On the Limitations of Therapy Manuals

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While the benefits of training manuals can hardly be questioned, they are exceedingly limited in reducing variability attributed to the "therapist factor." We propose that manuals provide a useful outline of the *general principles* of a therapeutic approach, but can only reduce therapist variability at the expense of other essential therapeutic phenomena. Manuals cannot adequately convey, for example, how the effective therapist functions as a model of adult living and as a person who provides guidance. We suggest that such an experience cannot readily be packaged in manualized form, though manuals may serve as a useful beginning. Recommendations for therapist manualized training include greater attention to the subtleties of human relationships and adequately conveying that any technique is effective only when catalyzed by a living, relational process.

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Therapy manuals appear to offer so many advantages and are now so widely used that it seems almost sacrilegious to point to their limitations. Although treatment manuals have been in existence only a brief time, their widespread acceptance is nothing short of astounding. Indeed, outcome studies that do not employ treatment manuals have become almost unthinkable (Lambert & Bergin, 1994). Society at large has likewise shown increasing enthusiasm for manualized treatments, as have managed care companies (Koss & Shiang, 1994). The latter see them as the answer in the accelerating concern for economy and abbreviated therapies.

Therapy manuals came into existence for several reasons, among them (a) the need for more specific descriptions of particular treatments, (b) as an aid in the training of therapists, and (c) to standardize a particular treatment approach. These goals have been approximated to some extent in a relatively brief period of time: Treatments that were once described only in global terms (e.g., psychodynamically oriented, client-centered) are now delineated more precisely, and greater attention is given to detailed descriptions of techniques. This trend has also made possible clearer statements of didactic goals in the training of therapists and facilitated the development of better criteria for the evaluation of "adherence" to a particular approach. In short, manuals have aided researchers in arriving at improved specifications of the "independent variable" in therapy. No doubt, manuals have aided in the replication of studies and brought us somewhat closer to the identification of the "active ingredients" in different treatments.

These methodological developments have also facilitated empirical research in other respects. For example, some findings suggest that in addition to increased adherence to a therapeutic approach, training manuals may also enhance outcomes (Beutler, Machado, & Neufeldt, 1994). Rounsaville, O'Malley, Foley, and Weissman (1988) have presented evidence that manuals tend to accelerate the pace of therapist training. Crits-Christoph and Mintz (1991) found that manuals are useful in significantly decreasing variance attributable to therapists. In a meta-analysis covering the past 20 years they found that

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research which employed training manuals had significantly decreased the variability of the therapist as a contributor to outcome variance.

SOME LIMITATIONS OF MANUALS

Clearly a convincing case has been made for the virtues of training manuals, and some of their benefits can hardly be questioned. We accept the usefulness of manuals as a method for outlining *general principles,* as a methodological tool in research and as providing the "training wheels" for learning a new therapeutic approach. Nonetheless, some fundamental questions remain. First, can a psychotherapeutic approach be stringently described in a manual, and second, is it possible to standardize the behavior of a therapist by providing trainees with specific instructions concerning the implementation of the treatment, the therapist's stance, techniques to be followed, and so on? Let us examine these questions in somewhat greater detail.

To take as an example our approach to time-limited dynamic psychotherapy (TLDP; Strupp & Binder, 1984), the Vanderbilt group carried out a long-term study in which experienced therapists were given a full year's training (including approximately 100 hours of supervision in small groups). Numerous problems emerged in our effort to standardize the training. Most important, perhaps, it appeared that, far from constituting radically new learning, the TLDP approach was "grafted" on the therapists' previous techniques and skills. The results of our study (Henry, Schacht, Strupp, Butler, & Binder, 1993; Henry, Strupp, Butler, Schacht, & Binder, 1993) demonstrated that, following training, (a) therapists made greater use of what we termed TLDP-specific techniques but (b) they often appeared to be uncomfortable using them. In short, the new learning did not come "naturally." As noted by Butler and Strupp (1993), therapists often "delivered" TLDP interventions in a fairly forced and mechanical manner, suggesting that adherence to particular aspects of a protocol and skillful performance were far from identical. Most problematic were therapists' attempts to employ TLDP-specific interventions dealing with the therapeutic relationship. In particular, they were often premature in addressing the therapeutic relationship before a pattern had been explored sufficiently to permit plausible connections between the patient's concerns outside of therapy and specific events in therapy.

Furthermore, whereas therapists demonstrably made greater use of TLDP-specific techniques (e.g., focusing on the patient-therapist relationship, addressing transactions in the here-and-now), they also, as might be expected, made extensive use of numerous other techniques that were already part of their therapeutic repertoire. Parenthetically, we gathered no data on how training in TLDP affected these "traditional" techniques in the therapists' repertoire, although we did obtain ratings of what we termed "general dynamic" techniques. These ratings, however, provided only limited information on the preceding question.

Among other things, we came to believe that it might have been preferable to use novice therapists rather than practitioners who already had several years of postgraduate experience and had developed a style of their own. The use of novice therapists might also have resulted in a more homogeneous sample, but individual differences would still have persisted and exerted a considerable influence.

More importantly, therapists' newly acquired TLDP skills[1] were filtered through their preexisting personal dispositions, which were unlikely to be significantly altered through a program of manualized study. Specifically, we found that therapists whose introject ratings emerged as self-controlling and self-blaming showed the highest technical adherence to TLDP. When we examined treatment outcomes as a function of the therapist's introject, we found that self-controlling and self-blaming therapists had outcomes that were significantly poorer than those of therapists having different introject patterns (Henry, Schacht et al., 1993). Finally, therapists with self-indicting introjects were judged to display in their therapy sessions the least warmth and friendliness, and their patients showed the highest level of hostility. In sum, these therapists were not interchangeable units, and their adoption of techniques could not be standardized.

Let us state the basic point more boldly: Psychotherapy in general, and the therapeutic relationship in particular, represents a very broad and multifaceted social influence, and it appears highly artificial–indeed, fallacious–to presume that it can be reduced to a few simple parameters. Yet in contemporary society there are several important pressures that promote this kind of simplistic thinking. Within psychotherapy, the threat is very real (perhaps it has already become reality!) that the skillful, theoretically sophisticated therapist is being re-

placed by technicians with very limited training and expertise.

To illustrate further, in the typical treatment-outcome study it is assumed that training manuals, somewhat analogous to cookie cutters, will produce therapists who are equivalent, perhaps even identical, in terms of the treatment they "deliver." In this spirit, it has been recommended that researchers should routinely perform preliminary analyses in order to reduce therapist variability (Crits-Christoph et al., 1991). Similar procedures were performed in the NIMH collaborative study of depression, when 2 of the 11 interpersonal therapists were scrutinized for adherence/competence to the manual—ultimately leading to the release of one of these therapists from the study (Rounsaville et al., 1988). Clearly, the balance between the gains accruing to internal validity and the losses detracting from external validity is debatable. Yet the goal of scientific control via internal validity is admirable only if it does not distort or eliminate the basic nature of the object being studied. Thus, if the "therapist factor" should turn out to be inherently intertwined with techniques, the control of this so-called factor in any study would be moot.

We propose that manuals can only minimize therapist variability at the expense of other essential therapeutic phenomena. While manuals have significantly reduced variability associated with the therapist, several studies have shown that therapists may widely differ even when manuals are used under the best of circumstances (Miller, Taylor, & West, 1980; Najavits & Strupp, 1994; Turner & Ascher, 1982). For example, Luborsky, McLellan, Woody, O'Brien, and Auerbach (1985) reported that therapists have widely different outcomes, despite valiant attempts on the researcher's part to minimize individual differences. Shapiro, Firth-Cozens, and Stiles (1989) similarly reported therapist effects in the Sheffield project, in which therapists who were particularly well suited for prescriptive treatments accounted for the study's main effects. These studies highlight the fact that treatment manuals can go only so far in eliminating the therapist factor in highly controlled designs. Further studies of this sort would go a long way toward clarifying this and other issues relating to the personal contributions of the therapist and the extent to which manualization might be possible. Our point is that heretofore there has been an overwhelming—perhaps blind—acceptance of manuals as a correction for factors that are difficult to control. We only wish to suggest that in the long run psychotherapy research will be best served by understanding the limitations of standardization procedures (in this case, manualization of therapy). Clearly, studies of the type described above not only will assist in recognizing the limitations of manuals but may also provide direction for increasing their incisive, effective implementation.

In addition, manuals can do little to counteract larger ecological influences that may be present. For example, despite the use of an identical training manual and data collection at the same site, the two trainers in the Vanderbilt II study had a differential impact on the therapists in their respective groups (Henry, Schacht et al., 1993). Similarly, manuals may not be capable of controlling for phenomena such as site differences (see the NIMH collaborative study of depression; Elkin, 1994), or for the influence of demand characteristics in the Vanderbilt II study (Anderson & Strupp, 1996). Such findings highlight the overriding importance of personality variables in training, supervision, and therapy.

We wish to emphasize that the most essential therapist characteristics cannot be culled out of some sort of "psychic centrifuge" for the purposes of empirical study. As Lambert (1989) noted, "the therapist is more than the sum of the dimensions (and interaction of dimensions) that is usually studied in traditional process and outcome research" (p. 471). Standing in isolation, the therapist's demographic characteristics, attitudes, values, professional affiliations, and *techniques* have little to do with the ability, as a person, to relate comfortably with others, to serve as a model for adult living, to be sensitive to subtle but essential interpersonal dynamics, and to allow oneself to be privy to the unfolding of the patient's cyclical maladaptive patterns while appropriately maintaining professional distance (this is no small order!). The "techniques" used by the therapist who successfully embodies these qualities are not easily captured in manualized form. While techniques may be taught and rotely implemented, it is the person of the therapist who provides the θlan vital to these lifeless abstractions. Indeed, the reason that some "master therapists" have had difficulty teaching their strategies to others may be due to the fact that their techniques are intertwined with their very being.

An Illustrative Example

While researchers in any well-designed study need to assure control of the therapists' performance, there are distinct limits to such efforts, which may also have the effect of dissipating what, in our opinion, is crucial in

psychotherapy, namely, the uniqueness of each patient-therapist match. This point was driven home vividly when we undertook to study intensively the performance of particular therapists with two of their patients, one of whom had a good outcome whereas the outcome of the other was at best unimpressive. These analyses paralleled a series of earlier comparisons (Strupp, 1980a, 1980b, 1980c, 1980d). As had been expected, it became abundantly clear that the tenor of the therapists' communications was markedly affected by the personality as well as the nature of the difficulties presented by the patients with whom they were interacting.

The following case example, while not necessarily representative of all cases, will serve.

Therapist J., a female psychologist with 8 years of postdoctoral experience, was treating a middle-aged woman patient whose major problem was a grief reaction precipitated by the untimely death of her husband. The patient, clearly in need of understanding and support, formed a warm relationship with Dr. J., who, in keeping with her customary directive stance, responded well to the patient's needs, and a productive therapeutic alliance resulted. The outcome of the treatment was clearly positive.

The second patient, seen by Dr. J., was also a woman, of somewhat comparable age as the first. Her difficulties related to a painful divorce she had recently experienced. As a result, she felt abandoned by her husband and other important support figures in her life. However, unlike the first patient, she suffered from significant characterological deficits, an inability to relate meaningfully to other people, and a pervasively superficial style that reflected an inner emptiness and gave her human relationships a "two-dimensional" appearance. There were numerous indications that Dr. J. liked this patient markedly less than the first, and her directiveness, which in the first case had a warm, nurturing quality, in this instance came across as controlling and harsh. The treatment outcome, as judged by the various measures we had routinely obtained, was unimpressive and the patient remained essentially unchanged.

Did the two treatment outcomes have much to do with the manualized training in TLDP that this therapist had received? Had the training been successful in "standardizing" the therapist's performance? Our answer to both questions is in the negative. To be sure, we cannot "prove" this point and our evidence largely derives from an intensive naturalistic, albeit research-informed, study of the two cases; however, we also contend that it would be difficult to obtain more compelling evidence from other extant forms of process analysis.

To state the point somewhat differently: Although it is clearly possible to provide therapists with specialized training based on a particular treatment manual and to measure the effects of such training by an "adherence scale" (as we and other researchers have done), the therapeutic process and its outcome are undoubtedly influenced to a far greater extent by personality characteristics of the patient, the therapist, and the resulting quality of their interaction. To return to our example, when speaking of her more difficult patient, Dr. J. tended to refer to the "technical" issues she faced. Nonetheless, this therapeutic strategizing was interlaced with more personal observations, for which she somewhat awkwardly attempted to "treat" with "techniques." Even after the first session, Dr. J. noted in her summary: "When the patient first came in, it's easy for a person to feel a little bowled over by her. That did not persist through the session, plus I'm a fairly difficult person to bowl over, I think." As might be surmised, her adherence to the training manual did little to prevent the power struggles that were to develop in the relationship.

Another important contributor to a particular treatment outcome is the therapist's skill in dealing with the vicissitudes of the patient-therapist relationship—in psychodynamic terminology, with transference and countertransference reaction. This was also clear in our study of Dr. J. In her successful case, she was more relaxed and comfortable in making interpretations—especially interpretations of an interpersonal nature. For example, what first appeared to be a casual discussion of a seemingly benign issue (clothing or attire) quickly metamorphosed into a more substantive exploration of the patient's perception of the therapist's view of the patient's worth. On the other hand, such discussions never seemed to evolve in Dr. J.'s second case: Casual discussions remained monotonously casual, and transference interpretations, when they occurred, were awkward and poorly timed. Observations like the foregoing strengthened our belief that skill is only partially, and often not significantly, manifested by the therapist's "adherence" to a given manualized treatment; in fact, skill may have little to do with "adherence."

An Alternative to Manuals: A Reprise

In a recent article dealing with the future role of the university in the computer age, Noam (1995), a professor of Finance and Economics at Columbia University made a point that is of impressive significance for the enterprise of psychotherapy as well: "True teaching and learning," the author asserts, "are more than information and its

transmission. Education is based on mentoring, internalization, identification, role modeling, guidance, socialization, interaction, and group activity" (p. 249). With equal validity we might say that psychotherapeutic treatment is considerably more than the application of techniques set forth in a treatment manual. As a large psychodynamic literature has long attested, therapeutic change is likewise a function of mentoring, internalization, identification, role modeling, guidance, socialization, and interaction.

Early in the history of psychoanalysis, Freud characterized psychotherapy as a form of "after-education" (*Nacherziehung*), in other words, a teaching and learning process (Alexander & French, 1946). He understood that psychotherapy is not a treatment except in a metaphoric sense and that it can never be a product or a commodity delivered by a technician to a passive individual. As has frequently been discussed over the years, the therapist functions as a teacher and mentor whose attitudes and values the patient internalizes and with whom he or she identifies; furthermore, the therapist functions as a model of adult living and provides guidance as well as a benign and nurturing social milieu in which the patient can "grow" and mature. In the therapeutic context, too, the therapist is in a position to demonstrate to the patient beliefs and patterns of behavior that have been self-defeating, painful, and troublesome. In other words, the therapist effectively mediates *unlearning* that typically is a prerequisite to new learning. Clearly, such a *corrective emotional experience* cannot be prescribed, easily packaged, and dispensed, nor can it be readily mediated through manuals.

Indeed, it was one of Freud's most original and impressive contributions to have created a vehicle—psychodynamic psychotherapy—that places in the center of attention the kinds of learning the patient has carried forward from childhood that have poorly served him or her in later life. In short, the therapist helps the patient to discover what works and what doesn't work in interpersonal living, with special reference to the latter. As Harry Stack Sullivan (1954) put it in a memorable phrase: "Work toward uncovering those factors which are concerned in the person's recurrent mistakes, and which lead to his taking ineffective and inappropriate action. There is no necessity to do more" (p. 239).

Whereas the general principles of what constitutes therapeutic unlearning and learning are well understood, their application *in a specific case* often calls for consummate empathic understanding, sensitivity, tact, and *skill* on the therapist's part. It is an intricate and intuitive process in which each therapeutic hour may become an artistic creation that is highly personalized and tailored to the needs of the individual patient at a particular time. The therapist needs to determine the center of the patient's current difficulty and to frame his or her communications in a way that is most helpful to the patient at this juncture. Often this means "not getting in the way," staying out of power struggles, avoiding interpretations that might be complementary to the patient's provocations. In each instance there are probably a number of ways in which this can be accomplished and there is no single sure-fire formula for success. On the other hand, there are undoubtedly many ways in which the therapist can interfere with, undercut, sabotage, or otherwise derail the therapeutic process.

How does the therapist acquire the requisite skills? Like any complex and intricate process, it takes time, effort, instruction, and practice. Toward this goal a treatment manual can be a useful *beginning* or a reference. Perhaps this is the most that can be expected. By the same token, an adherence measure can provide only a gross index to what the therapist practices and only rarely can it capture the essence of the therapist's communications. The trap that continues to threaten unwary researchers as well as managed care companies is that of reifying a living process. Goethe understood this perfectly:

> *Mephistopheles:* He who wishes to know and describe anything living
> seeks first to drive the spirit out of it.
> He has then the parts in his hand.
> Only, unfortunately, the spiritual bond is wanting.
> Chemistry terms it *Encheiresis Naturae* [manipulation of nature, art of getting at nature's secrets by manipulation] and mocks herself without knowing it.
>
> *Student:* I cannot quite comprehend you.
>
> *Mephistopheles:* You will soon improve in that respect, if you learn to reduce and classify all things properly.
>
> (*Faust,* Part I, Scene IV)

No truer words were ever spoken for psychotherapy process researchers!

Where does this leave us regarding the use of manuals in the training of therapists? Shall we return to the traditional supervisory model in training therapists? Manuals undoubtedly are a first step in developing training models of the future. However, the current preoccupation with

manuals may have exceeded its usefulness, and further emphasis on the standardization of "techniques" and manualized control of the "therapist factor" may impede, rather than further, the advancement of productive models for therapist training.

Currently, instruction in psychotherapy based on manuals tends to be brief and provides little opportunity to practice and explore the gamut of issues confronted in therapy. As our research group has shown, some therapists, especially those with self-blaming and self-controlling introjects (Henry, Schacht, & Strupp, 1990), may be excellent in adhering to a manualized model but they may have difficulty communicating to patients what they have learned without sounding mechanical or artificial. These therapists (like other novices) may rely rigidly on technical rules that, in practice, may interfere with full attention to the patient's communications. As is often the case, and as we showed in the Vanderbilt II study, the process of acquiring new skills may involve an extended period of disorganization and awkwardness. Furthermore, enhancing the skills of therapists is a complex and demanding process that calls for a new–and perhaps radical–reconceptualization of psychotherapy training procedures. We have elsewhere presented some proposals for this kind of training (e.g., Strupp, 1993).

In conclusion, we feel very strongly that psychotherapy training has not kept pace with the times–it has remained essentially unchanged over the past 80 years and has, for the most part, remained quite unsystematic. In particular, it is just beginning to make use of modern technology (e.g., CD-ROM) that undoubtedly will come to play a major role in presenting to students various technical problems and serve as a vehicle for learning and discussion.

NOTE

1. We agree with Schön (1983) that "competent practitioners usually know more than they can say. They exhibit a kind of knowing-in-practice, most of which is tacit" (p. viii).

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