Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 2, Module 1, Article 3, pp. 1-5, 02-17-06 [copyright by author]

Commentary on Identifying and Targeting Idiosyncratic Cognitive Processes in Group Therapy for Social Phobia: The Case of Vumile

Evaluating Adherence and Flexibility in the Use of a Manual in Clinical Practice

WILLIAM C. SANDERSON [a,b]

[a] Department of Psychology, Hofstra University, Hempstead, NY
[b] Correspondence concerning this article should be addressed to William C. Sanderson, Department of Psychology, Hauser Hall, Room 227, Hempstead, NY 11549
Email: mailto: William.C.Sanderson@hofstra.edu

ABSTRACT

The value of the use of evidence-based treatment manuals in clinical practice has been a controversial topic within the field of clinical psychology. One of the most significant areas of debate surrounds the perception of how treatment manuals are used. Are they rigid treatment prescriptions, not to be deviated from, and as a result their use may lead the clinician to miss important idiosyncratic aspects of the client? Or, should they be used flexibly, insuring that clinicians apply the essential evidence-based treatment strategies, but at the same time allowing for modifications to address unique clinical aspects of the client? I examined the case description provided by Edwards and Kannan (2006) with an eye on the balance of adherence to the manual and clinical flexibility. Overall, there was an excellent balance of the two. However, there were several examples noted where adherence to the manual may have limited clinical flexibility. Ideally, sensitizing clinicians to these issues will increase their comfort in using manualized treatments and facilitate their use in the most effective way possible by allowing for clinical flexibility.

Key words: evidence-based treatment; treatment manuals; social phobia

---

INTRODUCTION

There has been much debate about the use of empirically-based treatment manuals in clinical practice (cf. Kazdin, 1998 for an introduction to a special issue of *Clinical Psychology: Science & Practice* on this topic). Perhaps the most significant area of contention relates to beliefs about the way in which manuals are applied. Those in favor of the use of manuals favor standardized therapy, rather than an idiographic approach, and note that integrity to a manual allows the clinician to deliver the most effective treatment for a specific condition/diagnosis (e.g., Wilson, 1998). On the other hand, there are those who are not in favor of manualized treatment, noting that this approach may lead to ignoring the unique needs of the client (e.g.,

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 2, Module 1, Article 3, pp. 1-5, 02-17-06 [copyright by author]

Garfield, 1996).

I have been an advocate for the use of empirically supported manualized treatments for quite some time (e.g., Sanderson, 1995; Bruce & Sanderson, 2004) and favor, as a general approach, implementing "treatment guidelines" to insure patients uniformly receive the best available psychosocial treatment (Sanderson, 2002). As a researcher, I have been involved in defining criteria for evidence-based treatments (Chambless, Sanderson, Shoham, Johnson, Pope, et al., 1996) and identifying their accompanying manuals to facilitate dissemination to practitioners (Woody & Sanderson, 1998). But my experience as a clinician has sensitized me to the necessity of manualized treatments being used in a flexible manner, when necessary, to allow unique clinical aspects of the client (i.e., those not anticipated in the manual) to be addressed (Sanderson & McGinn, 1997).

As a result, in my opinion, the best use of a manualized treatment in clinical practice lies somewhere in between. If an empirically-validated treatment exists for a particular problem, then a relevant client should invariably receive that treatment. However, if idiosyncratic clinical issues emerge in the course of therapy that are not covered in the manual, the clinician must be allowed flexibility to address these unique aspects. Optimal treatment will be achieved by striking a balance between providing the essential ingredients of an evidence-based manual while at the same time not overlooking unique aspects of the individual.

Edwards and Kannan's (2006) detailed case presentation provides an opportunity to evaluate the implementation of a manualized treatment in light of the issue presented above. Specifically, how well do they balance adherence to the manual with clinical flexibility. Adherence to the manual involves insuring that the core treatment strategies are utilized. Flexibility can be judged by the way the clinician addresses idiosyncratic aspects of the individual not anticipated by the manual. As will become clear, adherence to the manual does not necessarily preclude flexibility. In this paper, I will attempt to identify the coordination of adherence and flexibility, in addition to discussing where one was sacrificed for the other.

ANALYSIS OF THE CASE OF VUMILE

Overall, the case presented is an excellent example of the application of an evidence-based treatment manual for social phobia. The treatment was carried out in a group format.

Assessment. As is often the case with evidence-based treatments, detailed, structured assessment is a key component. In the present example the clinicians administer a clinical interview in addition to a range of self-report questionnaires. Adherence to the manual requires the use of these standard assessment methods for each client. Measures selected are those that are likely to be most relevant to individuals suffering from social anxiety. However, the information derived from the various assessment tools enhances treatment flexibility in that it provides a thorough understanding of the idiosyncratic features of the client. A qualitative examination of the questionnaires completed the by the client will allow the clinician to determine the specific thoughts, phobias, and other symptoms experienced by the individual.

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 2, Module 1, Article 3, pp. 1-5, 02-17-06 [copyright by author]

Another strength of a typical evidence-based treatment manual, demonstrated in this example, is the use of a post-treatment assessment battery, which increases the accountability of the clinicians. This allows them to determine the efficacy of their treatment. In addition, a qualitative review allows the clinicians to examine what changed and what did not, and thus, what should continued treatment be focused on.

Although the treatment was administered in a group format, the clinicians conducted an individual "pre-treatment interview" with each client. This allowed them to acquire unique information for each individual and develop an idiosyncratic case formulation based upon that information. This is an excellent example of introducing clinical flexibility into the standardized assessment.

Treatment. Of course, evidence-based treatments require the use of a manual spelling out the treatment strategies. The specific strategies contained in the manual are based upon the theoretical model for the development and/or maintenance of the disorder. In Section 3, the authors do an excellent job of elaborating a cognitive behavioral theory of social phobia, and then lay out how specific treatment strategies emanate from the theory. For example, the model posits that cognitive distortions maintain the disorder by generating anxiety in social situations. Thus, identifying and "correcting" cognitive distortions is a treatment strategy used to reduce social anxiety.

Treatment strategies are operationalized and the manual presents an order (treatment phases) in which strategies are to be employed. Adherence to the manual requires the use of specific strategies such as cognitive restructuring and exposure. However, the application of these strategies is in fact idiosyncratic – the thoughts or phobias addressed for one person are likely to be different from someone else, etc. For example, role-play exercises were conducted with each client. Flexibility of the manual allows each role-play situation to be selected by the client so that it is most relevant. Vumile role-played approaching a young woman at a party. Clinical flexibility is also illustrated during session seven, when Vumile expressed pessimism about his ability to change. The clinicians were able to set up a specific role-play to demonstrate that he was capable of making the desired changes.

Missed opportunities to demonstrate flexibility. As noted above, in many ways this case write-up is an excellent illustration of providing flexible clinical treatment while still adhering to a manual. However, I believe there are several examples worth noting where adherence to the manual presumably limited flexibility (and perhaps optimal treatment).

First, in Section 2 ("The Client") the authors note that as a child Vumile was hit with a belt, especially the metal buckle, and frequently received harsh corporal punishment, sometimes drawing blood. It was also noted that his parents had "violent quarrels." The presence of this information was not discussed further. In my opinion this information provides a compelling reason to break from the manual, at least slightly, to discuss this issue with the client. Specifically, did these experiences contribute to Vumile's social anxiety? Was he in fact fearful of others mistreating or abusing him rather than typical social anxiety content (i.e., fear of

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 2, Module 1, Article 3, pp. 1-5, 02-17-06 [copyright by author]

negative evaluation)? Is there any evidence of post-traumatic stress disorder (PTSD)from these early life experiences? Perhaps it would have been a dead end, but to not at least note the clinical significance of this information seems to suggest the clinicians were paying to close attention to the manual and missed important, unique information.

Second, the authors note that Vumile had the slowest response to treatment. Yet they do not offer a plan to deal with this rather than just doing more of the same. Apparently in this case that worked, however, it seems as though the slow response provided an opportunity to think about modifying the treatment to deal with whatever factors were identified as being responsible for the lack of response to treatment. How does one deal with refractory cases when the manualized treatment is not working? Clinical flexibility would be demonstrated if modifications to "treatment as usual" were made in the context of a poor response to treatment.

Third, it appears as though comorbidity was not taken into account. I have already mentioned the possibility of PTSD in the case of Vumile. How would treatment be altered if in fact this were relevant? Would this be ignored because it is not in the manual? Along the same line, it seems as though Vumile suffered from depression in addition to social anxiety. He noted that he felt "miserable" much of the time and had a moderate score on the depression inventory. As noted above, a concern about manualized therapies is that they encourage a narrow focus on treating the "disorder," and as a result, miss the full range of psychopathology. Clinical flexibility would be demonstrated if symptoms beyond the principal diagnosis were taken into account and treated. How would someone in the group who had both social phobia and depression be treated versus someone with social phobia alone? Over-adherence to the manual would treat them both the same. Clinical flexibility would allow for the treatment to be modified addressing the individual's depression as well.

Finally, the majority of manualized treatments have been developed by and tested on American and European Caucasians. Much less is known about how well these treatments generalize beyond those populations. On a positive note, this study provides evidence about the generality of the treatment. However, it seems as though it would have been a useful discussion to consider how this treatment may need to be modified to address individuals from other cultures. Specifically, what types of cultural issues are specific to Vumile that may be relevant to treatment but not included in the manual?

CONCLUSION

Edwards and Kannan (2006) are to be commended for bringing a treatment manual to life. They provide a richly detailed case description using a manualized treatment. I examined the case description with an eye on the balance of adherence to the manual and clinical flexibility. Overall, there was an excellent balance of the two. However, there were several examples noted where adherence to the manual may have limited clinical flexibility. Ideally, sensitizing clinicians to these issues will increase their comfort in using manualized treatments and facilitate their use in the most effective way possible by allowing for clinical flexibility.

Pragmatic Case Studies in Psychotherapy, http://pcsp.libraries.rutgers.edu
Volume 2, Module 1, Article 3, pp. 1-5, 02-17-06 [copyright by author]

REFERENCES

Bruce, T.J. & Sanderson, W.C. (2004). Evidence-Based psychosocial practices: The past, present, and future. In C. Stout & R. Hayes (Eds). *Evidence-based practice: methods, models and tolls for mental health professionals.* New York: Wiley.

Chambless, D.L., Sanderson, W.C., Shoham, V., Johnson, S.B., Pope, K., Crits-Christoph, P., Baker, M., Johnson, B., Woody, S.R., Sue, S., Beutler, L., Williams, D., McCurry, S. (1996). Update on empirically validated therapies. *The Clinical Psychologist, 49,* 5-15.

Edwards, D.J.A., & Kannan (2006). Identifying and targeting idiosyncratic cognitive processes in group therapy for social phobia: The case of Vumile. *Pragmatic Case Studies in Psychotherapy [Online]*, Vol. 2(1), Article 1. Available: http://hdl.rutgers.edu/1782.1/pcsp_journal

Garfield, S. (1996). Some problems associated with 'validated' forms of psychotherapy. *Clinical Psychology: Science and Practice, 3*, 218-229.

Kazdin, A.E. (1998). Treatment manuals in clinical practice: introduction to the series. Clinical Psychology: Science and Practice, 5, 361-362.

Sanderson, W.C. (1995). Can psychological interventions meet the new demands of health care? *American Journal of Managed Care, 1*, 93-98.

Sanderson, W.C. (2002). Why we need evidence-based psychotherapy practice guidelines. WebMD. Medscape General Medicine, *4* (4). http://www.medscape.com/viewarticle/445080

Sanderson, W.C. & McGinn, L.K. (1997). Psychological treatment of anxiety disorder patients with comorbidity. In S. Wetzler & W.C. Sanderson (Eds), *Treatment strategies for patients with psychiatric comorbidity* (pp. 75-104). Wiley: New York.

Wilson, G.T. (1998). Manual-based treatment and clinical practice. *Clinical Psychology: Science and Practice*, 5, 363-375.

Woody, S.R. & Sanderson, W.C. (1998). Manuals for empirically supported treatments: 1998 update from the task force on psychological interventions. *The Clinical Psychologist, 51*, 17-21.