes and maintenance variables of the clinical disorder (Barlow, 2001; Spiegler, 1983). Second, interventions should be developmentally sensitive and take account of the varying level of cognitive-verbal skills and affective development across the lifespan (Ollendick, Grills and King, 2001; Toth and Cicchetti, 1999). Third, interventions should be flexible and fine-tuned in the light of unique client or family/school characteristics (Barlow, 2001; Kendall et al., 1992). Fourth, interventions should be action-oriented with an emphasis on coping skills training and competency building (Curwen, Palmer and Ruddell, 2000; Sanders and Dadds, 1993). Fifth, the ideal intervention anticipates future setbacks and stressors and has a relapse prevention training component (Wilson, 1992; Kanfer and Schefft, 1988; Kendall et al., 1992). Sixth, effective interventions are typically structured, multi-component and target cognitive, behavioural and physiological improvements (Kazdin, 1984; King, Hamilton and Ollendick, 1988; Ollendick and Davis, 2004). For example, a flexible mix of psycho-education, cognitive skills training, and behavioural exposure tasks was evaluated as effective in the treatment of social phobia in adults across multiple outcome criteria (Heimberg et al., 1990). Seventh, treatment-related homework tasks form an integral part of the intervention, and may be vital to maintenance and generalization of therapeutic change (Kanfer and Schefft, 1988; King et al. 1998; Sanders and Dadds, 1993). Eighth, the ideal intervention involves teaching or empowering clients to be their own therapist (Curwen et al., 2000). Ninth, the ideal intervention is time limited.

The drive or push for brief therapy (i.e. limited number of sessions) comes from the overall pressure of consumerism, the increased demand on psychotherapy and counselling in mental health services, as well as the demands of the purchasers of psychotherapy services requiring the most cost-effective interventions and the best value for money (Curwen et al., 2000; Feltham, 1997). In response to this challenge, for example, Öst and colleagues have developed an effective one session treatment program for specific phobia in children and adults (e.g. Öst, Branberg and Alm, 1997; Öst, Svenson, Hellstrom and Lindwall (2001). Others are developing brief interventions for a host of other problems (see Norcross et al., 2006). Tenth, the ideal intervention should be available in group format in order to reach more clients. Fortunately, excellent group-based programs have been reported for a variety of frequently seen adult problems such as assertion difficulties (Lange and Jakubowski, 1976), social phobia (Heimberg, et al., 1990), and depression (Lewinsohn, Antonuccio, Breckenridge and Teri, 1984). Effective group based programs have also been developed for children with internalizing and/or externalizing problems (Flannery-Schroeder and Kendall, 2000; Kendall, 2006). Lastly, given wide spread and increasing access to the internet in recent decades, the final challenge should be for treatments to be available through the internet. The advantages and disadvantages of internet-based therapy have been debated elsewhere (Marks, Shaw and Parkin, 1998). Positive findings have been reported in several controlled studies of the efficacy of internet-based cognitive-behavioural treatments for depression (e.g. Seligman, Steen, Park and Peterson, 2005) panic disorder (e.g. Carlbring, Westling, Ljungstrand, Ekselius and Andersson, 2001), and recurrent headache (Strom, Pettersson and Andersson, 2000, 2004). Thus internet based cognitive-behaviour therapies are shaping up as realistic, cost-effective effective options for clients in regional Australia, Europe, UK or US.

Manualization

Treatment manuals serve two major purposes (Chambless et al., 1996; Ollendick and King, 2004). First, treatment manuals provide an operational definition of what actually occurs in treatment, and make it possible for research designs to investigate whether treatments are delivered as intended (i.e. treatment integrity). Second, use of a manual allows other mental health professionals to know what treatment occurred and what procedures are now supported for use (i.e. dissemination). A flood of commentaries have greeted the use of treatment manuals, some pejorative such as "promoting a cook book mentality" (Smith, 1995, p. 40) and "more a straightjacket than a set of guidelines (Goldfried and Wolfe, 1996, p.1007). Others viewed them in more positive terms. Wilson (1998, p. 363), for example, asserted that the "use of standardized, manual-based treatments in clinical practice represents a new and evolving development with far reaching implications for the field of psychotherapy." Debates continue on the wisdom and folly of treatment manuals. Based on the overall success of treatment manuals in controlled trials, we maintain that treatment manuals are an important feature of the ideal psychosocial intervention.

Research support

Interventions must be effective, as shown through controlled clinical outcome studies and clinical case series in various treatment settings (Barlow et al., 1984; Kazdin, 1984, 1992). Further, as well as being statistically significant, treatment-related changes must produce clinically significant changes for clients. Long term positive treatment outcomes over many

years should also be demonstrated for claims or assumptions of long term maintenance to be considered valid.

In 1995, the Society of Clinical Psychology Task Force on Promotion and Dissemination of Psychological Procedures, chaired by Diane Chambless, published its report on empirically validated psychological treatments. Task force members included representatives from a number of theoretical perspectives, including psychodynamic, interpersonal, and cognitive-behavioural points of view. This approach was taken to emphasize a commitment to identifying and promulgating all psychotherapies of proven worth, not just those emanating from one particular school of thought.

Three categories of treatment efficacy were suggested in the 1995 report: i) well-established treatments; ii) probably efficacious treatments; and iii) experimental treatments. The primary distinction between well-established and probably efficacious treatments was that a well-established treatment should have been shown to be superior to a psychological placebo, pill, or another treatment, whereas a probably efficacious treatment must be shown to be superior to a waiting list or no treatment control only. In addition, effects supporting a well-established treatment must have been demonstrated by at least two different investigators or investigatory teams, whereas the effects of a probably efficacious treatment need not be (the effects might be demonstrated in two studies from the same investigator or investigatory team, for example). For both types of empirically supported treatments, characteristics of the clients must have been clearly specified (e.g. age, sex, ethnicity, diagnosis) and the clinical trials must have been conducted with treatment manuals. These outcomes can be shown in "good" group design studies or a series of controlled single case design studies. Experimental treatments, on the other hand, are those remaining treatments that have not been established as at least probably efficacious, such as a very recent treatment (Chambless et al., 1996). Based on these criteria, not all treatments were found to enjoy the preferred status of being designated as "well-established". Some treatments were found to have more support than others (Chambless, 1996; Chambless et al., 1996; Chambless and Ollendick, 2001; Task Force on Promotion and Dissemination of Psychological Procedures, 1995). The task force report, and updates, continues to have a major influence on clinicians and researchers and how we conceptualize treatment, patient and therapist variables (Norcoss et al., 2006).

Acceptability

As numerous writers have observed (Gullone and King, 1989; King and Gullone, 1990; Kazdin, 1977; Wolf, 1978), it is not sufficient for a psychosocial intervention to be effective in the management of emotional and behavioural problems. As well as being effective, intervention strategies must also be acceptable to our clients and society. As noted by Wolf in his classic paper on the social validation of behavioural intervention, clinicians must respect the rights of individuals who are treated and determine the acceptability of proposed interventions. At the pragmatic level, it will be recognized that the attitude of patients and significant others towards an intervention program can also have an important bearing on treatment adherence and cooperation. As noted by Wolf (1978) "if participants don't like the treatment then they may avoid it, or run away, or complain loudly, and thus society will be less likely to use our technology, no matter how potentially effective and efficient it might be" (p. 206). Of course, social validation can be investigated empirically through specific purpose instruments designed to assess participant reactions ("consumer satisfaction") to treatment goals, methods and outcome.

For example, Dudley and colleagues recently developed the Adolescent Depression Treatment Consumer Satisfaction Questionnaire (ADTSQ) to assess the consumer satisfaction of depressed adolescents and their parents (Dudley, Melvin, Williams, Tonge and King, 2005). Thirty-eight adolescents with a unipolar depressive disorder and parents who participated in a randomized clinical trial (CBT versus Sertraline versus CBT plus Sertraline) completed the ADTSQ. High levels of consumer satisfaction were reported by adolescents and their parents in all three treatments, but those treated with CBT treatments reported higher levels of skill acquisition. Full results of the trial have been published elsewhere (Melvin et al., in press).

Case formulation and therapeutic alliance

We do not downplay the significance of sound case formulation skills and the need for collaborative relationship with clients. Best practice case formulation should involve multi-method assessment (consider interview, behavioural observations, self-monitoring, self-report scales, and so forth) (Bellack and Hersen, 1998; Mash and Terdal, 1997). Further, the assessment tools used should be psychometrically sound and also age-appropriate, taking into account the individual's level of functioning and cognitive-verbal skills (King, Muris and Ollendick, 2005; Ollendick, Davis and Muris, 2004). Assessment information is used to clarify the problem(s), generate hypotheses about development and maintenance variables (functional analysis), and what type of intervention is appropriate. Moreover, best practice case formulation is on-going and helps in the evaluation and implementation of the intervention program. Empathy and counselling skills facilitate the therapeutic alliance, with much being written on the process of entering therapy and motivating clients (Kanfer and Schefft, 1988).

Summary and utility of framework

Building on clinical psychology evaluation research over the past three decades, we propose that the ideal or most "elegant" intervention has a sound theoretical footing or rationale, clear problem identification and delineation of the client group, salient program features such as clear goals and flexibility, is set out in a useful therapist manual format, has research support for its efficacy/effectiveness under controlled conditions, and is acceptable to clients and society. Such a framework helps mental health professionals make informed critical evaluations about intervention programs. Further, such a framework also helps clinical researchers in the design of future interventions and controlled evaluation. Those attracted to scientist-practitioner philosophy and evidence-based practice are most likely to concur. Finally, although this brief commentary has examined these issues for treatment interventions, it is likely that they also apply to prevention programs as well.

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