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The Six-Point Dial of Treatment: A Useful Framework for Novice Therapists

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Abstract

The six-point dial of treatment described in this case report was developed to guide graduate student psychological trainees through treatment and includes the following components: assessment of dangerousness, diagnosis, diagnosis-based treatment, ongoing evaluation of treatment response, obstacles to treatment, and motivation. In this case report, we describe the dial of treatment and present a case study of a client with paranoid schizophrenia (John) who presented at a graduate student training clinic to illustrate how this framework can be successfully applied. John has exhibited marked improvement, based on both objective measures and clinician judgment of global functioning.

Keywords

clinical training; paranoid schizophrenia; suicidal behavior

(1) Theoretical and Research Basis

A common source of anxiety for novice therapists is being faced with difficult clinical situations that entail ambiguity (Pica, 1998; Skovholt & Ronnestad, 2003). Although most clinicians are likely to recall challenges involved in their early clinical experiences, there is scant research on the topic of reducing anxiety of novice therapists (Pica, 1998). Graduate coursework and practicum training often involve teaching students specific therapeutic techniques, but may not always provide students with a useful heuristic for integrating these techniques with other important (indeed, crucial) clinical activities (e.g., suicide risk assessment, monitoring treatment progress). Thus, when faced with difficult or ambiguous situations, novice therapists may not feel prepared to cope with them adequately. In this manuscript, we propose a scientifically oriented framework that may help novice and seasoned therapists alike in clinical decision-making and treatment. Next, we present a case example of a client with a difficult-to-treat mental disorder (i.e., paranoid schizophrenia) who made significant treatment gains utilizing this framework.

Six-Point Dial of Treatment

The director of the Florida State University (FSU) Psychology Clinic (T.J.) instructs graduate students to use a six-point approach to case conceptualization and intervention. The six points

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on this “dial” are: *assessment of dangerousness*, *diagnosis*, *diagnosis-based treatment*, *ongoing evaluation of treatment response*, *obstacles*, and *client motivation* (see Figure 1). The approach is designed such that each of the six points is an important focus throughout the therapeutic process and can be returned to as needed (in a dial format as opposed to utilizing them in a sequential step-like fashion), although it is recommended to begin with the first point on the dial. Furthermore, the elements of the dial are all consistent with an evidence-based approach, which provides an integrated and systematic way to approach clinical work in a scientific manner. Throughout treatment, *dangerousness* is regularly assessed according to the clinic’s suicide assessment protocol (Joiner, Walker, Rudd, & Jobes, 1999, for details and description of its scientific basis). If a client is judged to be at risk for hurting himself/herself or others, the therapist is instructed to take appropriate actions to increase his/her safety (e.g., discuss hospitalization if appropriate, provide the client with emergency numbers, plan a phone check-in between sessions, etc.). Regarding *assessment* for the purposes of diagnostics, the clinic policy requires use of multiple methods (e.g., structured clinical interviews, standardized self-report measures) and multiple informants when possible (e.g., the client’s family members) to formulate diagnostic impressions. Using multiple methods and informants is a crucial component of ensuring the content validity of the psychiatric diagnosis (Haynes, Richard, & Kubany, 1995). Once the available client information has been integrated and reviewed by the therapist and his/her supervisor, diagnoses are formulated on the five axis classification system of the *Diagnostic and Statistical Manual, Fourth Edition, Text Revision* (American Psychiatric Association [APA], 2000).

After the diagnoses are formulated, the available scientific literature is examined for the appropriate *diagnosis-based treatment* [empirically supported treatment(s) for the client’s presenting problem(s)]. In choosing an intervention, empirical support for its efficacy is important, but individual variables, such as the client’s strengths, weaknesses, and practical needs are also considered. Once treatment is selected, therapists strive to be cognizant of motivational issues and *obstacles* that arise during the course of therapy, so that they can be properly addressed (often through motivational enhancement techniques). Techniques for addressing client *motivation* are drawn from principles of Self-Determination Theory, which has been supported by a relatively large empirical base (Ryan & Deci, 2000; 2002). All of this is accomplished with ongoing assessment of the other points on the dial as well as response to treatment. Such *ongoing evaluation of treatment response* allows the therapist to determine whether the approach he/she is utilizing is effective. Mash and Hunsley (1993) emphasized the importance of such ongoing assessment and the use of assessment tools that are theory-based and have adequate sensitivity to detect change (or lack thereof). The advantage of the six-point dial approach to treatment is that it outlines specific steps to achieve optimal client care, while providing structure for novice therapists who treat challenging clients. Furthermore, it has a strong basis in theory and research. In this way, novice therapists have a very clear (i.e., unambiguous) way to conceptualize their cases and to structure each treatment session, regardless of the particular type of therapy being utilized.

Treatment of Schizophrenia

Schizophrenia is a debilitating mental illness that negatively impacts an individual’s social, cognitive, and physical functioning. Lifetime risk for suicide among people with schizophrenia has been estimated from 1.8% to 5.6% (Palmer, Pankratz, & Bostwick, 2005), although rates between 10% and 13% have also been reported (Caldwell & Gottesman, 1990; Inskip, Harris, & Barraclough, 1998). Among those with recently diagnosed schizophrenia spectrum disorders, approximately one-fourth report current suicidal ideation, and nearly one-half have made at least one suicide attempt (Tarrier, Barrowclough, Andrews, & Gregg, 2004). Even if a client with schizophrenia is optimally compliant with his or her medication regimen (which is certainly not the norm, given the evidence that less than one half of patients with

schizophrenia are compliant; Dolder, Lacro, Dunn, & Jeste, 2002), between 25% and 50% continue to experience marked difficulties in functioning (Rector & Beck, 2002). These statistics emphasize the importance of psychotherapy in conjunction with psychopharmacological treatment for schizophrenia; the goal of such therapy is to increase a client's adherence to his or her medication regimen as well as to increase his or her ability to function in society.

The extant literature suggests that young males (i.e., age 18–35) who have been diagnosed with schizophrenia in the past 10 years are among the most difficult to treat (Lu, Yanos, Minsky, & Kiely, 2004). The current case report describes the treatment of an individual who fits this description and thus can be considered a challenging case by virtue of this fact alone. That he was treated by novice therapists in an outpatient graduate training clinic makes the case more challenging still. We are not aware of any published case reports that describe a case being treated in a similar setting, perhaps because many graduate training clinics do not provide services for clients with schizophrenia spectrum disorders. This case report will be used to illustrate the utility of the dial of treatment for the treatment of paranoid schizophrenia by novice therapists (therapists, it should be noted, who were under the close supervision of experienced and credentialed psychologists).

(2) Case Introduction

The FSU Psychology Clinic is a training clinic designed for graduate students who are enrolled in the clinical psychology Ph.D. program at FSU. Although the clinic is university-affiliated, it also serves community clients who are not associated with FSU. The clinic employs minimal exclusionary criteria for clients; individuals who are actively psychotic, in a manic episode, and/or of imminent threat to themselves or others, are referred elsewhere (e.g., to a hospital or psychiatrist for medications) until they are stabilized, after which these clients often return to the clinic. Thus, our clients present with disorders typical of a community mental health outpatient clinic.

Upon application, all clients are informed of the research and training nature of the clinic, and are asked to sign a form consenting to their inclusion in clinic research. All therapists are graduate students who are trained in empirically-informed assessment and treatment through coursework and weekly didactic meetings. In addition, all graduate students receive three hours of weekly supervision by clinical psychology faculty members. Because of the training nature of the clinic, therapists are beginning clinicians and spend a limited time working at the clinic (typically during their second and third year of graduate school). Therefore, there are unique challenges in this setting: the therapists are relatively inexperienced and long-term clients must be transferred to new therapists when trainees complete their requirements at the clinic.

John (name has been changed to protect client identity) is a man in his late 20's who has been seen for a total of 120 sessions. Since arriving at the FSU Psychology Clinic, he has been treated by four different individual clinical psychology graduate student trainees, two of whom are the first author and the second author.

(3) Presenting Complaints

When John presented at the clinic, he was virtually housebound. He reported experiencing severe depressive symptoms, was completely unable to work, had poor hygiene, and had minimal interpersonal interactions. At the time, he was living with a relative, who was the only person with whom he interacted on a regular basis. He also reported experiencing paranoid thoughts (e.g., believing that some people are spies for the U.S. government) and delusions of reference (e.g., when favorite television shows were repeated, he believed they were played specifically for him). John also described experiencing some bizarre sensory experiences, such

as feeling as if his ear were tingling when people talked about him and seeing an animal that was not actually there. He also reported that he had irregular sleep patterns and often stayed up late and slept until the afternoon of the next day.

(4) History

When John first presented to the clinic, he reported that he had been previously diagnosed with both borderline personality disorder and bipolar disorder. He had been hospitalized twice following each of his two suicide attempts, one of which consisted of cutting himself and one of which involved ingesting alcohol, sleeping pills, and aspirin. John had a history of non-suicidal self-injury as well, which typically involved making superficial cuts on his arms. One of his parents was diagnosed with schizophrenia and died by suicide when he was a young child. John had been prescribed Effexor, Zyprexa, and Depakote to treat psychotic and depressive symptoms. His medication was prescribed by a community psychiatrist, whom he visited approximately once every three months.

(5) Assessment

The six-point dial of treatment emphasizes two separate but related facets of assessment. All clients are regularly assessed for dangerousness to self and others. Therapists also use psychometrically sound semi-structured clinical interviews and assessment instruments to formulate a diagnosis and evaluate symptoms throughout the course of therapy.

The Six-Point Dial: Point 1, Assessment of Dangerousness

As stated above, people with schizophrenia are at an increased risk for suicidal behavior. Furthermore, John's status as a multiple suicide attempter warranted extra precaution, given the evidence that past multiple suicide attempts predict subsequent suicidal ideation (Joiner et al., 2005) and death by suicide (Zonda, 2006). The FSU Psychology Clinic follows a standardized protocol for suicide risk assessment (Joiner et al., 1999) that heavily weighs multiple attempt status in the determination of risk. John's status as such, in combination with his current diagnosis and psychological symptoms, led to him being considered at moderate risk (or higher, depending on current suicidal symptoms) throughout the course of therapy, even if he was not experiencing current suicidal symptoms. Because of this, his therapists assessed his risk for suicide at each session (which is good practice even in the case of someone at low risk), consistently documented the results of this assessment in his progress notes, and also created a "coping card" with John describing actions he should take in the event that he becomes suicidal (e.g., seek social support, call 1-800-273-TALK [a national 24-hour crisis line], call 911). Furthermore, his therapists phoned him for mid-week check-ins every week in order to assess suicide risk. Since beginning treatment at the FSU Psychology Clinic, John has not attempted suicide and infrequently experiences suicidal ideation. Having a standardized suicide assessment protocol to follow helped alleviate the anxiety/apprehension of John's graduate student therapists and also ensured that the standard of care is met for his safety.

There is evidence that individuals with schizophrenia have a higher likelihood of violence toward others in the general population (Wallace, Mullen, & Burgess, 2004). In order to assess John's risk of dangerousness toward others, his therapists utilized a framework similar to the clinic's standard suicide assessment protocol. Just as having a history of multiple suicide attempts increases an individual's suicide risk rating, having a history of physical violence increases current risk for harm to others. John's negative history of physical violence decreased his baseline risk for such behavior. His therapists regularly assessed him for ideation about homicide and resolved plans and preparations for homicide. Similar to the suicide risk protocol described by Joiner et al. (1999), John's therapists were less concerned with mild homicidal desire and ideation and would have been more concerned about resolved plans and preparation

for homicide, had they occurred. John was considered to be at low risk for violence throughout the duration of treatment.

The Six-Point Dial: Point 2, Diagnosis—Psychological trainees in the FSU Psychology Clinic are required to use multiple methods to arrive at an accurate diagnosis (i.e., self-report measures, semi-structured interviews, consultation with supervisors). At intake, John was administered several self-report measures, which included the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988), the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), and the Beck Suicide Scale (BSS; Beck, Steer, & Ranieri, W.F., 1988). He also completed the Minnesota Multiphasic Personality Inventory-II (MMPI-II; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989). Finally, his Global Assessment of Functioning (GAF; APA, 2000) was rated by the graduate student trainee who administered his intake interview. At intake, his scores on the self-report measures were as follows: BAI = 41 (Severe Range); BDI = 24 (Moderate Range); BSS = 4 (Mild Range). His MMPI-II profile was elevated on both the Paranoia and Schizophrenia Clinical Scales. Finally, given his poor hygiene, limited social functioning, and paranoid delusions, his GAF at intake was judged to be 20.

John was also administered a semi-structured interview, which consisted of both the Structured Clinical Interview for Diagnosis of Axis I disorders (SCID-I-IV; First, Gibbon, Spitzer, & Williams, 1996) and the Structured Clinical Interview for Diagnosis of Axis II disorders (SCID-II-IV; First, Gibbon, Spitzer, Williams, & Benjamin, 1997). This interview was supplemented by an interview with a close relative. According to the assessment tools utilized, John met criteria for Schizophrenia, Paranoid Type. This diagnosis was based on the fact that he was experiencing paranoid delusions, had obvious social and occupational dysfunction, the duration of his illness had persisted for at least six months, and his symptoms could not be better accounted for by any other disorder (e.g., a mood disorder or pervasive developmental disorder). This diagnosis was consistent with John's elevations on the MMPI-II (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989).

(6) Case Conceptualization

John's affliction with Schizophrenia, Paranoid Type was conceptualized within the context of scientific knowledge about risk factors for schizophrenia. Specifically, he was viewed as vulnerable to schizophrenia because he had a genetic predisposition for it (a biological parent had schizophrenia; Gottesman & Erlenmeyer-Kimling, 2001), and his history included exposure to several stressful events (e.g., his parent's suicide; Norman & Malla, 1993). Though the specific mechanisms by which genetics increase biological vulnerability to schizophrenia are unknown, there is evidence that neurotransmitter and structural brain abnormalities may contribute to schizophrenia symptoms (Conklin & Iacono, 2002) and that antipsychotic medications effectively reduce schizophrenia symptoms in most people who suffer from them (Chakos, Lieberman, Hoffman, Bradford, & Sheitman, 2001). However, the empirical literature also suggests that psychosocial treatments (in conjunction with medications) can be effectively used to assuage residual symptoms, enhance medication adherence, and improve overall functioning and quality of life (Patterson & Leeuwenkamp, 2008).

Therefore, John's treatment plan included receiving regular care from a psychiatrist, and we also integrated empirically supported psychotherapeutic techniques in order to target John's presenting problems (Patterson & Leeuwenkamp, 2008). Given John's fairly severe social isolation, our first goal of treatment was to enhance his social skills in such a way that would facilitate interpersonal interactions. To do this, we targeted his relatively poor personal hygiene, gave him social skills training, and engaged in social exposure exercises to decrease his anxiety around other people. A second (but related) focus for John was on his affective

presentation; he reported experiencing both dysphoria and anhedonia, which were potentially dangerous symptoms given his propensity toward suicidal behavior. Our hope was that increasing the likelihood that John would have positive interactions with others, as described previously, would serve as behavioral activation, which would enhance his mood. We also wished to address his irregular sleeping and eating patterns, which have also been shown to be related to mood lability (Frank et al., 1997). Finally, we addressed the core symptoms of John's schizophrenia (i.e., paranoid delusions) using cognitive behavioral techniques.

(7) Course of Treatment and Assessment of Progress

The six-point dial emphasizes the selection of empirically supported treatments based upon the clients' diagnosis and other presenting problems. Progress is assessed regularly throughout the course of treatment, using psychometrically sound instruments.

Six-Point Dial: Point 3, Diagnosis-Based Treatment

At the beginning of treatment, the therapist focused on addressing John's deficits in personal hygiene. His hygiene deficits (e.g., not regularly showering or brushing his teeth) were addressed through direct feedback and instruction as to how often the average individual engages in these behaviors. John improved in this respect over time, although his hygiene declines during times of distress and when he has other symptom flare-ups. With regard to John's social skills deficits, there is considerable evidence in the literature that teaching social skills to clients with schizophrenia produces long-term benefits (Dilk & Bond, 1996) and that skills taught in therapy generalize into real life settings (Kopeliwicz, 1998). Given that John was engaging in almost no interpersonal interaction at the beginning of therapy, most of the social skills training initially was related to his interactions with clinic staff. When he first began treatment, John was very anxious about interacting with others and often did not make eye contact with people with whom he interacted at the clinic. He markedly improved in this regard; he eventually felt comfortable greeting clinic staff with a smile. John also began looking forward to coming to therapy because it gives him a chance to interact with people. As he commenced doing more things on his own in the community, his therapists expanded social skills training to include role-playing for situations, such as asking women out on dates. John has admitted that he often feels as if he does not know what to say and that he often has difficulty discerning inappropriate questions from appropriate ones. Thus, his therapists' role is both to model appropriate behavior and to provide immediate feedback when he says something clearly inappropriate.

John's therapists also incorporated exposure exercises into his therapeutic regimen. A recent case report (Dudley, Dixon, & Turkington, 2005) demonstrated efficacy of systematic desensitization for a dog phobia in a schizophrenic client. Although John did not meet criteria for any comorbid anxiety diagnoses, his extreme social isolation led him to experience anxiety about interacting with strangers. To address this issue, his therapists required John to engage in exposure exercises similar to those that would be required of a client with social phobia. At first, these exposure sessions were conducted primarily with clinic staff, but they gradually were broadened to include walks around the university campus and trips to nearby restaurants (issues of possibly decreased privacy and confidentiality were thoroughly discussed beforehand). These exposure sessions actually served multiple roles, as they provide opportunities for social skills coaching, remediation of paranoid thoughts about the interaction partner, and extinction of anxious responses to interacting with others. John was eventually able to easily have a conversation with any member of clinic staff, and he began willingly greeting strangers in the community.

Given John's irregular sleeping and eating patterns, another goal of therapy was to normalize these behaviors, with the end goal being to increase mood stability. His therapists drew from

principles of Interpersonal and Social Rhythm Therapy (IPSRT; Frank, Kupfer, Ehlers, & Monk, 1994), which was originally designed for bipolar disorder, to address these issues. Although this treatment has not been empirically validated with schizophrenic individuals, it has been shown to address two of John's presenting problems (i.e., unstable mood patterns and irregular circadian rhythms; Frank et al., 1997). We implemented IPSRT in a modified way by requiring John to complete a very simple food and sleep log (i.e., simply checking a box indicating whether he ate breakfast, lunch, and dinner and writing his time in bed and time out of bed) and to rate his mood each day on a scale from 1 to 10. Through trial and error, we found John to be much more compliant when given more simplified homework assignments. Furthermore, the purpose of this log was to provide data for John's benefit that indicated that he tended to be in much worse moods on days when he had gone to sleep late, and this goal was accomplished with the modified food and sleep log. Throughout the course of therapy, John struggled with regulating his social rhythms, although he exhibited some improvement. He eventually became cognizant of the fact that his mood his sleeping and eating schedules impact his mood. John was also able to independently describe this relationship, although he was not always able to follow through behaviorally.

Finally, John's therapists implemented Cognitive Behavioral Therapy for schizophrenia (CBT; Rector & Beck, 2002). Rector and Beck (2002) emphasize the notion that delusions are similar to any other thought, and thus can be challenged using similar techniques as one would use for a depressed or anxious client. In John's case, a major focus was placed on his paranoid and hostile delusions about others. For example, if he stated that he believed that his therapist was just trying to get him "locked up" (e.g., in a prison or a hospital), the therapist would encourage John to examine the evidence for that thought and to consider alternative possibilities that might more closely reflect the reality of the situation (e.g., the therapist was simply trying to ensure his safety according to a pre-determined risk assessment framework). John's ability to remediate his thoughts improved greatly; he was able to describe situations that occurred during the week in which he independently decided to consider the evidence for his paranoid thoughts and was able to remediate them. Similar to his progress in the above arenas, when John was experiencing periods of lower functioning, he became less able to engage in cognitive remediation. It appeared to be especially difficult for him during periods of intense anger.

Six-Point Dial: Point 4, Ongoing Evaluation of Treatment Response

As we have stated previously, a key characteristic of the dial of treatment is that the points on the dial are continuously revisited throughout the course of therapy. Although the goal of therapy is for clients to progress within each of these spokes (e.g., decreasing in suicide risk, increasing in motivation), it is important that all clients be regularly assessed on each of the points on the dial. At the FSU Psychology Clinic, this is done formally every six months, at which point treatment summary updates are required to be written about each client. More importantly, less formal assessments are performed much more frequently than this, with assessment of dangerousness, symptom level and attendant functioning, motivation, and obstacles occurring in some form at every session (and sometimes multiple times within a given session). The therapists at the FSU Psychology Clinic are encouraged to be as forthright as possible about ongoing evaluations so that clients and therapists alike can reap the benefits of the obtained knowledge.

This continuing evaluation can be accomplished by administering self-report measures (e.g., the BDI), re-administering a semi-structured diagnostic interview, and/or by engaging in dialogue with the client regarding his or her functioning and progress. Providing a client with objective information about his or her progress (or lack thereof) can help foster optimism, increase motivation, and inform treatment planning. For example, there are some disorders for which there are several different treatments that appear to be equally effective in the literature.

If the ongoing treatment evaluation determines that a certain type of therapy is not bringing about expected symptom reduction, it may be time to consider switching to a different type of diagnosis-based treatment.

John evidenced notable improvement since beginning treatment at the Clinic. His score on the BAI decreased from a 41 to a 12 (Mild range), his BDI score decreased from a 24 to a 19 (Mild range), and his GAF score increased from a 20 to a 51. Aside from the improvement on these objective measures, John also demonstrated marked behavioral improvements. He did not make any suicide attempts since beginning treatment at the clinic. Furthermore, he moved into his own apartment and was able to successfully live on his own. This is a major improvement in his functioning, as he has become more independent and less reliant on his relative for care. John also got involved to some extent in community activities (e.g., volunteering) and has attained part-time, gainful employment. Thus, John has become a more active member of the community and has become more independent in meeting his basic functional needs. John still has areas in which he struggles. Nevertheless, the gains that he has made in therapy bode well for his capacity for future improvement. His current and future therapists will continually revisit the points on the dial of treatment and will make adjustments as his situation changes and his symptoms decrease.

(8) Complicating Factors

One advantage of the six-point dial is that it directly addresses factors that complicate progress in therapy. This is especially helpful for novice therapists; the knowledge that there will likely be challenges along the way during the course of therapy assuages fears of inadequacy and also provides them with the confidence and skills to address these challenges. Below, we discuss two general categories of complicating factors: obstacles toward treatment and client motivation issues.

Six-Point Dial: Point 5, Obstacles

Due to the fact that John's treatment occurred in a training clinic, one unique obstacle in the course of his treatment was being transferred to new therapists as graduate student therapists completed their training requirement and left the clinic (approximately once per year). Such transition was particularly difficult for John, given his tendencies toward paranoia and anxiety about interacting with new people. He typically experienced a decline in functioning when transitioning to a new therapist, but then returned to his baseline functioning after rapport was established. Strict enforcement of clinic policies with regard to treatment expectations (i.e., continuing the same treatment techniques with the new therapist), along with engaging in joint sessions between his incoming therapist and his outgoing therapist, appeared to aid in these transitions.

In addition to disruption that accompanied a change in therapist style, John also tended to experience feelings of sadness and frustration with not being allowed to remain in contact with his former therapists once they left the clinic. Although this changed over time, John's major source of social contact was with people who work at the clinic; thus, he reported feeling a sense of loss when the relationship with his former therapist ended. In the past, he asked the outgoing therapist if he could become friends with him/her and see him/her socially once therapy was terminated. In an effort to help John cope with his feelings of loss, both his outgoing therapist and incoming therapist maintained an empathic stance towards John, while explaining the rationale for his contact ending with his former therapist (e.g., ethical reasons for therapists not having dual relationships with clients). This experience also helped prepare John for real-world beginnings and endings of relationships in the future.

Another obstacle that arose was John's repeated verbal hostility toward his therapists. Typically, John's hostile verbalizations appeared to emerge from paranoia about the therapist negatively evaluating him or thoughts about the therapist's desire to involuntarily hospitalize him. For example, John sometimes insulted his therapists regarding their appearance and has accused therapists of thinking that he is "mentally retarded." When John's verbal hostility was mild, the therapist attempted to model appropriate social behavior (e.g., by saying, *It offends me when you insult my appearance*) and to elicit an apology. This method was typically successful, and John usually apologized for his transgression. In other cases, the therapist would utilize cognitive-behavioral techniques to challenge John's paranoid thoughts (e.g., *What evidence do you have for the thought "My therapist thinks I am mentally retarded"?* and *What evidence do you have for the thought, "My therapist is trying to have me hospitalized"?*). After John and his therapist reframed his thoughts into more accurate cognitions through the examination of relevant evidence, his paranoia typically decreased. These types of in-session experiences served as valuable opportunities for social skills training and cognitive reframing practice and were communicated to John as salient examples of how his paranoia and hostility might elicit the negative evaluations he fears from others.

If John became more than mildly hostile (e.g., engaged in name calling or cursed loudly toward the therapist), the therapist would tell him that they would take a five-minute break from therapy. Then, the therapist would leave the room for that amount of time. If this type of behavior persisted once the therapist returned to the room, the therapy session ended early. This method of behavioral modification appeared effective and led to relatively few incidents where the therapy session had to be terminated early. Furthermore, John frequently apologized for his behavior during a phone check-in following the session or during the next therapy session.

Six-Point Dial: Point 6, Motivation

As for motivation to change, John frequently expressed ambivalence about his desire to adhere to treatment. For example, he stated that he did not want to take his antipsychotic medication due to side effects (e.g., weight gain, sexual side effects, acne) and often stated that he did not wish to engage in exposure exercises designed to treat his social anxiety and paranoia symptoms. According to the dial of treatment, even the most effective treatment will be rendered ineffective if the client is not motivated to adhere to the treatment plan. Thus, motivational interviewing techniques (e.g., responding to resistance, Miller & Rollnick, 2002) were used regularly throughout the course of therapy in an effort to enhance treatment compliance. Although motivational interviewing is not a standard therapeutic technique utilized with schizophrenic patients, its use is becoming more common, and appears to work better when combined with standard behavioral treatments (Martino, 2007). In our adapted form of motivational interviewing techniques, the therapist took an empathic stance toward John (e.g., said, *I understand why it is hard for you to take your medication when it causes side effects*), an important component of perspective-taking according to Self-Determination Theory (Ryan & Deci; 2000, 2002), and followed up with motivational enhancement exercises such as weighing pros and cons of adhering to medication and therapy. Consistent with the motivational interviewing framework, the therapist reminded John that, in the end, it was his decision to adhere to treatment but that it seemed that treatment adherence may help him to reach some of his goals (e.g., independent living, building interpersonal relationships, not being hospitalized). This served to foster feelings of autonomy, another key component of Self-Determination Theory (Ryan & Deci; 2000, 2002).

John's motivational difficulties sometimes led to his canceling therapy sessions with less than 24-hour notice as well as not appearing for scheduled appointments. In order to curb these behaviors, his therapists strictly enforced the clinic's cancellation and no-show policy (i.e.,

clients are charged for sessions for which they do not show up or cancel with less than 24-hour notice). This policy increased John's therapy attendance and served the dual purpose of preventing him from engaging in anxious avoidance of clinic staff. Furthermore, following clinic policy without exception is helpful in that it helped to limit John's paranoid beliefs that he was being singled out in any way.

(9) Managed Care Considerations

The FSU Psychology Clinic operates on a sliding fee scale; clients pay for services rendered out-of-pocket. Thus, there were not any managed care issues in this case, as John was able to afford his treatment on his own.

(10) Follow-Up

John continues to be seen at the FSU Psychology Clinic and has progressed considerably in the past year. He continues to live independently in an apartment. There have been times of difficulty in the past year (e.g., times when John has experienced suicidal symptoms); however, the skills that John has learned to date have helped him to recover from these episodes more quickly than in times past.

(11) Treatment Implications of the Case

The current case study has demonstrated that it is possible to make great strides with an individual diagnosed with paranoid schizophrenia in an outpatient, graduate student training clinic. Given the multitude of difficulties faced by John, it was important to take a multi-faceted approach. The six-point dial of treatment assisted relatively novice therapists in providing care that enabled John to increase his independence while still providing a "safety net" for times of symptom exacerbation. This outpatient treatment is most likely the factor that limited John's inpatient admissions (during the course of therapy described, he was never admitted as an inpatient to a psychiatric facility), which resulted in reduced psychological suffering and discomfort on his part as well as reduced financial costs. Although John will likely require the services of the Psychology Clinic for some time to come, it is our expectation that his quality of life will continue to improve.

(12) Recommendations to Clinicians and Students

Above, we have described a concise, empirically informed framework that has enabled four graduate student trainees to provide effective treatment for a client with a difficult-to-treat mental disorder. This framework simultaneously provides structure and flexibility, both of which are necessary when providing treatment for those with chronic mental illness. This framework also ensures some degree of continuity when John's case is transferred to subsequent graduate student trainees. Aside from being a useful framework for novice therapists, we also believe that the six-point dial of treatment is a useful framework for seasoned clinicians. If graduate student trainees can provide excellent psychological care by using the framework, the potential for its utility with more seasoned therapists is also quite promising. It is important that we acknowledge that six-point dial has not been formally evaluated for its efficacy (i.e., in a randomized controlled trial). Nevertheless, the components contained within the dial do have empirical support, and we believe that the case example presented in the current paper provides preliminary evidence of its promise.

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Figure 1. Six-point dial of treatment. Arrows are meant to indicate that the dial is “turned” to the appropriate activity as clinically indicated.