Implicit and Untested Assumptions About the Role of Psychotherapy Treatment Manuals in Evidence-Based Mental Health Practice

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We consider Carroll and Nuro’s (this issue) model of treatment manual development in the broader context of attempts to bring accountability and evidence-based practice to clinical services. The current zeitgeist surrounding treatment manual dissemination is guided by several implicit and largely untested assumptions. We describe each assumption, consider how it guides current thinking about dissemination of empirically supported treatments, and briefly summarize relevant research. We conclude that treatment manual development and dissemination, while clearly a worthwhile pursuit, is only one way to merge science and practice.

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Carroll and Nuro (this issue) suggest that psychotherapy treatment manuals are not a single breed and serve different functions in different contexts. Such flexibility in thinking about empirically supported treatments is a refreshing break from highly polarized debates over what these treatments can and cannot provide for practitioners. Yet at the same time that Carroll and Nuro successfully dispel one uniformity myth surrounding manuals (Addis & Krasnow, 2000; Kiesler, 1966), they risk introducing another: the idea that all treatment manuals should progress through a fixed series of stages to serve the evolving functions of treatment description, evaluation, and dissemination. This move toward better formalizing the process of treatment development reflects, from our perspective, an increased emphasis in the field on dissemination of manual-based treatments as the primary means for increasing evidence-based mental health practice.

In this brief commentary, we consider Carroll and Nuro’s model within the broader context of attempts to bring accountability and evidence-based practices to clinical settings. The move to broadly disseminate empirically supported manual-based treatments (ESMBTs) is one of many different ways to merge science and practice (Addis, 2002; Lambert, Hansen, & Finch, 2001) that carries with it several implicit, and largely untested, assumptions about what these treatments can and should accomplish in clinical practice. We consider five related assumptions that surround the current zeitgeist regarding dissemination of ESMBTs. Our goal here is to keep our eyes on the forest rather than the trees and to consider the ways in which such careful attention to treatment manuals can both facilitate and impede the mergings of science and practice.

Assumption 1: ESMBTs Will Achieve Outcomes in Clinical Practice Comparable to Those Demonstrated in Controlled Research Contexts

It has often been suggested that the results of randomized clinical trials of ESMBTs have little or no relevance for clinical practice (Garfield, 1996; Silberschatz, quoted in Persons & Silberschatz, 1998; Silverman, 1996). Clinical practice, so the argument goes, brings much more client heterogeneity, clinical judgment, theoretical integration, and therapist flexibility than clinical research. How could the results of randomized clinical trials, with all their experimental controls, ever replicate in the “real world” of clinical practice? In fact, the accumulating data suggest that cognitive behavioral ESMBTs maintain effects when translated to clinical practice (Franklin, Abramowitz, Kozak, Levitt, & Foa, 2000; Persons, Bostrom, & Bertagnoli, 1999; Sanderson, Rau, & Wetzler, 1998; Tuchsen-Caffier, Pook, & Frank, 2001; Wade, Treat, & Stuart, 1998). The majority of these studies show that manual-based treatments produce comparable results in tightly controlled research settings and in clinical practice. It remains to be seen whether approaches other than cognitive behavioral show similar patterns of generalization.

The results of these benchmarking studies provide support for Carroll and Nuro’s model of treatment manual development. If ESMBTs can maintain effects in clinical practice, it seems worthwhile to continue to develop clinician-friendly treatment manuals that detail the core ingredients of particular treatments and facilitate the dissemination process.
Assumption 2: ESMBTs Will Enhance Outcomes in Clinical Practice

It is one thing to show that manual-based treatments can fare as well in clinical practice as in controlled research. It is another to demonstrate that clinical practice outcomes are improved by disseminating ESMBTs (e.g., Addis, 1997; Wilson, 1996). At this point, we know very little about the effectiveness of existing clinical practices for treating different problems in living. Such knowledge depends on large-scale process and outcome evaluations comparing ESMBTs to treatment as usual (TAU) in a variety of practices. In the only such study to our knowledge, Morgenstern, Blanchard, Morgan, Labouvie, and Hayaki (2001) found that disseminating CBT for substance abuse to community practitioners did not enhance outcomes compared to existing services. If such findings continue to emerge they will certainly call into question the necessity of disseminating ESMBTs to some clinical practice contexts, or at least the methods currently used to do so.

At this point, the assumption that ESMBTs will enhance the effectiveness of clinical practice remains precisely that: an assumption. It is worth considering that some empirically supported treatments may be no more effective than existing treatments in particular practice contexts. Such a scenario is not necessarily bad news for proponents of ESMBTs. Determining the range of effectiveness for common clinical practices can lead to targeted areas of treatment development and dissemination (e.g., difficult, treatment-resistant populations or problems), rather than the current shotgun approach.

Assumption 3: It Is Practical to Disseminate ESMBTs to Clinicians in Different Practice Contexts

Several authors have noted pragmatic obstacles to training front-line practitioners in manual-based treatments (Addis, Wade, & Hatgis, 1999; Hatgis et al., 2001; Strosahl, 1998). These include, among others, constraints on practitioner time, length, and cost of training; limits on practitioner and clinical administrator buy-in to the ESMBT rationale; and constraints on clinical services inconsistent with many ESMBTs (e.g., limited session frequency or intensity).

The stage model of manual development raises another practical constraint on disseminating ESMBTs. Carroll and Nuro suggest that “a stage III manual would be viable only after the completion of several clinical trials and the resultant accumulation of a great deal of process and outcome data for a variety of patient populations.” Assuming one study per phase lasts 3 to 5 years, it will be 9 to 15 years before a stage III manual is widely available to clinicians (unless different phase studies run concurrently, which seems contrary to a stage model of dissemination). Most practitioners are hungry for treatment innovations and will likely seek out stage I and II manuals and integrate them as they see fit into their clinical practices. If the boundaries between stages were more fluid, practitioners could be involved early in the treatment development and evaluation phase, leading to manuals that describe internally valid and user-friendly treatments.

Assumption 4: Practitioners Can Learn and Adhere to Structured ESMBTs

The only obstacle to testing whether practitioners can learn and adhere to ESMBTs is the development and dissemination of brief and valid measures of therapist adherence and competence. The stage model paves the way for measure development by utilizing a template for adherence assessment (Waltz, Addis, Koerner, & Jacobson, 1993) as the basis for manual development. It is interesting to note that we developed this category system in the context of a tightly controlled clinical trial (Jacobson et al., 1996), where the emphasis was strongly on internal validity, maximum treatment separation, and therapist adherence. How important is adherence to ESMBTs in clinical practice? At this point, we cannot say. Some data from tightly controlled trials suggest that therapist adherence is associated with more positive outcomes (Foley, O’Malley, Rounsaville, Prusoff, & Weissman, 1987; Frank, Kupfer, Wagner, McEachran, & Cornes, 1991). Other data suggest that adherence may be associated with poorer therapeutic process and outcome (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996). Either way, the emphasis on adherence in clinical practice assumes not only that adherence will facilitate better ESMBT outcomes but that these treatments will enhance existing clinical practice (assumption 2, which is essentially untested). It is possible that optimal outcomes will result from effectively balancing the dialectic between adherence and flexibility (Addis, Hatgis, Soysa, Zaslavsky, & Bourne, 1999). Thus, Carroll and Nuro’s suggestion that optimal levels of flexibility be central to stage III manuals is a good one.
Assumption 5: ESMBTs Must Be Tied to Particular DSM Disorders

One of the most widely accepted and least tested assumptions about manual-based treatments is that they must be tied to particular psychiatric (i.e., DSM) disorders. A thorough critique of the advantages and disadvantages of the DSM is beyond the scope of this commentary. However, we would like to point out that the treatment utility (Hayes, Nelson, & Jarrett, 1987) of diagnosis-based treatments has yet to be tested; the medicalization of psychotherapy research may have more to do with research funding priorities than with treatment efficacy or utility (Goldfried & Wolfe, 1998). The fact that many problems respond well to non-specific psychotherapies (Wampold, 2001) provides reason to wonder whether widespread dissemination of diagnosis-based treatments is necessary; it may simply be overkill. As we pointed out in assumption 2, if the field could determine the range of effectiveness of general non-ESMBT practice, we may be able to target those problems that require a more tightly structured diagnostic-driven approach. It may also prove helpful to develop and disseminate broad-band manual-based treatments suitable for a range of different presenting problems (Addis, 1997).

CONCLUSION

The development and dissemination of structured empirically supported psychotherapies are major accomplishments for the field. Such treatments offer a potentially viable way to bridge the gap between science and practice and facilitate accountability and outcome evaluations in clinical settings. At the same time, the intensive focus on dissemination of manual-based treatments for specific DSM disorders is guided by several implicit assumptions that, together, may obscure the variety of possible ways to merge science and practice.

NOTE

1. Or therapist constraint, as is increasingly the case in capitated managed care contexts.

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REFERENCES


ment for depression. *Journal of Consulting and Clinical Psychology, 64,* 295–304.


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