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PERSONALIZED PSYCHOLOGICAL TREATMENTS: CLINICAL INSTRUCTIONS

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En la actualidad existe una amplia concienciación para personalizar los tratamientos psicológicos en función de las características individuales del paciente y de la singularidad de su contexto vital. Utilizar el mismo tratamiento para cada paciente y para cada trastorno es una práctica clínica contraindicada y una conducta poco ética. En el presente trabajo se revisan siete factores importantes en este ámbito: el grado de reactancia con respecto al cambio, la fase del cambio en la que se encuentra el cliente, la cultura, el estilo de afrontamiento, el estilo de apego, las preferencias terapéuticas y los sentimientos religiosos y espirituales. Los resultados de diversos estudios metanalíticos sugieren que dichos factores influyen sensiblemente en la eficacia de los tratamientos psicológicos, y que su aplicación deja un amplio margen de mejora para la eficacia de los tratamientos psicológicos.
Palabras clave: *Tratamientos personalizados, Practica-basada-en-la-evidencia, Revisión-narrativa-de-metanálisis, Psicoterapia, Tratamientos adaptados.*

Today therapists are more aware of the importance of personalizing psychological treatments according to patients' individual characteristics and the singularity of their life contexts. Using the same treatment for every patient and every disorder is not advisable and it is a poor ethical behavior. In this study, seven important personalizing factors are reviewed: patient reactance level, stage of change phase, culture, coping style, attachment style, therapeutic preferences, and religious and spiritual dimension. Meta-analytic studies suggest that these factors notably affect the efficacy of psychological treatments, and that their application will allow for further improvement in psychotherapy efficacy.
Key words: *Personalized treatments, Evidence-based practice, Narrative review of meta-analysis, Psychotherapy, Treatment adaptations.*

Numerous studies have shown that psychological treatments are therapeutic procedures that are indicated to reduce the very high costs in personal, economic, and social terms that arise from mental and behavioral health problems (Holmes et al, 2018).

Today there is a variety of psychotherapeutic systems that can be used to treat a wide range of psychological problems. However, it should be noted that there are notable differences in the empirical evidence and the scientific basis obtained by each of the various procedures (Prochaska & Norcross, 2018).

In the search for effective psychological treatments various movements have developed in the last 30 years, such as empirically validated psychological treatments (Task Force on Promotion and Dissemination of Psychological Procedures, 1995) or psychological treatments with empirical support. Due to controversies that arose from the dogmatic application of psychotherapy (Wampold & Imel, 2015), a new initiative emerged, known as evidence-based practice (EBP), that was more consistent with psychotherapeutic practice, and which developed under the auspices of evidence-based medicine.

The American Psychological Association (APA) defines EBP as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA Presidential Task Force on Evidence-Based Practice, 2006, p. 273). Compared to evidence-based medicine, the client occupies a more prominent place and assumes a more active role. Therefore, the aim is to identify psychological problems and provide evidence, using as a reference research with rigorous procedures which, together with the individual clinical trial, the values, and the expectations of the patient, can help make the most accurate decision to obtain the most indicated treatment. This definition subsumes the lists of evidence-based treatment, thus establishing a more comprehensive and enriching definition of what "evidence-based" means.

EBP has brought a substantial improvement in the implementation of psychological treatments in the area of health and has promoted the need to obtain evidence of efficacy and effectiveness both in terms of the type of psychotherapy applied and the level of progress of the client (Pérez-Álvarez, 2019). Therefore, EBP is undoubtedly one of the most outstanding advances of recent years in the area of psychological treatments.

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However, today the complexity of psychological disorders is a challenge for clinical research and practice (Galán-Rodríguez, 2018). Psychological disorders are complex phenomena that cannot be fully covered by clinical guidelines and are characterized by large differences between one individual and another, even in the same disorder (Cramer, Waldorp, van de Maas, & Norsboom, 2010).

In this regard, several studies have found that focal protocolized interventions do not present a good fit with this type of patient (Marchette & Weisz, 2017). A priori, this situation would imply the use of multiple focal manuals, but clinicians who have tried to follow this line of action have found an absence of guidelines on how to work with different manuals during the treatment of people with comorbid symptoms. In addition, it should be noted that patients often present fluctuations derived from stressors, that is, the co-occurrence of the problems that affect them during treatment, so the application of a linear intervention design does not adequately accommodate these oscillations (Marchette & Weisz, 2017).

To all this is added the problem that evidence-based psychological treatments present difficulties for professionals involved in mental health to accept them in their routine practice. This is mainly due to the economic and personal effort involved in the institutions and for the clinicians themselves being trained in the treatment manuals for the different psychological disorders (Barlow, Bullis, Comer, & Ametaj, 2013). Psychotherapists affirm that in clinical practice they have to work with a very wide range of psychological problems, however they have little time or resources to train in the different treatment manuals for each type of psychological disorder. Also, the criticism has been made that manualized treatments lack sufficient external validity, especially in the infant-juvenile area (Weisz, Krumholz, Santucci, Thomassin, & Ng, 2015).

On the other hand, various initiatives have been carried out to move towards a unique model of psychotherapy, beyond the classical theoretical approaches, in an attempt to maximize communality to the detriment of individuality (Prochaska & Norcross, 2018). To this end, five approaches or strategies have been used principally: theoretical integration, technical eclecticism, common factors, transdiagnostic treatments, and postmodern treatments.

Theoretical integration refers to the synthesis of two or more theoretical psychotherapeutic orientations in one single conceptualization (Norcross & Goldfried, 2019). As the name implies, the emphasis is placed on the integration of the theoretical concepts of psychological treatments, although the techniques are also integrated by virtue of the theoretical synthesis.

In eclecticism, the search for the most appropriate intervention is obtained through empirical evidence, so the theory is unimportant. Thus, eclecticism represents the use of techniques and procedures of different theoretical systems. The technique that is believed to work best with a specific client or patient is selected.

The common factors approach is based on the idea that aspects of treatment that are common to different psychotherapies are primarily responsible for the success of the treatment, as opposed to factors specifically associated with a particular psychotherapeutic model, the treatment protocol and the underlying theoretical model. One of the common ingredients of all psychotherapies is the therapeutic relationship. The APA, through the Task Force on Evidence-Based Relationships and Responsiveness working group, in a recent report, has presented a review on what works in the therapeutic relationship (Norcross & Lambert, 2019). It should be noted that this report concludes that the therapeutic relationship makes a substantial and consistent contribution to the outcome of the therapy, regardless of the type of psychotherapy applied. Likewise, it is argued that certain elements (e.g., empathy, the congruence/genuineness of the therapist, collecting client feedback, etc.) predict and contribute to good therapeutic results, so it is currently necessary to speak of evidence-based therapeutic relationships (Norcross & Lambert, 2019).

On the other hand, transdiagnostic treatments are evidence-based interventions designed to be effective with a category of disorders or problems that share common characteristics. Transdiagnostic treatments are based on a conceptualization of mental disorder that transcends individual classification systems such as the DSM-5 or ICD-11 and aligns with the dimensional model, such as, for example, Research Domain Criteria (RDoC, Hershenberg & Goldfried, 2015).

It should be noted that the initial results of the application of transdiagnostic treatments have been promising (Craske, 2012; Marchette & Weisz, 2017), especially in the area of eating disorders (Fairburn et al., 2009) and in emotional treatments (Farchione et al., 2012). Results have even been obtained that are equivalent to the interventions carried out with systematized protocols for the treatment of a certain disorder (Barlow et al., 2019). Therefore, it can be concluded that we are facing a new way of understanding psychotherapy and acting in the clinical setting, since with the use of a single unified intervention protocol, multiple disorders that share common characteristics can be treated, with the same efficacy as the use of standardized manuals for each disorder, which would considerably facilitate both the training and the work of the clinician.

On the other hand, the psychotherapeutic procedures that emerge from postmodernism, mainly represented by multicultural treatments, narrative therapy, or feminist therapy, are based on the fact that reality and knowledge are not objective and absolute entities, but rather they are the result of social exchanges. They question the idea that people can be treated from the perspective of mental disorders, which are mainly located in mental life. On the contrary, they propose that cultural issues must occupy a central place, both to

understand the manifestation of psychological problems and their treatment (Coleman & Wampold, 2003; Gielen, Draguns, & Fish, 2008). This notion is incompatible with the development of specific treatments for certain disorders, particularly those that pose an intrapsychic locus of the problem and ignore cultural influences.

Finally, deserving a noteworthy mention is the observation that a considerable variance of the success of psychological treatments depends exclusively on the therapist (Prado-Abril, Gimeno-Peón, Inchausti, & Sánchez-Reales, 2019), differentiating extraordinary psychotherapists (supershrinks) in a wide variety of dysfunctional conditions and clinical situations, from psychotherapists whose performance leads to a lower rate of success in treatment (pseudoshrinks). This is known as the movement of evidence-based therapists (Miller, Hubble, Chow, & Seidel, 2013). Supershrinks are characterized by presenting an ability to establish a solid therapeutic alliance with a wide range of patients, they have interpersonal facilitation skills, they question their own level of performance, and they are inclined to develop a deliberate practice. It should be noted that variables such as the mere accumulation of experience, age and gender, theoretical orientation, personal psychotherapy, supervision, or adherence to a protocol and competence in specific aspects of a treatment have not been related to the efficacy of the clinician (Prado-Abril et al., 2019).

All these approaches, like EBP, have their strengths and weaknesses. To delve deeper into the tension and dialectics between process research and results in psychotherapy, between the specific effects and the common effects that account for the results of psychological treatments, we suggest the reader reviews the various manuscripts published recently in this journal (Galán-Rodríguez, 2018; Gimeno-Peón, Barrio-Nespereira, & Prado-Abril, 2018; González-Blanch & Carral-Fernández, 2017; Perez-Álvarez, 2019; Prado-Abril et al., 2019).

Despite the richness of the contributions, in this tidal wave of unequal movements, we are still immersed in an intense debate about the differential efficacy of psychological treatments that is often unproductive for the clinician (Galán-Rodríguez, 2018) and widens the gap that exists between clinical practice and a psychotherapeutic science governed by theories and subject to statistical validity (González-Blanch & Carral-Fernández, 2017). In this context, in order to shed light on this issue and move forward in the identification of the mechanisms of change, it is argued that psychological treatments must include both a personalized treatment perspective and a focus on the transdiagnostic vision that has as an objective the common mechanisms of psychological disorders (Holmes et al., 2018; Prochaska & Norcross, 2018).

Currently, there is widespread awareness among clinicians to personalize psychological treatments based on the individual characteristics of the patient and the uniqueness of their vital context, which has been endorsed in the recent report issued by the APA on this subject (Third Interdivisional APA Task Force on Evidence-Based Relationships and Responsiveness, Norcross & Lambert, 2019; Norcross & Wampold, 2019). Using the same treatment for each patient and for each disorder is a contraindicated clinical practice and a rather unethical behavior (Norcross & Wampold, 2019). This vision was included in the famous litany of Gordon Paul (1967, p.111): "What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances, and how does it come about?" In other words, what works for one client may not work for another; therefore, the treatment must be adjusted in a personalized way to each particular patient.

Based on this perspective, the meta-analytical studies offer some guidance on how to improve the results of the treatments by adapting them to the personal characteristics of the clients (Norcross & Wampold, 2019). The recent publication of the third edition of the influential book *Psychotherapy Relationships that Work, Volume 2: Evidence-Based Therapist Responsiveness* (Norcross & Wampold, 2019) synthesizes the vision of personalized psychological treatments exceptionally. Although in the first volume of this work (Norcross & Lambert, 2019) evidence-based contributions are reviewed in relation to the therapeutic relationship, the present article, within the framework of deliberate practice (Prado-Abril et al, 2019), focuses on the topic of the response of the evidence-based therapist regarding the transdiagnostic characteristics of the patient. Specifically, accumulated empirical studies have been carried out on aspects that have to do with the degree of reactance to change, the phase of the change in which the client is situated, the culture, the coping style, the attachment style, the therapeutic preferences, and the religious and spiritual feelings (Norcross & Wampold, 2019). Next, the most representative contributions with respect to the indicated variables are presented.

THE DEGREE OF REACTANCE TO CHANGE

The patient's resistance to change is one of the main challenges that every therapist has to face. It involves a tendency to avoid making the changes recommended by the therapist, due to apprehension or an aversion to change (Beutler, Edwards, & Someah, 2018).

To refer to what is known as resistance to change it is pertinent to mention the concept of reactance to change. Although a distinction is made between resistance and reactance, the two terms refer to two points on a continuum of avoidance of change (Beutler et al., 2018). Reactance is a form of avoidance in which in addition to resistance to change there is also an opposition reaction with respect to the therapist. In both cases the patient makes changes in a different direction than the one recommended by the therapist. Thus, the resistant patient avoids performing the prescribed tasks or manifests behaviors that favor the

maintenance of the symptoms. In the case of the reactant patient, it is possible to perform the prescribed tasks, but even the simplest tasks will be performed incorrectly or may suddenly manifest an increase in clinical symptoms and be very contrary to the therapist's guidelines or recommendations.

Beutler et al. (2018) suggest that reactance is activated if the therapist is too confrontational or over-involved, so it is moderated by the therapist's directive style. Directivity is defined as the degree to which the therapist uses suggestions, interpretations, and assignments, both within the session and outside it, to guide the patient towards change.

In the recent meta-analysis performed by Beutler et al. (2018) with 13 studies (1,208 patients), an association was found between the patient's level of reactance, the level of directivity of the therapist, and the results of the treatment. Specifically, it was observed that patients with high levels of reactance respond better to non-directive and less structured psychological treatments (d = 0.79). Thus, it is concluded that, with highly reactive patients, it is recommended to emphasize the patient's self-control and use a less directive posture. On the other hand, with clients that show low levels of reactance it has been observed that they respond better to managerial treatments.

Beutler et al. (2018) consider that the manifestations of the client's reactance must be seen as a sign that ineffective therapeutic methods are being used. In other words, reactance is best characterized as a problem in the administration of the treatment (not of the patient) and, as such, it is a problem that the therapist must solve. Therefore, trying to adjust the therapist's degree of directivity to the patient's reactance level may be a good measure to take in order to solve this problem. To do this, first of all, routine measurement is recommended of the level of reactance (as if it were a personality trait) and of the resistant behaviors that emerge in session (as a specific state of the therapeutic environment). In parallel, it is recommended to perform routine outcome monitoring (Gimeno-Peón et al., 2018). That is, to carry out systematic actions to obtain and use patient feedback about the progress of the psychotherapeutic treatment. With reactant patients this practice seems vital to avoid premature abandonment of the treatment and guarantee its proper course. Thus, in situations of impasse or stagnation, in which manifestations of resistant behaviors are evident, monitoring the evolution of the results and attending to patient feedback will be of great influence (Lambert, Whipple, & Kleinstäuber, 2019).

In the same way, it has also been detected that the client's reactance affects the stability of the therapeutic relationship, resulting in its rupture (Eubanks, Muran, & Safran, 2019). At that moment, it will be necessary to repair the therapeutic alliance either with direct strategies, which implies that the therapist and the patient recognize this rupture and attempt to solve the problem, or with indirect strategies, through which the therapist will try to re-direct the problem without explicitly recognizing it (Eubanks et al., 2019).

The results of various studies are in favor of the first option are (Chen, Atzil-Slonim, Bar-Kalifa, Hasson-Ohayon, & Refaeli, 2018; Muran, Safran, Gorman, Samstag, Eubanks-Carter, & Winston, 2009) that have found that the recognition of the rupture by the therapist is a critical component for the successful resolution of problems related to the therapeutic alliance. If no close therapist-patient relationship exists, it is suggested to use indirect strategies that may involve, for example, the modification of either the prescribed tasks or the therapeutic objectives that concern the patient (Eubanks et al., 2019).

Several meta-analytical studies (Eubanks et al., 2019; Safran, Muran, & Eubanks-Carter, 2011) have shown that the resolution of the rupture of the therapeutic alliance is associated with a better treatment outcome, so it is suggested to promote specific training for therapists in the skills for resolving situations of rupture of the therapeutic alliance.

In short, it is recommended to respond reflectively and sensitively to the client's reactance. In other words, to recognize the patient's concerns through reflection, to talk frankly about the therapeutic relationship, to adjust the therapeutic contract to include greater control on the part of the patient, to explore underlying mechanisms that are causing the reactance, and to try to modify the resistance to change.

THE STAGE OF CHANGE

The transtheoretical model of change (Prochaska & DiClemente, 1983) is conceptualized as a progressive process that runs through five stages: Precontemplation, Contemplation, Preparation, Action, and Maintenance. Each stage corresponds to a period of time and the fulfillment of a series of tasks. In the Precontemplation stage, individuals do not plan to change, and most are not aware of their problems. However, the people around them do perceive that they are having difficulties. Contemplation is the stage in which patients are aware that they have a problem and are seriously thinking about how to overcome it but have not yet committed to taking action. Contemplaters struggle with the positive evaluations of their dysfunctional behavior and the amount of effort, energy, and cost that addressing their problems would involve. Preparation is the stage in which individuals intend to take short-term measures to alleviate their problems and report small changes they have made to overcome them. Although they show reductions in their problematic behaviors, patients in the Preparation stage have not yet reached effective criteria to change them. Action is the stage in which individuals make changes in their behavior, their experiences, and their environment in order to overcome their problems. Action involves the clearest behavioral changes and requires a considerable commitment of time and energy. Individuals are classified in the Action stage if they have successfully modified

dysfunctional behavior for a period of between one day and six months. Maintenance is the stage in which people work to prevent relapses and to consolidate the positive changes made during the Action phase. This stage extends from six months to an indeterminate period after the initial action. Not having problems and/or presenting a new behavior that is incompatible with the problem for more than six months are the inclusion criteria of the Maintenance stage (Prochaska & DiClemente, 1983, see Figure 1).

The meta-analysis of 76 studies (25,917 patients) conducted by Krebs, Norcross, Nicholson, and Prochaska (2018) found that therapists who adjusted the stages of change with the therapeutic procedure obtained better therapeutic results (d = 0.41). Thus, for example, with regard to proceeding with action-oriented treatments, they suggest that the therapist has to make sure that the client is at the indicated stage. Otherwise, they warn of a high risk of therapeutic failure. In this regard, Krebs et al. (2018) estimate that 40% of clients are in the Pre-Contemplation phase, 40% are in Contemplation, and only 20% are ready for the Action stage. Therefore, they warn that therapists who offer only action-oriented programs are likely to ignore the majority of their target population. The therapeutic recommendation is to move from a paradigm of action to a paradigm of stages, so, first of all, it is necessary to evaluate the stage of change the client is at.

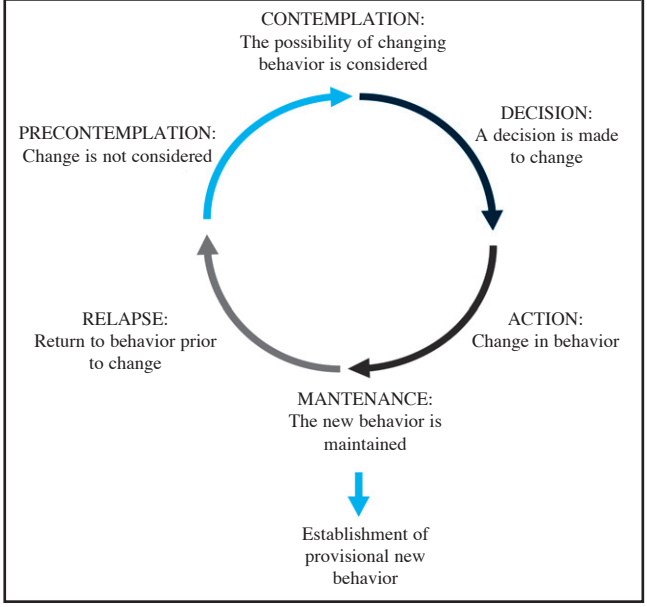
Likewise, it is suggested to establish realistic goals that contribute appropriately to the clients' progress. An example of this would be to help patients move from the Precontemplation phase to the Contemplation phase. In relation to this, Krebs et al. (2018) warn that working with precontemplators requires great caution. In patients with a diversity of diagnoses, it has been proven that people who are in the Pre-Contemplation stage underestimate the advantages of the change, overestimate the disadvantages, and are not aware that they are making these evaluations (Hall & Rossi, 2008). Thus, if psychotherapists try to impose actions on precontemplators, they are likely to abandon treatment and this is mistakenly attributed to the clients' resistance behavior (Beutler et al., 2018). The motivational interview (Miller & Rollnick, 2015) is a good example of how to incorporate these principles into clinical practice.

Table 1 presents a summary of the stages of change, the interventions consistent with each of them, and the role of the therapist.

Similarly, therapeutic methods have to be adapted to the stages of change. Krebs et al. (2018) showed that patients advance better through the stages of Precontemplation and Contemplation to Preparation if methods are applied to increase awareness and stimulate emotional release and relief. On the other hand, customers progress better through the stages of Preparation, Action, and Maintenance through the use of counterconditioning, stimulus control, and reinforcement techniques. In short, it is beneficial to use techniques to promote or expand awareness in the initial stages and continue with procedures aimed at action in the later stages (Krebs et al., 2018).

Finally, Krebs et al. (2018) also propose adjusting the type of therapeutic relationship according to the stage that the client is at, which will help him/her to progress from one stage to another. Thus, a caring, empathic, and supportive attitude will be the most advisable with a precontemplator, the role of Socratic professor with a contemplator, that of an experienced coach with a patient who is in the Action phase, and a consultant relationship is most recommended in the Maintenance stage.

FIGURE 1
TRANSTHEORETICAL MODEL OF CHANGE
(ADAPTED FROM PROCHASKA & DICLEMENTE, 1983)



COPING STYLE

When faced with unusual or stressful situations, people use externalizing or internalizing coping styles to adapt to these environmental conditions. These are relatively stable personality traits (Beutler, Kimpara, Edwards, & Miller, 2018). It should be noted that coping styles do not necessarily involve the expression of psychopathology. However, if the coping style becomes extremely prominent, variable or rigid, it can facilitate the appearance of psychopathology (Beutler et al., 2018).

In the recent meta-analysis with 18 studies conducted by Beutler et al. (2018), it is concluded that coping styles influence the treatment effects (d = 0.60). Thus, among patients with internalizing coping styles there is a better outcome of therapies oriented towards interpersonal change and insight or realization, while among patients with externalizing coping

styles better results are observed with therapies that focus on symptomatic change and learning skills.

Therefore, in order to improve the fit of the treatments offered to clients, it is first recommended to evaluate the patient's coping style based on their life experiences and to develop a conceptual approximation of the patient's coping styles in stressful or aversive situations. Once this is done, if the patient presents an externalizing tendency, it is recommended to use symptomatic-oriented therapeutic procedures such as cognitive behavioral therapy, while in the case of patients with an internalizing coping style, it is suggested to use treatments aimed primarily at generating insight or oriented towards the relationship, such as experiential treatments (Beutler et al., 2018).

CULTURE

The culture of the client is another cornerstone of personalized psychological treatments. The cultural adaptation of psychological treatments refers to "systematic modifications of an evidence-based treatment or intervention protocol that considers language, culture, and context in order to be compatible with the client's values, meanings, and cultural patterns" (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009, p.362). Thus, this entails, for example, making linguistic modifications orally and in writing and using the languages, dialects, or jargon of the patient's specific culture of belonging. It also involves carrying out adaptations to the content of the treatments depending on the customs or cultural values of the client.

Likewise, the cultural adaptation of psychological treatments implies that therapists have multicultural competence. In 1961, C. Gilbert Wrenn coined the term "culturally encapsulated counselor" to describe a type of therapist who is centered on a worldview of his own culture and does not pay enough attention to the effect that cultural differences have on the therapeutic process. In 2003, the APA published a policy of psychological practice for psychologists who are dedicated to education, psychologist training, research, and clinical practice. Three important aspects are emphasized for the cultural competence of psychotherapists: cultural knowledge, cultural awareness, and cultural skills.

At present, sufficient empirical evidence has been obtained to conclude that psychological treatments are more effective when they align with the client's culture and when the therapist shows multicultural competence (Soto, Smith, Griner, Domenech Rodríguez, & Bernal, 2018). The meta-analysis conducted with 99 studies by Soto et al. (2018) found a moderate effect size (d = 0.50) in favor of culturally adapted psychological treatments. Likewise, in another meta-analysis with 15 studies carried out by the same authors in which they studied the effect of the therapist's cultural competence (Soto et al., 2018), they observed that the therapist's cultural competence correlated strongly (r = .38) with better treatment outcomes when evaluated by the client, although not by the therapist himself (r = .06). Therefore, it can be concluded that clients view it positively when therapists manifest competencies to adapt to their culture of origin and that this positively affects the results of the treatment, even if the therapist does not give it so much importance.

TABLE 1
SUMMARY OF THE STAGES OF CHANGE, INTERVENTIONS CONSISTENT WITH EACH OF THEM, AND THE ROLE OF THE THERAPIST

<table>
<tr><th>Stage of change</th><th>Characteristics</th><th>Concordant interventions</th><th>Therapist's role</th></tr>
<tr><td>Precontemplation</td><td>No change is contemplated.

Underestimating the benefits of change and overestimating the disadvantages.</td><td rowspan="3">Awareness

Stimulate the release.

Emotional relief.</td><td>Careful, empathetic and supportive attitude.</td></tr>
<tr><td>Contemplation</td><td>Awareness of the problem.

Ambivalence about change.</td><td>Socratic professor.</td></tr>
<tr><td>Preparation</td><td>Intention to make changes in the short term.

Small advances.</td><td colspan="2">Intermediate stage in which the interventions and therapist roles of the two groups of stages converge.</td></tr>
<tr><td>Action</td><td>Changes in behavior.

Commitment to change.</td><td rowspan="2">Counterconditioning techniques

Stimulus control and reinforcement.</td><td>Experienced trainer</td></tr>
<tr><td>Maintenance</td><td>Consolidate the changes.

Prevent relapses.</td><td>Consultant.</td></tr>
</table>

Thus, it seems clear that adjusting treatments to cultural diversity improves treatment outcomes. In addition, the research offers us some concrete guidelines to improve the cultural adjustment of the treatments. On the one hand, it is recommended to adapt the treatment for a specific cultural group, rather than a group of clients with diverse cultures. The greater the cultural specificity, the better the treatment outcome (Soto et al., 2018). In addition, the idea of including translators in the application of the treatment is suggested when the client's level of linguistic competence in relation to the natural language of the therapist is very low.

Finally, it is important to include in the therapeutic context work on how the client perceives the psychotherapist culturally and to assess the effect that this has on the therapeutic process. In addition, as an indicator of the client's therapeutic progress, routine evaluation is recommended of the cultural adjustment of the applied treatment and the level of cultural competence shown by the therapist (Soto et al., 2018).

ATTACHMENT STYLE

Attachment theory holds that humans have an attachment system whose primary function is to ensure the proximity of the human with the person who takes care of them and provides assistance and protection if necessary (Bowlby, 1969/1998). Although it is considered that, regardless of the age of the individual, each person has a certain attachment system, individuals differ in what in attachment theory is defined as the "quality of attachment", and this quality varies in terms of security versus insecurity (as well as in the type of insecurity). Contrasted studies promulgate that these differences are determined, to a large extent, based on differences in the type of care received in childhood (Mikulincer & Shaver, 2016).

The attachment system exists and has a cross-sectional presence/influence in the person's life, in numerous fields, especially in social behaviors in general and, more particularly, in social behaviors that require intimacy (Mikulincer & Shaver, 2016). Attachment style in adulthood is determined based on two underlying structures: anxiety regarding attachment and avoidance regarding attachment. Low scores in both dimensions are identified with a secure attachment pattern.

How does the client's attachment style affect the therapeutic process? In the meta-analysis with 36 studies (3,158 patients) carried out by Levy, Kivity, Johnson, and Gooch (2018), it was observed that patients who presented a secure attachment style in pretreatment obtained better results after treatment than those who had an insecure attachment style, although a small effect size was found (d = 0.36); therefore, new studies must be carried out to confirm this relationship.

Regarding clinical applications, based on the results obtained in the abovementioned meta-analysis, Levy et al. (2018) recommend carrying out an evaluation of the patient's attachment style before starting treatment. It should be noted that, in general, with people presenting an insecure attachment style in pretreatment, Levy et al. (2018) found preliminary results that support the use of therapeutic procedures focused on working on interpersonal interactions and intimate relationships.

Regarding the specific differences according to the style of insecure attachment, with patients that present an anxious attachment style, it is advisable to activate therapeutic strategies aimed at helping them contain the emotional spiral that usually overwhelms them, which includes a very structured treatment framework and refraining from using experiential therapeutic techniques that may make the client feel overwhelmed and thus promote emotional decompensation (Levy et al., 2018).

Regarding clients who have an avoidant attachment style, it is known that these people are resistant to treatment, have difficulty asking for help, and often refuse it when it is offered (Miculincer & Shaver, 2016). It is advised that the therapist be active, but without harassing the patient; committed, but not over-involved (Levy et al., 2018).

THE PREFERENCES OF THE CLIENT

The client's preferences refer to the therapist's behaviors or attributes, or the type of treatment that the client values, wants, or hopes to receive (Arnkoff, Glass, & Shapiro, 2002). There are three main components of these preferences: preferences that refer to the role of the therapist, the characteristics of the therapist, and the treatment given.

The client's preferences regarding the role of the therapist refer to the type of role that he or she expects the therapist to adopt and the activities in which the client wishes to be involved and expects the therapist to promote throughout the therapeutic process (Swift, Callahan, Cooper, & Parkin, 2018). Examples of this would be a role of the counselor therapist vs. a role focused on active listening, and whether or not they request the filling out of self-reports or require homework. This also refers to the treatment format (individual, group, couple therapy, etc.). Preferences regarding the therapist are the characteristics that clients expect to find in the clinician, such as, for example, clinical experience, multicultural competence, etc. Finally, preferences regarding treatment refer to the intervention model to be applied. That is, having the option to choose between a predominantly psychotherapeutic or psychopharmacological treatment or the type of psychotherapeutic orientation (psychodynamic, cognitive-behavioral, humanistic, or systemic).

Accumulated empirical studies have shown that taking customer preferences into account can affect the outcome of the treatment. A recent meta-analysis conducted by Swift et al. (2018) with 53 studies (16,000 clients) observed that people who received a treatment adjusted to their preferences showed better results (d = 0.28). Although the effect size was small, the differences were statistically and clinically significant. However, it should be noted that perhaps a more significant result was that of the clients who had a treatment

that was more adjusted to their preferences, a lower rate of treatment abandonment was found (*OR* = 1.79).

Therefore, these results suggest that not only does taking client preferences into account affect the client outcome, but it also promotes adherence to treatment. The lack of adherence to treatment is one of the greatest challenges in the field of global health since it has been found that as treatment adherence decreases, the burden of chronic disease increases (World Health Organization, WHO, 2003). In general, it has been observed that patients suffering from various physical and/or psychological pathologies who show low adherence to treatment have a higher risk of more intense relapses, a higher risk of dependence on psychoactive drugs, a higher risk of withdrawal and rebound effect, a higher risk of developing resistance to treatments, and a higher risk of toxicity and accidents (WHO, 2003).

RELIGIOUS AND SPIRITUAL FEELINGS

For a long time, in order to apply related treatments with a scientific and aseptic stance, in psychotherapy the position of exempting all moral content of a religious and spiritual nature as much as possible has prevailed (Vietem & Scammell, 2015). However, the movement known as *"religious-accommodative therapies"* that advocates the inclusion of religious and spiritual content (R/S) to psychological treatments is becoming more and more relevant, stating that many clients request it and that it improves the treatment outcomes.

In this regard, various meta-analyses (Captari et al., 2018; Smith, Bartz, & Richards, 2007; Worthington, Hook, Davis, & McDaniel, 2011) have found that R/S treatments have a beneficial effect on a variety of psychological problems such as depression, anxiety, and behavioral disorders. Specifically, a moderate-high effect size has been found (in a range between 0.40 and 0.74), compared to the control conditions. Moreover, it has also been found that religious-accommodative therapies are equally as effective as secular therapies and are more effective in clients who have high religious values or with clients who prefer to be treated by therapists who have similar religious convictions as their own.

These results show the need to include in the training of psychotherapists the skills for working with clients' R/S feelings (Vietem & Scammell, 2015), an aspect that could be included in the multicultural competence that we mentioned above. The results also increase the interest in integrating spiritual and religious issues into traditional psychotherapeutic treatments.

CONCLUSION

The personalization of psychological treatments is an important element in the efficacy of psychological treatments. In the present work, seven strategies of personalization of psychological treatments have been described that may help to increase the effectiveness of therapists, regardless of their theoretical orientation. However, the application of these therapeutic personalization strategies cannot be carried out in an automated way and is not without difficulties. Next, we present some nuances that can be observed in the strategies presented.

Although the idea that promotes personalization strategies and the studies that support them is that these interventions are valid for any therapeutic approach, the theoretical orientation of the therapist will influence the applicability of this set of strategies. In other words, certain strategies fit better with certain approaches, and worse with others. For example, when it comes to the patient's coping style, psychodynamic, systemic, or humanistic counseling therapists will perform better with those patients who employ internalizing coping strategies, whereas cognitive behavioral therapists will fit better with more externalizing patients. The same could be said of the stage of change: the different psychotherapeutic approaches are better or worse suited to the different stages of therapeutic change. Unless it is accepted to be effective only with certain types of patients, more cognitive-behavioral counseling therapists will have to learn to work with a more interpersonal approach, and dynamic, systemic, and humanistic therapists will have to adapt to working with externalizing patients. This requires a greater effort to apply techniques from different approaches, which is a big effort for therapists (Norcross & Goldfried, 2019).

The strategy that refers to the patient's treatment preferences may also conflict with other principles that are at work in the psychotherapeutic meeting. The fact that a patient receives a treatment adjusted to their preferences is not necessarily always a positive thing per se. A patient may want a certain type of treatment, for example, because someone he or she knows has done well with that therapy, but the therapist may well think that the patient needs a different treatment. In this case, therapists will have to choose between doing what they consider most appropriate—and running the risk of losing the patient—or choosing to do what the patient demands—and running the risk of less effective therapy. In summary, the personalization of psychological treatments requires a disposition to flexibility in therapists (Prado-Abril et al., 2019). This is a particularly difficult skill, since in many cases it implies a certain relativization of the psychotherapeutic approach itself, and a willingness to use techniques and ideas from other approaches. In other words, the therapeutic skill of flexibility is connected—to some extent at least—with the theoretical problem of the integration of psychotherapy. Although the 1970s battles among the theoretical approaches have come to an end, today there are still many problems and difficulties in this area (Galán-Rodríguez, 2018; Norcross & Goldfried, 2019; Pérez-Álvarez, 2019).

Another general difficulty in applying the personalization strategies cited in this work is that they often come from an intensely American vision of psychotherapy and the human being. Psychotherapy, beyond its scientific and professional

status, is sociologically a North American cultural product, and as such, there has been—and continues to be—a tendency to universalize certain aspects of American culture to the rest of the countries of the world (Beauvois, 2017). In the US there have been cultural or ethnolinguistic groups that constitute clearly defined social categories for many decades, and the cultural adaptation to be made with these groups is more or less clear. However, in Europe the situation is different, not only with respect to America, but among the countries in Europe themselves. Historically, France, Germany, and the United Kingdom have been countries of destination for world emigration, while this phenomenon in Spain is much more recent. To all this, we must also add the new wave of migration of recent years, caused by the war in the Middle East. This whole situation is configured to a certain extent in a different way from that of the United States, and it represents a significant challenge for European therapists, who must progressively face a new reality as regards the cultural origin of their patients.

What has been said about cultural accommodation can also be said about the religious/spiritual aspects. There may be religious/spiritual patients who in some way do not need the religious/spiritual aspects to be included in the therapy, whereas other patients do wish or need it. It could even be the case that for some patients it is even counterproductive, in the sense that the religious/spiritual aspect is part of the difficulties that are the subject of their psychotherapeutic assistance. The religious/spiritual orientation of the therapist is also relevant: many atheist or agnostic therapists may be reluctant to deal with spiritual issues. In summary, we feel it is important on the one hand to understand the role that religiosity can play in the problems that are being treated, and on the other to understand that a well-done psychotherapy will always be a psychotherapy in which the therapist is coherent with the clinical task and with him- or herself.

Like most of the decisions that a therapist must make in the course of his or her professional work, along with all the clinical and professional knowledge that he or she has been able to accumulate, it is ultimately the weighting of various factors (clinical experience, particular characteristics of the patient, or ethical and moral values of the therapist) which will lead to the best decision. These strategies, therefore, are not suggested so much as a task to be automated by therapists, but rather as a resource for them to be able to turn to if it should be useful.

CONFLICT OF INTERESTS

There is no conflict of interest.

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