Place toward *uncharacteristic* direction if therapist's activity during the hour includes no attempts to link the interpersonal aspects of therapy with experiences in other relationships when there are opportunities to do so.

Appendix IIA Introduction to Manualized Treatments for Psychodynamic Psychotherapy Research

Carolina Seybert, Ingrid Erhardt, Raymond A. Levy, and Horst Kächele

About 30 years ago, a methodological innovation began under the title of "Psychotherapy Manuals." The change in the structure of research studies began with Beck et al.'s. [1] manual for CBT and the IPT manual for interpersonal therapy for use in the NIMH Treatment of Depression Collaborative Research Program [2]. Soon, two psychodynamic manuals appeared: Luborsky [3] and Strupp and Binder [4]. The launching of these manuals reflected the new requirements in order to qualify for psychotherapy research funding: in order to be sponsored, research had to take the form of controlled trials modeled after medical research, where, in psychopharmacology studies, an experimental procedure aims to determine whether a certain substance is effective. Within this model, psychotherapy studies with only two points of measurement (beginning and end) are considered insufficient, and psychotherapeutic interventions have to be defined reliably and related to treatment effect or outcome.

Psychotherapy manuals need to fulfill the following three criteria (according to Luborsky [3], p. 4):

1. The specification of technique needs to be as clear as possible for the type of treatment in question.
2. The manual should describe treatment principles explicitly and specify the prescribed actions for the therapist.
3. The manual should include scales to evaluate the extent to which the therapist adhered to the principals described.

The first step in the development of a manual consists of defining and clarifying the elements that are characteristic to a particular psychotherapy method. For this reason, in the preface to Strupp's manual, Merton Gill recognized "the beginning of a movement towards the integration of classical and interpersonal psychoanalytic theory and technique" ([4], p. VIII). Luborsky's text [3] also claims to have included the main curative principles of psychoanalytic psychotherapy. Similarly, Klerman and his colleagues [5] position their treatment, "interpersonal psychotherapy," as being close to psychodynamic treatment theory, and they support their claim with empirical evidence.

For many clinicians, especially those who are psychodynamically oriented, the introduction of such manuals into clinical practice induces the fear that the manualization of therapies restricts the freedom, spontaneity, and variety of individual practice. However, if for a given therapy, an individual action is recommended within the framework of the treatment, this instruction is only a guideline to evaluate therapeutic action. Consequently, a rigid conformity to the rules is likely to decrease efficacy for that treatment. For psychoanalytic therapies, this stimulates rich reflections about creating the structure for a psychoanalytic treatment [6]. These manual-based specifications are certainly less problematic for cognitive-behavioral therapy approaches, but they are never completely problem-free.

Is conducting therapy and conforming to a manual (which is also conforming to a single theoretical approach) related to positive outcome? This is a critical question for psychotherapy research.

Luborsky et al. [7], in a treatment project with drug-addicted patients, included psychoanalytic psychotherapy, cognitive-behavioral therapy, and structured drug counseling and demonstrated for these diverse psychotherapy modalities that the therapist with the strongest adherence to their technique – measured by evaluating the correlation of applied interventions with the theoretical frame – also had the best therapeutic results. The results of this first study suggested that one must consider not only the variation of quality within and between therapists. Given that it has been repeatedly found that a large amount of variability is due to the severity of patient pathology [8], these results suggest more attention must be given to the techniques of psychotherapeutic treatments with patients whose pathology indicates a poor prognosis. Within this difficult-to-treat population, therapeutic competence could be decisive. As an illustration of this diversity of therapist competence, Crits-Christoph et al. [9] reported an average of 12% variance of therapist effects (with a range of 0–50%). In their meta-analytic evaluation study, the factors were examined which could be responsible for such effects. These included the usage of a therapy manual, the degree of therapist's expertise, the treatment's duration, and the type of treatment (psychodynamic vs cognitive-behavioral).

For verification of the hypothesis, data from 15 comparative studies were included. The results can be summarized succinctly: the use of a therapy manual and the degree of the therapist's expertise can significantly reduce variance among therapists. Perhaps, the use of a manual keeps very good therapists from being as good as they can be, while placing a floor under the efforts of the less competent ones. Can we conclude that manual adherence and individual expertise are two of the critical variables in psychotherapy outcome?

In the second Vanderbilt study from Strupp's research group, the effect of a targeted training program for experienced therapists was examined in terms of therapeutic process and outcome. The analysis focused on the individual patient–therapist dyads before and after the therapist's training in the manualized treatment [10]. This more recent study, concerning the advantages and disadvantages of manualization, compared equally experienced therapists with and without explicit training in manualized therapy with the finding that the training did not result in significant differences in outcome.

In the German-speaking world, the cognitive-behavioral therapist Schulte has been propagating, for some time now, the superiority of standardized treatments as opposed to customized treatments with phobic patients [11]. A Dutch cognitive-behaviorally oriented group demonstrated, on the other hand, the negative effect of manualization in the case of obsessive-compulsive disorders, both on a symptomatic level and on the level of general functioning [12].

The same tendency is shown in the results of a re-analysis of the "Multi-Center Collaborative Study for the Treatment of Panic Disorder" from Barlow's cognitive-behavioral group [13]. This study procured even stronger results concerning the effect of therapist expertise than the NIHM project for treatment of depression in a re-analysis by Blatt et al. [14]. Surprisingly, a large effect size was discovered for general therapist experience and its influence on patient's fear level, and only a low effect size was observed from adherence to cognitive-behavioral technique.

The conclusion thus derived may be that therapist experience prevails! In other words: General therapeutic knowledge and experience are more important than expertise in the procedures of a specific treatment orientation [13]. This conclusion is supported by an extensive meta-analysis of 90 studies by Shaddish et al. [15] which "demonstrates that the application of naturalistic psychotherapy and manualized treatment yield equal outcomes; whether in clinically representative or in non-representative patient samples, both forms of therapy achieved equal levels of symptom reduction, which also increased with treatment length" ([16], p. 246). Phrased in a most convincing manner:

> that which is relevant about experience may be general clinical contact rather than developing specific proficiencies ([16], p. 240).

Thus, the use of manuals for beginners can rightfully be recommended, but research findings contradict the necessity of manuals for experienced clinicians.

Practice Teaches Research?

Since the paradigm of randomized control trials (RCTs) was elevated to the gold standard of the current scientific and professional-political situation, the degree of acceptable evidence for therapeutic methods has emerged solely from studies that conform to such a scientific design. Given that the majority of practitioners plead for inclusion of naturalistic studies for defining the degree of evidence, one wonders why. Presumably, practitioners realize from their clinical experience that the practice of psychotherapy proves little resemblance to the laboratory situation of randomized controlled trials. This is often referred to as the problem of ecological validity (e.g., [17, 18]).

It seems fair to conclude that the development of disorder-specific, evidence-based treatments [19] enhances the technocratic perspective. However, a new problem has emerged as, for example, outcome studies have demonstrated that depressive disorders can be equally treated by cognitive therapy, behavioral intervention, interpersonal therapy, or psychodynamic therapy (for the comparison cognitive vs. psychodynamic, see [20]).

Moreover, for borderline disorders, several treatments of diverse orientations have shown similar effect sizes: Linehan's Dialectical-Behavioral Therapy [21], Kernberg's Transference-Focused Therapy [22], Rockland's Supportive Therapy [23], and Fonagy and Bateman's Mentalization-Based Therapy [24]. Another newly described intervention is Young's Schema-Focused Therapy [25]. What should the practitioner do given such abundance of evidence? Should he watch and wait? Should he choose his favorite or most comfortable type of intervention? Should he find some videoclips for the patient to choose a therapy from? In a practical sense, the therapist's duty will include deciding about the preferred form of therapy for a specific patient from the abundance of possibilities in his or her region. Therefore, criteria for determining the preferred, individually based treatment would be helpful. The therapy community may benefit from guidelines in order to determine which approach to psychotherapy matches a specific patient or which aim matches a specific patient [26]. Randomized controlled studies are unlikely to be able to provide an answer to these questions due to the overwhelming effort that is needed to make such distinctions considering the variety of personality dimensions which need to be taken into account. Perhaps, the therapist's expertise can contribute to arriving at highly useful criteria. Naturally, the therapist's individual expertise would not be the only criterion to be considered, but an experience-based discussion could be started in which skilled clinicians could clarify questions about preferred treatment indications with each other.

Who Teaches What to Whom?

One might often think that researchers teach practitioners; but it would be equally reasonable to ask: Who learns what from whom? Researchers learn from practitioners. Regarding the exponential heterogeneity of research findings, one must respect clinical knowledge. For more than 30 years now, the Dodo Bird Verdict, "Everyone has won, and all must have prizes," [27] has summarized the only conclusion possible from research findings. And this was equally true two decades later when Luborsky reinforced his earlier statement [28]. Also, if the most recent handbook article from Lambert and Ogles [8] generally reinforces this conclusion, no one actually believes it when thinking of an individual case, and for good reasons. Clinicians are accustomed to knowing that, in any individual case, the psychotherapeutic treatment goal is not easily achieved; instead of arguing about differences in effect sizes, it is urgent to care for the individual clinical situation. More than ever, the variety of scientific findings necessitates the need for diligence in finding the right treatment for each single patient. The researcher cannot solve this challenge; here, the well-informed practitioner must be asked.

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Appendix IIB Listing of Psychodynamic Manualized Treatments

Compiled by Carolina Seybert, Ingrid Erhardt, Raymond A. Levy, and Horst Kächele

Affect-Focused Dynamic Psychotherapy
Name: Affect-Focused Dynamic Psychotherapy
Developer: Leigh Mc Cullough
Manual reference: McCullough L, Kuhn N, Andrews S, Kaplan A, Wolf J, Hurley C. Treating affect phobia: a manual for short term dynamic psychotherapy. New York: Guilford Press; 2003.
Study reference: Svartberg M, Stiles TC, Seltzer MH. Randomized, controlled trial of the effectiveness of short-term dynamic psychotherapy and cognitive therapy for cluster C personality disorder. Am J Psychiatry. 2004; 161(4): 810–817.
Training: unknown

Brief Dynamic Psychotherapy
Name: Brief Dynamic Psychotherapy
Developer: Per Høglend
Manual reference: Høglend P. Dynamisk kortidsterapi (Brief dynamic psychotherapy), in Poliklinikken Psykiatrisk Klinikk 25 år. In: Alnes R, Ekern P, Jarval P, editors. Oslo, Universitetet i Oslo, Norway: Psykiatrisk klinikk Vinderen.;1990. pp 27–38. (manual only in Norwegian)
Høglend P. Psychotherapy process scales. Manual. Oslo: Department of Psychiatry, Universtiy of Oslo; 1995.
Study reference: Høglend et al. The mediating role of insight for long-term improvements in psychodynamic therapy transference interpretations in dynamic psychotherapy: do they really yield sustained effects? J Consult Clin Psychol. 2010; 78(3): 438–448.
Training: unknown

Brief Therapy of the Stress Response Syndrome
Name: Brief therapy of the stress response syndrome
Developer: Mardi J. Horowitz
Manual reference: Horowitz MJ. Treatment of stress response syndromes. Arlington: American Psychiatric Publishing; 2003.
Study reference: Horowitz MJ, Marmar C, Weiss D, DeWitt KN, Rosenbaum R. Brief psychotherapy for stress response syndromes: the relationship of process and outcome. Arch Gen Psychiatry. 1984; 41(5): 438–448.
Training: http://istsstest.sherwoodgroup.com/AM/Template.cfm?Section=ISTSSTreatmentGuidelines&Template=/MissingInclude.htm

Brief Relational Psychotherapy
Name: Brief Relational Psychotherapy
Developer: Jeremy D. Safran
Manual reference: Safran JD, Muran JC. Negotiating the therapeutic alliance: a relational treatment guide. New York: Guilford; 2000.
Study reference: Muran JC, Safran JD, Samstag L, Winston A. Evaluating an alliance-focused intervention for personality disorders. Psychotherapy. 2005; 42: 532–545.
Training: unknown

Dynamic Deconstructive Psychotherapy (DDP)
Name: Dynamic Deconstructive Psychotherapy (DDP)
Developer: Robert J. Gregory
Manual reference: Gregory RJ, Remen AL. A manual-based psychodynamic therapy for treatment-resistant borderline personality disorder. Psychother Theor Res Pract Train. 2008; 45: 15–27.
Study reference: Gregory RJ, Chlebowski S, Kang D, Remen AL, Soderberg MG, Stepkovitch J, Virk S. A controlled trial of psychodynamic psychotherapy for co-occurring borderline personality disorder and alcohol use disorder. Psychother Theor Res Pract Train. 2008; 45: 28–41.
Training: www.upstate.edu/ddp (The website has a free pdf of the manual and the link to a free multimedia training module)

Dynamic Interpersonal Therapy (DIT)
Name: Dynamic Interpersonal Therapy (DIT)
Developers: Alessandra Lemma, Mary Target, Peter Fonagy
Manual reference: Dynamic interpersonal therapy (DIT). Oxford University Press (in press)
Study reference: The development of a brief psychodynamic protocol for depression: dynamic interpersonal therapy (DIT). J Psychoanal Psychother Appl Theor Res (in press)
Training: http://www.annafreud.org/shortcourses.php

Intensive Short-Term Dynamic Psychotherapy
Name: Intensive Short-Term Dynamic Psychotherapy (ISTDP)
Developer: Habib Davanloo
Manual reference: Davanloo H. Short-term dynamic psychotherapy. New York: Jason Aronson; 1980.
Study reference: Abbass A, Joffres MR, Ogrodniczuk JS. A naturalistic study of intensive short-term dynamic psychotherapy trial therapy. Brief Treat Crisis Interv. 2008; 8: 164–170
Training: http://ridistdp.org/index.htm

Interpersonal Reconstructive Therapy (IRT)
Name: Interpersonal Reconstructive Therapy (IRT) for Individuals with Personality Disorder
Developer: Lorna Smith Benjamin
Manual reference: Benjamin LS. Interpersonal reconstructive therapy: an integrative, personality-based treatment for complex cases. New York: Guilford Press; 2006.
Study reference: Benjamin LS, Critchfield KL. An interpersonal perspective on therapy alliances and techniques. In: JC Muran, JP Barber, editors. The therapeutic alliance: an evidence-based approach to practice and training. New York: Guilford; 2010.
Training: http://www.psych.utah.edu/people/person.php?id=49

Mentalization Based Treatment for Borderline Personality Disorder
Name: Mentalization Based Treatment for Borderline Personality Disorder
Developer: Anthony Bateman and Peter Fonagy
Manual reference: Bateman AW, Fonagy P. Mentalisation-based treatment for borderline personality disorder: practical guide. Oxford: Oxford University Press; 2006.
Study reference: Bateman AW, Fonagy P. 8-year follow-up of patients treated for borderline personality disorder: Mentalization-based treatment versus treatment as usual. Am J Psychiatry. 2008; 165: 631–638.
Training: http://www.annafreud.org/shortcourses.php

Panic-Focused Psychodynamic Psychotherapy
Name: Panic-Focused Psychodynamic Psychotherapy
Developer: Barbara L. Milrod
Manual reference: Milrod BL, Busch FN, Cooper AM, Shapiro T. Manual of panic-focused psychodynamic psychotherapy. Washington: American Psychiatric Press; 1997.
Study reference: Milrod BL, Leon A, Busch FN, Rudden M, Schwalberg M, Clarkin JF et al. A randomized controlled trial of psychoanalytic psychotherapy for panic disorder. Am J Psychiatry. 1997; 164(2): 265–272.
Training: unknown

Psychoanalytically Oriented Focal Therapy of Generalized Anxiety Disorder
Name: Psychoanalytically oriented focal therapy of generalized anxiety disorder (based on Luborsky 1995)
Developer: Falk Leichsenring
Manual reference: Leichsenring F, Winkelbach C, Leibing E. Psychoanalytisch orientierte Fokaltherapie der Generalisierten Angststörung - ein Manual (Psychoanalytic oriented focal therapy of generalized anxiety disorder). Psychotherapeut. 2005; 50: 258–264.
Study reference: Leichsenring et al. Short-term psychodynamic psychotherapy and cognitive-behavioral therapy in generalized anxiety disorder: a randomized, controlled trial. Am J Psychiatry. 2009; 166: 875–881.
Training: unknown

Psychodynamic psychotherapy for social phobia
Name: Psychodynamic psychotherapy for social phobia
Developer: Falk Leichsenring
Manual reference: Leichsenring F, Beutel M, Leibing E. Psychodynamic psychotherapy for social phobia: a treatment manual based on SE therapy. Bull Menninger Clin. 2007; 71(1): 56–83.
Study reference: Leichsenring F et al. SOPHO-NET Forschungsverbund zur Psychotherapie der Sozialen Phobie. Psychother Psych Med. 2009; 59: 117–123.
Training: unknown

Short-Term Anxiety-Provoking Psychotherapy
Name: Short-Term Anxiety-Provoking Psychotherapy
Developer: Peter E. Sifneos
Manual reference: Sifneos PE. Short-term anxiety-provoking psychotherapy: a treatment manual. New York: Basic Books; 1992.
Study reference: Svartberg M, Stiles TC. Therapeutic alliance, therapist competence, and client change in short-term anxiety-provoking psychotherapy. Psychother Res. 1993; 4(1): 20–33.
Training: unknown

Supportive-Expressive Therapy
Name: Supportive-Expressive Therapy
Developer: Lester Luborsky
Manual reference: Luborsky L. Principles of psychoanalytic psychotherapy. A manual for supportive-expressive treatment. New York: Basic Books; 1984.
Study reference: Vinnars B, Barber JP, Noren K, Gallop R, Weinryb RM. Manualized supportive-expressive psychotherapy versus nonmanualized community-delivered psychodynamic therapy for patients with personality disorders: bridging efficacy and effectiveness. Am J Psychiatry. 2005; 162(10): 1933–1940.
Training: unknown

Supportive Psychotherapy for Borderline Patients
Name: Supportive psychotherapy for borderline patients
Developer: Lawrence H. Rockland
Manual reference: Rockland LH. Supportive psychotherapy for borderline patients: a psychodynamic Approach. New York: Guilford; 1992.
Rockland LH. Supportive therapy: a psychodynamic approach. New York: Basic Books; 1989.
Study reference: Clarkin JF, Levy KN, Lenzenweger MF, Kernberg OF. Evaluating three treatments for borderline personality disorder: a multiwave study. Am J Psychiatry. 2007; 164: 922–928.
Training: unknown

Time-limited Dynamic Psychotherapy
Name: Time-limited dynamic psychotherapy
Developer: Hans H. Strupp and Jeffrey L. Binder
Manual reference: Strupp HH, Binder JL. Psychotherapy in a new key. a guide to time-limited dynamic psychotherapy. New York: Basic Books; 1994.
Levenson H. Time-limited dynamic psychotherapy: a guide to clinical practice. New York: Basic Books; 1995.
Study reference: Strupp HH. The Vanderbilt studies revisited I. Psychother Res. 1998; 8(1): 17–29.
Training: unknown

Time-Limited Psychotherapy
Name: Time-limited psychotherapy
Developer: James Mann
Manual reference: Mann J. Time-limited psychotherapy. Cambridge, Mass: Harvard University Press; 1980.
Study reference: Shefler G, Dasberg H, Ben-Shakar G. A randomized controlled outcome and follow-up study of Mann's time limited psychotherapy. J Consult Clin Psychol. 1995; 63: 585–593.
Training: unknown

Time Limited, Short Term Interpretative and Supportive Therapies
Name: Time limited, short term interpretative and supportive therapies
Developer: William E. Piper
Manual reference: Piper WE, Joyce AS, McCallum M, Azim HF, Ogrodniczuk JS. Interpretive and supportive psychotherapies: matching therapy and patient personality. Washington, DC: American Psychological Association; 2002.
Study reference: Piper WE, Joyce AS, McCallum M, Azim HF. Interpretive and supportive forms of psychotherapy and patient personality variables. J Consult Clin Psychol. 1998; 66: 558–567.
Training: unknown

Transference Focused Psychotherapy
Name: Transference Focused Psychotherapy for Borderline Personality Disorder
Developer: Otto F. Kernberg
Manual reference: Clarkin JF, Yeomans FE, Kernberg OF. Psychotherapy for borderline personality. Focusing on object relations. 2nd ed. Washington: American Psychiatric Publishing; 2006.
Study reference: Clarkin JF, Levy KN, Lenzenweger MF, Kernberg OF. Evaluating three treatments for borderline personality disorder: a multiwave study. Am J Psychiatry. 2007; 164: 922–928.
Training: http://www.borderlinedisorders.com/mental-health-professionals-index.php