

# The Dialectics of Manual-Based Treatment

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Treatment manuals are increasingly popular and controversial. Despite little consensus as to what constitutes a treatment manual, much has been written about the promises and potential pitfalls of manual-based practice (Addis, 1997; Fensterheim & Raw, 1996; Silverman, 1996; Wilson, 1996, 1998). Yet manuals themselves are simply documents describing therapeutic techniques and theories of change. Whether they enhance or impede the change process is largely an effect of how practitioners use them. It is surprising, then, that little has been written about the concrete ins and outs of manual-based practice (see Kendall, Chu, Gifford, Hayes, & Nauta, 1998, for a notable exception). Our purpose in this brief article is to offer a set of guidelines, or ways of thinking about manual based-treatment, that can (a) help practitioners to balance effective adherence with flexible adaptation to individual clients, and (b) cut across different manualized treatments rather than being treatment specific. We also hope to operationalize one important component of what might be considered the art of being a skilled empirically based practitioner. Our central premise is that effective manual-based intervention requires therapists to think, talk, and act in a dialectical fashion. Conceptualizing dialectics as tensions between apparent opposites, we apply the concept to a number of common tensions in manual-based practice. We also suggest concrete strategies for working creatively within these tensions.

### An Overview of Dialectics

What we understand as a dialectical perspective is largely derived from Marsha Linehan's approach to the treatment of borderline personality disorder (e.g., Linehan, 1993) and from the social and political philosophies of Marx and Hegel. Linehan describes dialectics as composed of three basic principles. The first is interrelatedness and wholeness. This principle suggests that elements cannot exist without each other and their relation to the whole. Parts are only distinguishable from one another through their relationship to the whole. One implication of this principle with regard to manual-based treatment is that individual therapeutic tech-

niques do not have meaning apart from their relation to treatment goals and a unifying theory of change. For example, it would make no sense to ask a client to complete a cognitive self-monitoring exercise unless one assumed that learning about specific thoughts was an important change mechanism. More broadly, the principle of interrelatedness underscores the mutual dependence between different interventions and an overarching treatment approach. An understanding of the "big picture" is often what allows therapists to develop creative and effective ways of adapting manualized interventions to the needs of individual clients.

The second principle is polarity and suggests that phenomena are comprised of two opposing forces: thesis and antithesis. The conflict between thesis and antithesis becomes temporarily resolved into a synthesis, which in turn contains a set of opposing forces. In terms of manual-based treatment, a common tension exists between adhering to a protocol and adapting or modifying it to meet the needs of individual clients. For example, a therapist may feel a strong pull based on previous research to stick closely to a structured protocol for treating depression (thesis). She or he may also feel that certain techniques will not be effective for a particular client (antithesis). The therapist may decide to modify the techniques (synthesis), but the synthesis does not provide a permanent resolution to the dialectic. This principle of polarity implies that therapists will often feel pulls in different directions when conducting a manualized treatment. It also suggests that such tensions are not to be avoided. They can be regarded as constructive dialectical processes that compel a clinician to think critically about therapeutic foci and interventions.

The third principle is continuous change and begins with the assumption that the ongoing tension between opposing forces works against contextual stabil-

ity. This is not necessarily a chaotic process (though it can be at times). Rather, the recognition of continuous change raises awareness of the need for flexibility and reevaluation as parameters shift. With regard to manual-based treatments, one example is the therapist's awareness of the ever-changing nature of the treatment process. A client who is highly involved and motivated one week (or one part of a session) may be depressed and demoralized the next. Thus, the principle of continuous change suggests the value of therapist flexibility and responsiveness, without an expectation for necessarily stable or linear progress in treatment.

In summary, the three dialectical principles suggest the interrelatedness of different aspects of treatment, tensions between opposite forces in treatment, and continuous change within treatment. Identifying these as organizing principles and exploring their implications can aid therapists in conducting artful manual-based therapy. In what follows we offer a set of more specific guidelines for bringing a dialectical perspective to manual-based psychotherapy.

### What Does Dialectics Have to Do With Manual-Based Treatment?

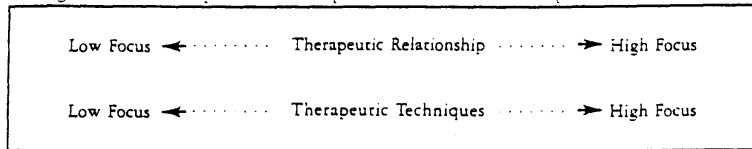
The first implication to be derived from a dialectical perspective is that numerous apparent dichotomies related to manual-based treatment can be regarded as continua. Several of these apparent dichotomies are listed in Table 1. Simply because one experiences a tension between, say, attending to the therapeutic relationship and implementing therapeutic techniques, this does not mean that the two are mutually exclusive. In fact, both foci lie on separate continua, as illustrated in Figure 1. Depending on the therapist, the client, the stage in treatment, or the stage in the session, the foci could be high on both, low on both, high on one, and low on the other, etc. Recognizing this helps therapists to avoid getting stuck for too long on one side of a tension (e.g., "I can't be directive with my client without sacrificing rapport").

The second implication of a dialectical perspective is that tensions between opposites can be a useful part of the treatment process. The goal of working dialectically is not to remove tensions, but rather to tolerate, accept, and work creatively with-

■ Table 1. A sample of apparent dichotomies that lie on continua

Individual client	←	.....	.....	→	General diagnostic category
Therapeutic relationship	←	.....	.....	→	Therapeutic techniques
Flexibility and integration	←	.....	versus	.....	Adherence to the manual
Being genuine with clients	←	.....	.....	→	Adherence to the manual

■ Figure 1. An example of two independent continua of therapeutic focus



in them. In fact, it is often the experience of tension itself that sets the context for creative interventions that are consistent with the manual (see Kendall et al., 1998, for several excellent examples). Below we describe two general strategies for working within tensions.

**Working Toward Synthesis: Using Opposites in Service of Each Other**

The first means of working within dialectical tensions is recognizing the continua and deriving a temporary synthesis. One way to set the stage for synthesis is to ask oneself questions like, Where is the middle ground? or How can I use these apparent opposites in service of each other? To illustrate this point, consider a client in manual-based cognitive behavior therapy (CBT) who prefers to discuss childhood causes of current problems, rather than current maintaining factors (e.g., coping strategies). Assume also that self-monitoring of different coping strategies is a technique central to the treatment. The dialectic is a tension between focusing on the client's current coping strategies versus focusing on the past. One synthesis might involve discussing past experiences as a means of discriminating effective and ineffective coping strategies:

"How did you cope with that then, and what would be effective now?" Another synthesis might involve modifying the treatment rationale to include past experiences. The therapist could emphasize the idea that beliefs about the self and automatic thoughts are products of experience. Or, if the client grew up in a critical environment, the therapist could suggest that learning to talk differently to oneself could be a process of "re-parenting."

**Moving Through Contrasts: It's Okay, and Often Productive, to Do Opposite Things**

Finding a synthesis is not the only way to work creatively with dialectical tensions. The second strategy we call "moving through contrasts"; or, as we often remind ourselves, "It's okay, and often productive, to do opposite things." The goal here is to engage in a range of therapeutic behaviors even though they may appear inconsistent with each other. Continuing with the previous example, a therapist might spend half the session exploring past antecedents and half the session exploring current possibilities for change. The movement between contrasts can also occur moment by moment.

A therapist might, for example, inquire about where a particular belief comes from and then quickly ask, "How can we change that?"

To illustrate the difference between synthesis and moving through contrasts, consider a client who finds venting about his stressful week a reinforcer for coming to treatment. The therapist, however, experiences this behavior as interfering with adherence to the treatment. A synthetic approach would involve finding a middle ground—perhaps agreeing with the client that he can vent if he also incorporates problem-solving into the process, or relating venting to the current issue in treatment. Movement through contrasts might involve alternating sessions between venting and problem solving, splitting the sessions in half, etc. Doing opposite things is only problematic if one expects the process to be consistent (treatment is either about processing feelings, or about sticking to the manual). If dialectical tensions are expected and accepted, or even welcomed, doing a lot of two apparently contradictory things makes perfect sense. Finally, working within dialectical tensions may involve combinations of both synthesis and movement between contrasts. The key point is to avoid getting stuck and, instead, to recognize and accept the inevitable pulls one feels when working within a structured treatment.

**Examples of Working With Dialectical Tensions**

To help therapists work within tensions and avoid getting stuck, we devel-

■ Table 2. Examples of dialectical tensions

Tension	Getting Stuck	Getting Unstuck	
		Possible Synthesis	Moving Through Contrasts
▲Adhering to the manual versus ▼Flexibly adapting it to meet the needs of individual clients	▲Am I too focused on the uniqueness of this client and forgetting that the treatment works for a range of people with similar problems?  ▼Am I too focused on adhering to the manual and not allowing myself to modify it as I see necessary for this client?	▲How does the manual provide a general framework for treating this individual?  ▼What aspects of this particular client facilitate my use of the treatment manual?	▲How can I adhere to the treatment as much as possible?  ▼How can I flexibly modify the treatment as necessary?
▲Utilizing therapeutic techniques versus ▼Creating and maintaining a strong therapeutic alliance	▲Am I so concerned with adherence to the manual that I'm not attending to my relationship with the client?  ▼Am I so concerned with maintaining rapport that I'm not utilizing the techniques described in the manual?	▲What type of therapeutic alliance can I create with this client to facilitate using these techniques?  ▼How can using these techniques strengthen my alliance with this client?	▲How can I make sure to create the conditions for a strong alliance with my client?  ▼How can I make sure to implement effective techniques as described in the manual?
▲Believing in the treatment and expecting it to be helpful versus ▼Recognizing that my client may not improve as much as I would like	▲Am I feeling so much pressure for this client to improve that I am unwilling to accept his/her current level of progress?  ▼Am I so demoralized by the client's lack of improvement that I have stopped communicating belief in the treatment?	▲How does my client's level of improvement enhance my understanding of this treatment?  ▼How can I use my understanding of this treatment to better help this client and similar ones in the future?	▲How can I accept that this client may not improve as much as I would like?  ▼How can I maintain confidence in the treatment and convey this to my client?

oped a list of common dialectical tensions in manual-based treatments (see Table 2). For each tension, we provide examples of getting stuck and ways to get unstuck, including both syntheses and moving through contrasts.

A few comments about the list are in order. First, it is important to remember that the goal is not to remove tension from treatment. We assume that if one is going to try and adhere to a manual-based treatment and also "breathe life into it" (Kendall et al., 1998), challenging and creative tensions will inevitably emerge. Second, it is important to remember that the tensions in Column 1 are apparent opposites. They can be experienced as X versus Y, but often a therapist can do both by finding a temporary synthesis or moving through contrasts. Third, many of the items in the table are phrased as questions. We often find it helpful to ask ourselves questions like, Am I stuck in this treatment? What am I stuck between? How can I do both? Finally, the list is by no means exhaustive. It serves only to illustrate some of the many tensions one might experience in conducting a manual-based treatment.

### Case Study

To illustrate the value of Table 2 we'll use an example from the current caseload of a therapist being trained in manual-based treatment for panic disorder (Craske, Meadows, & Barlow, 1994). The client was a 42-year-old female meeting criteria for panic disorder with severe agoraphobia, current major depression, post-traumatic stress disorder, and past alcohol dependence. Despite the multitude of problems, she clearly identified panic disorder as the most distressing and the one she most wanted to work on. At the second session, the client reported being so depressed during the previous week that she had rarely left the house and had barely eaten. She also spent the majority of the session recalling numerous distressing events from the past, such as an assault 3 years previously, and the loss of a valued job. At this point, the therapist chose not to continue with the protocol because she felt that the client was too depressed and had too many problems to focus only on psychoeducation about panic disorder.

During group supervision, the first step was to ask the therapist what sorts of pulls in different directions she was feeling (Column 1 of Table 2). The therapist identified a tension between adhering to the protocol for treating panic versus focusing on the other comorbid problems. She also described a strong concern that the treatment might not be effective for a client with so many presenting problems. These

corresponded to tensions 1 and 3 in Table 2. Recognizing and accepting them in supervision fostered a discussion of possible strategies for working within them. The therapist identified that she did not want to change the therapeutic focus every session, nor did she want to ignore the other presenting problems. Recognizing the potential for getting stuck was the first step in developing an intervention strategy. In searching for a synthesis, the group tried to find a way that the therapist could maintain a focus on panic disorder, retain her confidence in the treatment, and recognize and communicate to the client her recognition of the severity of the client's concurrent problems. In this case, this involved the therapist regularly discussing with the client the goals of the current treatment. The therapist explained to the client that the treatment would focus on panic disorder and that she expected it to be an effective treatment for that problem (adherence to and confidence in the treatment). At the same time, the therapist recognized that the client was struggling with other problems and understood the desire to work on all of them (validating the client's perspective and developing an alliance). The therapist also emphasized that making changes in any problem requires a sustained effort and focus. Having the experience of working successfully on the panic disorder while putting other problems on hold temporarily would enhance the client's belief in her ability to make changes in her life, as opposed to being overwhelmed by a multitude of concurrent problems (using the specific treatment in service of broader goals).

This synthetic approach allowed the therapist to stay focused in treatment while acknowledging the breadth of the client's current problems. Alternatively, the therapist could have chosen to move through contrasts by alternating sessions between panic and other problems, splitting sessions in half, or any number of other strategies for both adhering to the treatment and attending to other concurrent problems. Of course, time is not unlimited and a therapist has to prioritize different interventions. Yet we suspect that, had we not highlighted the dialectical tension and searched for some sort of resolution, the therapist would have tried to treat all of the presenting problems at once and made little progress on any of them. If, on the other hand, we had simply emphasized adherence without recognizing the therapist's dilemma, we would have risked sacrificing rapport with the therapist and/or the client.

### Conclusion

Conducting a manual-based treatment in a flexible and artful manner requires therapeutic skill. An overarching dialectical perspective on the treatment process can help to illuminate inevitable tensions and suggest productive ways for working within them. This perspective highlights the interrelatedness of different therapeutic elements, the inevitable pulls in different directions a therapist will experience, and the ever-changing nature of the therapeutic process. Therapists can work within a dialectical context by either finding a synthesis between apparently contradictory options (How can I use opposites in service of each other?) or by moving through contrasts (It's okay, and often productive, to do opposite things). Whether training in and utilization of the dialectical perspective will foster better manualized intervention is ultimately an empirical question. In our training experience, it is this ability to maintain overarching therapeutic goals, while moving flexibly through numerous tensions, that distinguishes artful and effective intervention from rigid adherence to a protocol.

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