Implications of the Empirically Supported Treatment Movement for Psychoanalysis

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In this article, I critique the *empirically supported treatment* (EST) movement and discuss the limitations of traditional psychotherapy research from a psychoanalytic perspective. The EST movement is based on a medical model that assumes that a psychotherapeutic treatment can be conceptualized independent of the human relationship in which it takes place. Psychotherapy and psychoanalysis are, however, treatments only in a metaphorical sense and are more akin to educational processes than medical treatments. Every therapeutic dyad is unique, and research that treats therapy as a standardized, disembodied entity will not contribute to our understanding. Nevertheless, there is a real need for psychoanalysts to become more actively involved in psychotherapy research both for political and scientific reasons. Although I do not believe that “empirical validation” in the form envisaged by the American Psychological Association task force is a realistic goal, I do believe in the value of microscopic studies of therapeutic process, particularly in the context of research-informed case histories.

Few if any Questions in Psychotherapy are of Greater Importance today and in the foreseeable future than the relationship among practitioners, researchers, and managed care. “Managed care” systems are really “managed cost” systems, their basic purpose being cost containment—that is, to conserve health care dollars as much as possible and to provide a rationale for an equitable distribution of public funds. As citizens and taxpayers, we must recognize the need for the development of a system that accomplishes this objective with

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a minimum of hardship to consumers, professionals, and the public purse. Given limited financial resources, the truth is that it probably cannot be done. What is already emerging and will become more sharply delineated in the coming years is a reemergence of the old two-tier system of medical care— that is, differential treatment of “private patients” and “clinic patients” or, in other words, a disjunction between “first-class” and “economy class.”

A good deal has been written about the allegedly conflicting interests of psychotherapy research and practice, the limited impact of research on clinical practice, and the manner in which the practicing therapist might make greater use of research findings (e.g., Talley, Strupp, and Butler, 1994). To be sure, in many ways, research in psychotherapy and the practice of psychotherapy are different enterprises; however, few would dispute that practice should be informed by empirical research, as research should be informed by practice. There is no simple, straightforward way to translate research findings into the consulting room, and no such direct translation should be expected. In my view, research exerts a more indirect and perhaps more subtle effect on the practitioner. For the moment, let it be noted that there need be no intrinsic animosity between practitioners and researchers, that each can profit from the other, and that both patients and society can profit from their mutual influence. Further, we need more collaboration between practitioners and researchers—a point to which I will return. On the other hand, I take exception to the manner in which research has been used, if not to say coopted, as a tool for justifying the rationing of therapeutic services and putting therapeutic techniques into a straitjacket. Let me elaborate.

When psychotherapy research came into being some 50 years ago, the driving force, as in any scientific discipline, was the search for knowledge, a better understanding of the therapeutic process, together with the isolation of the effective ingredients in psychotherapy. As a voluminous literature attests, notable progress has been made (for a brief summary, see Strupp and Howard, 1992). It also seems fair to say that research results have had a palpable effect on modifications of clinical practice.

Two or three decades later, voices began to be heard in public forums (e.g., the U.S. Senate) demanding greater accountability of practitioners. Licensing laws, eventually passed in all U.S. states, represented another step in that direction. Critics of psychotherapy (e.g., Eysenck, 1952) turned to empirical research to assess the utility and value of psychotherapy.
Organized psychoanalysis largely ignored and often deprecated empirical research as not worthy of their members' serious attention. The latter attitude has changed somewhat over the years, in the sense that analytically oriented therapists are now taking research more seriously, but, with relatively few exceptions, they have not become involved in systematic research themselves or sponsored such research (Luborsky and Spence, 1978). One of the difficulties is that research is no longer an activity that can be carried out in the practitioner's spare time. It has become an activity that requires commitment, training, and special skills.

The primary question that has been raised by an ever growing chorus of critics, legislators, and public policy makers relates to psychotherapy's effectiveness: Does psychotherapy work? When psychotherapy research got under way, this was certainly a reasonable question, and no one can take issue with the public's desire to be informed about this subject. As the voluminous literature of psychotherapy convincingly shows (cf. Smith, Glass, and Miller, 1980; Lambert and Bergin, 1994), this question has been dealt with in detail and depth by a growing cadre of researchers. What is troubling to the community of practicing therapists, as well as to researchers, is the monotonous manner in which the question continues to be raised. This state of affairs raises the strong suspicion that the questioners are driven by motives other than the quest for empirical demonstrations. What we are often dealing with, it seems to me, are political and ideological considerations that are largely impervious to empirical data: In this field, many people unfortunately continue to believe what they want to believe, and they don't want to be "confused" by facts.

**Treatment Manuals and Empirically Supported Treatments**

The latest version of this problem is the demand for *empirically supported treatments* (ESTs Task Force on Promotion and Dissemination of Psychological Procedures, 1995)—an objective that is rapidly producing what in my judgment is an unholy alliance between managed care organizations and hard-nosed researchers. Both groups seem to subscribe to the view that at some future date it may be possible to reduce the practice of psychotherapy to highly specific procedures that
can be set forth in treatment manuals and followed with great precision. Further, the view is gaining ground that treatments should be empirically validated or supported by empirical evidence. In the following discussion, I explore some of the implications of the EST movement for the practice of psychoanalysis and, more broadly, for psychoanalytic psychotherapy.

The EST movement may be traced to the appearance of so-called treatment manuals in the 1970s and 1980s. They came into existence for several reasons, including (a) to provide more specific descriptions of particular treatments, (b) to aid in the training of therapists, and (c) to standardize particular treatment approaches. 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) have now been delineated more precisely, and greater attention is being paid 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 criteria for measuring a therapist's "adherence" to a particular approach. In short, manuals have aided researchers in arriving at improved specifications of the "independent variable" in therapy. Thus, they 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 increasing adherence to a therapeutic approach, training manuals may enhance outcomes (Beutler, Machado, and Neufeldt, 1994). Further, Rounsaville et al. (1988) presented evidence that manuals tend to accelerate the pace of therapist training. My Vanderbilt University research team and I have endeavored, in a series of studies, to assess the effects of training in time-limited dynamic psychotherapy (TLDP). Crits-Christoph and Mintz (1991) found that manuals are useful in significantly decreasing variance attributable to therapists (and therefore in increasing researchers' ability to infer that differences in outcome are attributable to the different therapeutic modalities being investigated). In a meta-analysis covering the past 20 years, they discovered that training manuals had significantly decreased the variability of the therapist as a contributor to the variance in outcome.
However, a manual is not the treatment, and, even under favorable circumstances, it can provide no more than a crude outline of principles and techniques, which largely leave out of account individual differences between therapists and patients. These differences may be of far greater consequence for process and outcome than the proponents of manuals generally acknowledge. Admittedly, there are considerable differences between, say, cognitive-behavioral and psychoanalytic therapy, but the quality of the patient-therapist relationship is very likely a function of interacting factors that cannot readily be spelled out in a manual, at least not in the way currently envisaged.

**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. They are useful as a method for outlining general principles, as a methodological tool in research, and as “training wheels” for learning a new therapeutic approach. Nonetheless, fundamental questions remain. First, can a psychotherapeutic approach be stringently described in a manual? Second, is it possible to standardize the behavior of a therapist by providing trainees with specific instructions concerning the implementation of the treatment?

**Treatment Manuals and the EST Movement**

The appearance and ready acceptance of treatment manuals was soon followed by the empirically supported treatment (EST) project, which almost predictably became the logical successor. The driving force behind this emerging movement was “obviously financial and territorial” (Bohart, O'Hara, and Leitner, 1998, p. 142), based on a “simplistic analogy to medicine and use of the ‘drug metaphor’” (Stiles and Shapiro, 1989). Further, it was a clear-cut attempt to cater to the managed care industry, which has rapidly become the dominant force regulating the practice of psychotherapy.

In creating an EST Task Force, the Division of Clinical Psychology of the American Psychological Association envisaged the following major components:
1. Establishment of criteria for designating specific effective treatments for specific problems.
2. Generation of two lists of ESTs for specific problems: “well-established” and “probably efficacious.”
3. Dissemination of lists of ESTs to Ph.D. programs and predoctoral internships in clinical psychology.
4. Incorporation of ESTs into guidelines for accrediting doctoral training programs and internships in clinical and counseling psychology.

No sooner were the lists of “well-established” and “probably efficacious” programs promulgated did a lively controversy ensue between supporters and opponents of the project (see the special issue of Psychotherapy Research, 1998, Vol. 8, No. 2). Supporters judged the task force to have rendered a great service to the field; opponents regarded the EST movement as a politically inspired exercise, the ultimate goal of which is to denigrate the practice of psychotherapy, particularly of psychoanalysis and of the various forms derived from that model. Although the debate is far from over, it behooves practicing therapists to acquaint themselves with the issues that are already having a bearing on clinical practice and that will increasingly influence.

Growth Versus Treatment

There is a basic difference between contemporary forms of psychotherapy—particularly the time-limited or “brief” variety—and psychoanalytically oriented, time-unlimited treatment. The former typically follows the “medical model,” whereas the latter, which usually calls for a considerable investment of time and effort, embraces an educational one. For reimbursement purposes, regrettably, the medical model is the only one that is “officially” recognized. It is based on the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th ed.; American Psychiatric Association, 1994) nomenclature and starts with the conception of psychotherapy as a (medical) treatment for a (psychiatric) illness.

It is important to recognize that the medical model and the educational model subscribe to divergent goals. The former is primarily geared to symptom relief, whereas the latter has as its basic objective personality growth consequent on the alleviation of unconscious
conflicts and/or the modification of internal structures through constructive relational experiences. In keeping with the foregoing distinction, there must be palpable differences in the kinds of changes each approach seeks to achieve. Similarly, the outcomes of the two approaches must be assessed by very different criteria. This, I believe, is one of the reasons why symptom relief requires a yardstick very different from that used for personality change. Failure to recognize this difference has contributed markedly to the reigning confusion in the field.

Having participated in the creation of a treatment manual (Strupp and Binder, 1984) and having engaged in extensive research aimed at assessing its potential and limitations (Strupp, 1993; Henry, Schacht, et al., 1993; Henry, Strupp, et al., 1993), I have emerged with the conviction that manuals can be of value but that they will remain of limited value (Strupp and Anderson, 1997). I base this conclusion on the findings of my research group, on accumulating research evidence, particularly research addressed to the therapeutic alliance (Horvath and Greenberg, 1994), and on the following considerations:

1. Irrespective of its theoretical underpinnings, psychotherapy is anchored in, and is fundamentally inseparable from, a human relationship. Thus, whether or not relationship variables are specifically conceptualized as critical to the process and outcome of therapy, they are undeniably an integral part of the therapeutic enterprise.

2. Accordingly, psychotherapy is a treatment only in a metaphorical sense, and it is closer to education—to learning and unlearning—than to medical treatment, specifically drug treatment.

The dilemma faced by researchers, practitioners, and insurance carriers is the foregoing incompatibility between the medical model subscribed to by the managed care companies and implicitly by the EST Task Force and the educational model more appropriate to open-ended psychoanalytic treatment. The EST movement thus “buys into” a variety of assumptions that are problematic from a psychoanalytic perspective—for example, that consumers of psychotherapy suffer from conditions that are characterized as “psychiatric disorders,” which call

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1 Freud called it an “after education.”
for medical “diagnosis”; that psychotherapy as a form of healing, is akin to medical treatment; that many conditions for which psychotherapy is prescribed are the outcome of both biological and developmental defects; that the only acceptable model (in our society) for treating these conditions is the medical model; and therefore that the outcomes of psychotherapy are perforce measurable only in terms of symptom changes.

To be sure, there are measures, rating scales, and so forth that go beyond symptom reduction and that are focused on a person's life functioning and well-being. But, in our time, these are accorded scant attention, and for good reasons—symptom changes are incomparably easier to achieve and to measure than are emotional well-being, quality of life, contentment, inner peace, self-esteem, and the like (cf. Strupp and Hadley, 1977). Yet, psychotherapy at its best can lead to changes in these domains. But we also know that in most instances the latter cannot be brought about in 4, 6, 15, or even 30 hours of therapy. A majority of well-trained and experienced therapists are accustomed to think more realistically in terms of months and, not uncommonly, years.

In this era of cost-containment, managed care, downsizing, and the emergence of ever briefer forms of psychotherapy, it is almost sacrilegious to advocate a sober examination of what our field may be sacrificing in this process. However, it is one thing to recognize that, in the face of a shrinking health care economy, we must accept more or less severe restrictions on our professional activities—and quite another matter to create the impression (to the field, the public, and the managed care companies) that the outcomes of brief or time-limited forms of psychotherapy are fully comparable with, perhaps even superior to, more intensive or extended forms.

Our profession, including notably researchers, has contributed materially to what I consider a misinterpretation or inadequate recognition of clinical realities. For example, patients frequently recover relatively rapidly from, say, a single depressive episode, but this says little about relapse or recurrence. I am not suggesting that longer term or more intensive therapy can regularly lead to stupendous achievements, but it is a clinical fact that (a) many patients suffer from long-standing disorders (including personality disorders) that do not readily yield to short-term psychotherapy and (b) numerous patients, though not incapacitated, say, in the work area but significantly impaired in their interpersonal relations and enjoyment
of life, can be substantially helped by more extensive forms of psychotherapy in which reconstruction of the personality is the aim. Part of the problem lies with the character of the outcome assessments that are insufficiently comprehensive and/or insufficiently sensitive to more subtle aspects of human functioning.

A related problem is the quality of psychotherapists. Just as the quality and extent of therapy have become blurred by sociopolitical and economic issues, so have the quality of practitioners and the extent of their training, which in many instances has become diluted. Research studies are frequently cited in support of the contention that clinical training and skills are inconsequential and perhaps largely expendable (Dawes, 1994). Based on our research at Vanderbilt University involving the intensive study of psychotherapists before, during, and after training in time-limited dynamic psychotherapy, we have adduced evidence that (a) therapeutic skills are not easily acquired and perfected, (b) there are marked individual differences in competence, even among therapists who have undergone specialized training, and (c) many differences between therapists judged competent and less competent are subtle and hence extremely difficult to measure.

There is little doubt that managed care companies and various groups, primarily within organized psychology, are attempting to prescribe forms of psychotherapy that are analogous to painting by number. In my judgment, such a program is ultimately doomed to failure. As I see it, and as research has demonstrated, every patient-therapist dyad is more or less unique. Thus, the quality of its interaction is determined less by the formulations found in a manual than by the therapist's personal qualities and skills as well as by the manner in which these interact with the patient's ability and motivation to collaborate with the therapist. Every therapeutic encounter, therefore, if it is to be successful, is a creative endeavor that calls for a good deal of improvisation, sensitivity, and tact on the part of the therapist and willingness to collaborate on the part of the patient.

Empirical validation of any form of psychotherapy cannot be or should not be the goal at this juncture. Given the uniqueness of every therapeutic dyad and the multitude of relevant interacting variables influencing the course of treatment, the “empirical validation” of any therapy is utterly illusory.

This state of affairs does not preclude the possibility of training therapists to an acceptable level of clinical and interpersonal skills. In that endeavor, therapy manuals can play a useful role as long as their
limitations are recognized. What classroom training, supervision, and personal therapy can provide is a general framework of principles and techniques that can be used productively in conjunction with improvisation.

We must continue to ask: What can open-ended, skillfully delivered psychoanalysis and psychoanalytically oriented psychotherapy provide that renders them superior to short-term or time-limited therapies? Have there been convincing demonstrations? The answer, at this point, is in the negative. In fact, several studies in the research literature (e.g., Strupp and Hadley, 1979), if interpreted literally, lend no support to the importance of therapists' technical skill. If long-term psychoanalysis indeed leads to genuine changes that are more than transient, it is incumbent on the advocates of this modality to adduce empirical data that support such claims.

Analysts have traditionally viewed empirical research with a good deal of skepticism, and they have seen no need to demonstrate, even within the context of clinical case histories, that sustained therapeutic efforts lead to impressive treatment outcomes. To put the blame, as the critics are wont to do, on imperfect measuring instruments, the intractability of patients' problems, or other technical difficulties is no longer acceptable. Analysts cannot be expected to become dedicated researchers; they do not have the requisite training and research skills and, above all, the commitment to engage in the arduous study of microevents in therapy. However, unless and until they do, they can no longer sustain the claim that “special” rules of evidence apply to psychoanalysis and psychoanalytic therapy. There is thus a critical need for a change in the psychoanalytic culture in the direction of a greater interest in psychotherapy research as well as a need for serious and sustained collaboration between clinicians and researchers. In sum, if intensive psychotherapy can lead to personality changes that are not obtainable in other ways, its practitioners must invest the same serious effort in collaborative research that they are accustomed to invest every day in therapeutic work with their patients.

Concluding Comments

The Future of EST

The EST movement is bound to stay and to gain momentum. Apart from attention to cost containment, insurance reimbursement, and political pressures, there is a very real need to strengthen the empirical
and scientific foundation of psychotherapy. This means intensified effort for further research, together with an increased realization that all studies are imperfect and that progress will be slow. However, the past half-century has demonstrated that progress is possible—as a result of which we now have a better understanding of psychotherapy, its processes, and its outcome.

The dangers for the field are to jump on the bandwagon of “easy solutions” and to fail or be unwilling to recognize that, despite a deficient empirical base, we must continue to explore presumed differences between short-term and long-term psychotherapy, therapy practiced by novices versus experts, and the like. We must also become more keenly aware that long-term intensive therapy pursues goals very different from those of the short-term practitioner.

Treatment manuals, too, are here to stay, and they can be useful as long as their limitations are recognized and as long as they don’t displace thorough training and the acquisition of therapeutic skills. Above all, we must keep in mind that the manual is not the treatment.

As I have suggested, it is highly unlikely that, at any time in the foreseeable future, a particular psychotherapy can be “empirically validated” in the sense that the task force envisaged. A major reason is that the practice of psychotherapy is far too intricate and complex to be reduced to numbers and formulas. Indeed, therapeutic practice is unthinkable without a substantial amount of improvisation and creativity as well as a clear recognition that psychotherapy is firmly based on the existence of a specialized human relationship. Kiesler (1966) already recognized that patients and therapists are not interchangeable units (the “uniformity myth”) and that each dyad has unique features. As pointed out by Elkin (1999), one of the foremost researchers in the area, psychotherapeutic treatments as known today are not “disembodied entities,” and pretending that they are will not aid progress.

The Psychoanalytic Response

Over the years, psychoanalytically oriented practitioners have given scant attention to the need for adducing hard empirical data in support of their theoretical formulations and technical interventions. Like it or not, psychoanalytic therapists must play the “science game” by the same rules of evidence as anyone else, and they must desist from overly fanciful theorizing and from ignoring the need for empirical research.
In the quest for scientific progress, researchers must collaborate with clinicians, difficult though such collaboration may be at times. Research in psychotherapy has contributed valuable knowledge during the past half-century. Despite the fact that many research results are far from being directly applicable to practice, they have subtly influenced the practitioner's thinking in the field. Perhaps this is as much as can be expected from a young scientific discipline.

The Research-Informed Case History as a Compromise

The EST movement is beginning to exert a powerful influence in the direction of systematic research addressing therapeutic process and outcome. Although I do not believe that “empirical validation” as currently promoted is a realistic goal, there is no doubt that much can be learned from microscopic studies of the therapeutic process, particularly in the context of research-informed case histories.

The research design most highly valued by investigators is the randomized clinical trial (RCT), which has been followed in a number of studies. Without dwelling on the pros and cons of RCT, it may be said that it makes stringent demands on the investigator and that assembling appropriate samples is both difficult and accordingly expensive. Although large-scale studies are called for, few have been carried out.

As an alternative, my research group at Vanderbilt, following a proposal by Soldz (1990), has carried out a number of $N = 1$ studies in which individual cases were selected for intensive study from a larger database collected under controlled conditions. The therapeutic process in these cases was studied by means of various rating scales including the Structural Analysis of Social Behavior System (Benjamin, 1974), aided by careful, naturalistic observation. Whereas the RCT design rises or falls with one's ability to find between-groups differences that are statistically significant, the research-informed approach

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2 One example is the consistent finding that the quality of the therapeutic relationship contributes more to the outcome variance than to the specific treatment approach being practiced. Although the EST Task Force ignores this rather robust finding, it has, I believe, contributed to the documented movement toward eclecticism among practicing clinicians.
focuses on intensive study of the therapeutic process while giving freer rein to the investigator's powers of observation. There remains a great deal to be learned from this form of refined, naturalistic observation; conversely, the time is not ripe for large-scale studies along the lines of those recommended for randomized clinical trials.

It is essential for practitioners and researchers to acquire greater knowledge about the other's methodologies and to approach the efforts of their counterparts with respect and an open mind. History has shown that this is harder than it may appear. To the extent that this type of open dialogue and mutual influence can take place, however, it will increase the likelihood of conducting research that captures the subtlety of the therapeutic process and demonstrates the benefits of skillfully delivered open-ended psychoanalysis. It will also increase the likelihood of conducting research that has more of an impact on the development and refinement of psychoanalytic theory and practice.

In the meantime, practitioners should insist on thorough academic preparation and appropriate clinical experience for their students. Unfortunately, there are indications that training is continually being diluted as various shortcuts are advocated. However, even in the absence of hard empirical data, I believe we know enough to assert that psychotherapeutic practice demands considerable skill that, like those of any craft, must continually be maintained and honed.

References


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