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Manualization as Tool in Psychodynamic Psychotherapy Research and Clinical Practice—Commentary on Six Studies

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Manualization as Tool in Psychodynamic Psychotherapy Research and Clinical Practice—Commentary on Six Studies

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It is an honor to comment on six fine articles on these recently developed treatments that share the distinctive features of using treatment manuals. The first generation of shorter psychodynamic treatments like Malan (1976), Mann (1973), Sifneos (1979), and Davanloo (1980) were presented in a traditional textbook format. The term *manual* had not yet become popular. What is a manual? The New Oxford American Dictionary described it as "a book of instructions, esp. for operating a machine or learning a subject; a handbook*: a computer manual | a training manual*."

In the seventies of the last century, the term *manual* began to replace the textbook notion; Lester Luborsky (1984) pointed out that "less than a decade ago a small revolution in psychotherapy research style demanded that an official 'manual' be devised for each psychotherapy so that methods and theories could effectively be implemented and compared" (p. 19). He proudly pointed out that his concise primer on the principles of supportive-expressive psychotherapy was one of the first such manuals of which a first version, entitled "The Task of the Psychotherapist" was copyrighted on April 5, 1976. The result was a carefully designed guide for the practice of psychoanalytically oriented psychotherapy for practitioners, researchers, and supervisors.

According to Luborsky (1984, p. 4) therapeutic manuals need to fulfill the following three criteria:

a) The specification of technique needs to be as complete as the type of treatment permits.

b) The manual should make clear the treatment principles and the approaches which the therapist is supposed to perform.

c) The manual should have an accompanying set of scales to measure the degree to which the therapists have complied with its main technique.

Psychotherapy manuals should ensure that therapists do what they are supposed to do according to the specified theoretical and technical framework (i.e., ensuring adherence). The first step in the development of manual consists in defining and clarifying the elements that are characteristic to a particular therapy method. For this reason, Gill recognized the importance of describing the elements of therapeutic approaches in his preface to to Strupp and Binder´s (1984) guide to "time-limited dynamic psychotherapy" (Gill, 1984, p. VII).

For many clinicians, especially psychodynamically oriented ones, the introduction of such manuals into clinical practice induced the fear that the manualization of therapies would restrict the freedom, spontaneity, and variety of individual practice. However, if for a given therapy A, an individual action is recommended within the framework of defined rules, this instruction is only a guideline to evaluate therapeutic action. Guidelines are like sign posts: They do not tell one where to go (Wittgenstein). A rigid conformity to the rules will make therapy A less effective. For psychoanalytic therapies, this principle leads to fertile reflections about structuring a psychoanalytic treatment situation (Thomä & Kächele, 1994, p. 250). Q3

All six articles in this issue utilize manualized treatments (Levy et al., this issue; de Jonghe et al., this issue; Busch & Milrod, this issue; Lemma et al., this issue; Vinnars et al., this issue; Bateman & Fonagy, this issue). For the purpose of establishing scientific credibility in the era of evidence-based medicine, this is not surprising. The acceptance of such guidelines has advanced quite substantially. The agreement across the diverse "systems of psychotherapy" (Ford, 1963) that structure-providing treatments can be more reliably assessed seems strong. The time when only cognitive–behavioral treatments were manualized and psychodynamic treatments were believed not to require these efforts is over. The impact of the evidence-based medicine movement has dramatically changed psychodynamic therapists' view of manuals. We have recently compiled a (most likely incomplete) list of psychodynamic manuals that appeared in the period between 1980 and 2011 that demonstrates the exponential growth of manualized psychodynamic treatments (Seybert et al., 2012). Q4

What is surprising in all of the articles, however, is the nearly complete absence of clinical concerns about manualized treatments. As noted, it often was posited that manual-based specifications for psychodynamic treatments would be limiting or overly rigid. Although not addressed in the six articles in this issue, we may ask the following questions: Is there evidence that conducting therapy according to a manual does not interfere with positive outcome? What role does clinical experience play in the outcome of studies on treatment manuals? That is, is clinical experience as or possibly more important than manualized treatment in influencing outcome? There are a few studies on the issue that may help to answer these questions.

Luborsky et al. (1982), in a project with drug-addicted patients, studied three forms of manualized treatments: psychoanalytic psychotherapy, cognitive-behavioral therapy, and structured drug counseling. They demonstrated for the three modalities that therapists with the highest level of purity in their technique—measured by evaluating the convergence of applied interventions with the theoretical frame—also had the best therapeutic results. The results of this first study on manual adherence suggested that one must reckon with the considerable variation of therapeutic quality within and between therapists.

In addition to therapist quality, the level of patients' psychopathology may also play a role in outcome. It has repeatedly been found that a large amount of variability in treatment outcome is due to the severity of patient pathology (Lambert & Ogles, 2004). Thus, attention must be given to the technical problems of psychotherapeutic treatments with patients with more severe psychopathology. Within this problematic population, therapeutic competency could be decisive. In an illustration of this diversity, Crits-Christoph et al. (1991) analyzed data from fifteen comparative studies examining factors that could affect outcome, including the usage of a therapy manual, the degree of the therapist's expertise (competence), the treatment's duration, and the type of treatment (psychodynamic vs. cognitive-behavioral). They reported an average of 12%

variance derived from therapist competence effects (with a dispersion of 50–0%), indicating a significant degree of impact.

The importance of therapist experience was also highlighted in the NIMH project, the Treatment of Depression Collaborative Research Program (TDCRP; Elkin et al. 1985). The TDCRP was planned and executed by several senior members of the NIMH extramural staff, who designed an extensive, elegant, and well-conducted randomized clinical trial that compared several forms of brief treatment for depression: 16 weeks of medication (imipramine, the antidepressant medication of choice at the time; IMI-CM‘) and a double-blind placebo, PLA-CM, both with clinical management (minimal support but no specific therapeutic intervention), with 16 sessions of manual-directed cognitive-behavioral therapy or interpersonal psychotherapy. Eighteen experienced psychiatrists and 10 experienced PhD clinical psychologists (with a mean clinical experience of eleven years) saw patients at one of three treatment sites (medical schools at George Washington University, University of Oklahoma, and University of Pittsburgh). Surprisingly, Blatt et al. (1996) and also Kim et al. (2006) discovered a large effect for general therapeutic experience and its influence on patients' depression level, and only a low effect size from the use of specific therapeutic elements. The same tendency is shown in the results of a reanalysis of the "Multi-Center Collaborative Study for the Treatment of Panic Disorder" in Barlow's cognitive-behavioral group (Huppert et al., 2001). This study demonstrates even stronger results with regard to the impact of therapist experience on outcome than the reanalysis of the TDCRP.

In a study from Strupp's working group (Bein et al, 2000), the effect of a targeted training for experienced therapists in the Strupp-Binder manual (1984) was examined in terms of therapeutic process and outcome. This study compared equally experienced therapists with and without explicit training in manualized therapy; the two groups did not show a significant difference in outcome. A Dutch cognitive-behaviorally oriented group also demonstrated that manualization did not have a greater impact compared to a nonmanualized treatment in the case of obsessive–compulsive disorders, either on the symptomatic level, or on the level of general functioning (Emmelkamp et al. 1994).

In the same vein, Vinnars et al. (2005) reported that the comparison of a manualized supportive–expressive treatment versus non-manualized community-delivered psychodynamic therapy for patients with personality disorders—in contrast to their expectations—did not show any substantial differences. "The patients in the community therapy group received equally intensive psychotherapy, probably with a more supportive emphasis, delivered by experienced dynamic therapists receiving regular dynamic supervision" (Vinnars et al., 2005, p. 1938).

Taken together, a fair number of studies suggest that therapist experience prevails! In other words, general therapeutic knowledge is more important than expertise in a specific procedure. Phrased in a most convincing manner: "That which is relevant about experience may be general clinical contact rather than developing specific proficiencies" (Beutler et al., 2004, p. 240).

Psychoanalysts are faced with a certain lack of clarity in the field. An extensive meta-analysis of ninety studies by Shadish et al. (2000) showed that the application of naturalistic psychotherapy and manualized treatment were on par: "First, psychological therapies are robustly effective across conditions that range from research-oriented to clinically representative" (p. 522). Manuals are necessary for research purposes, but there is no evidence that they are superior in treating

disorders compared to the experienced clinician. Therefore, the presentation of new manuals should include a specification of the degree of clinical expertise necessary for adequate implementation.

In addition to the description of treatments and research results in these informative papers that increase the diversity of psychodynamic interventions I would like to learn more about the impact of therapist competence and experience on outcome with the new treatments. Would the authors agree with findings that suggest that clinical expertise overrides the advantages of manualized treatments? I am also interested in more information about how the authors think about implementation of the new tools into routine clinical practice. Are weekend trainings for already trained clinicians good enough or are the new products more suitable for basic teaching? Now that these treatments are increasingly accepted, questions about their implementation and role in clinical practice become paramount.

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