

Effects of Training in Time-Limited Dynamic Psychotherapy: Mediators of Therapists' Responses to Training

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Sixteen therapists were enrolled in a year-long manualized training program as part of the Vanderbilt II study of time-limited dynamic psychotherapy (TLDP). The training program successfully changed therapists' interventions in line with prescriptions of the TLDP manual, but some unanticipated changes ran counter to the intent of the training, including increased negative interpersonal transactions as indicated by process measures such as the Structural Analysis of Social Behavior (SASB). We examined therapist variables, patient variables, and training variables that appeared to mediate therapist responses to the training program. Results indicate that patient difficulty may mediate certain aspects of therapists' responses to training. Therapists with self-reported hostile and controlling introjects showed the greatest technical adherence, which was intriguing because prior research has linked hostile therapist introject to greater frequency of countertherapeutic interpersonal process. Of special interest were differences in effects of training associated with individual training faculty. This finding, if generalizable, has important implications for manualized therapy research, especially multisite trials.

The 5-year Vanderbilt II project examined the effects of 1 year's training in a manualized form of dynamic psychotherapy (time-limited dynamic psychotherapy [TLDP]; Strupp & Binder, 1984) on 16 experienced therapists across 80 cases. Because of the increasing use and acceptance of treatment manuals in psychotherapy research, a primary aim of the study was to explore the process of manualized training itself. A number of therapist behaviors in different domains were measured pre- and posttraining, with therapists serving as their own controls. Thus, the design focused on the effects of training in a single treatment manual rather than comparing the differential outcome efficacy of several competing protocol therapies.

Analyses of therapist changes at the group level revealed both intended and unintended results (Henry, Strupp, Butler, Schacht, & Binder, 1993). The training program successfully changed therapists' technical interventions in line with prescriptions in the TLDP manual. Therapists showed significant increases in interventions, such as focusing the therapeutic process on in-session transactions and the articulation of cyclical maladaptive interpersonal patterns (CMPs). However, other changes were unexpected and ran counter to the intent of the training. These included an increase in negative interpersonal transactions as reflected by such process measures as the Struc-

tural Analysis of Social Behavior (SASB) and the Vanderbilt Psychotherapy Process Scale (VPPS).

These group data, although presenting a picture of the overall effects of a manualized training program, mask considerable variation in individual responses to training. The study of individual therapist effects has only recently emerged as an issue in therapy outcome research (Crits-Christoph & Mintz, 1991). The corresponding issue in training research (i.e., individual therapist differences in skill acquisition) has received scant attention (Alberts & Edelstein, 1990). Accordingly, our study continues our exploration of the process of manualized training by examining variables mediating the observed behavioral changes that occurred in response to training. Potential mediating factors were grouped as follows:

1. *Training variables:* The growing emphasis on treatment manuals as a prerequisite for psychotherapy research reflects an understandable desire to standardize the "treatment variable." However, a standardized protocol must still be taught and overseen by different and presumably nonstandardized supervisors. The potential effects attributable to individual trainers may be a particular problem for multisite trials. The Vanderbilt II design offered the opportunity for a particularly stringent exploration of trainer effects caused by the standardization of most of the other aspects of training. The two trainers jointly authored the treatment manual and codeveloped the training format. Therapists were trained in the same physical location, saw carefully selected training cases, and were exposed to the same audio- and videotaped vignettes as part of their initial training. Thus, we examined the effects of *teaching style* on changes in therapists' technique given a standardized treatment manual. Given the scant research on training, we felt that it was important to study not only what to teach but how to teach it.

2. *Therapist variables:* Treatment manuals seem destined to move from limited use in major psychotherapy research proj-

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This study was supported in part by National Institute of Mental Health Research Grant MH-20369, "Effectiveness of Time-Limited Dynamic Psychotherapy," to Hans H. Strupp.

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ects to more widespread implementation as instructional texts. Therefore, it is important to begin to explore how therapist personal variables, particularly those related to previous training and competence, may influence their responses to manualized training. We were especially interested, from a theoretical standpoint, in the possible role of therapists' intrapsychic structure. Prior research has shown that therapists with certain self-hostile introjects engage in greater frequencies of countertherapeutic interpersonal process, such as complex communication (Henry, Schacht, & Strupp, 1990). In our earlier article (Henry, Strupp, Butler, Schacht, & Binder, 1993), we reported a significant increase in complex communications at the group level after training. Accordingly, we wanted to explore whether the posttraining increase in complex communications was caused by a subset of therapists based on introject quadrant.

3. *Patient variables:* TLDP was originally developed, in part, to help therapists work more productively with difficult patients whose behavior and attitudes threaten the therapeutic alliance. Thus, an examination of technical changes as a function of patient difficulty is central, particularly because some research has suggested that technical adherence declines with difficult patients (Rounsaville, O'Malley, Foley, & Weissman, 1988). A significant increase in general dynamic technique or interviewing style was expected for the low-potential patients because interviewing style reflects more general alliance and communication variables often impaired in more difficult patients. A corresponding improvement with high-potential patients was not necessarily expected. Because specific TLDP technical strategies are less confounded with variables reflecting patient difficulty, we expected no differential TLDP adherence changes related to patient difficulty. As noted, however, some previous research has reported reduced technical adherence with more difficult patients.

Method

Subjects

Therapists. Psychotherapists were licensed psychologists ($n = 8$) and psychiatrists ($n = 8$) recommended by senior colleagues who typically had been their teachers. Ten were men, 6 were women, and all were White. All therapists had at least 2 years of full-time postinternship or postresidency clinical experience and were in private practice ($M = 5.6$ years, range = 2–14). As part of their previous training, most therapists had received instruction and supervision in psychodynamic principles and techniques but had no formal specialized training in short-term dynamic psychotherapy. Each therapist's interpersonal history was assessed via the INTREX questionnaire based on the Structural Analysis of Social Behavior (Benjamin, 1983). The introject portion of the INTREX measures how individuals act toward themselves at best and at worst in terms of affiliation (self-loving vs. self-hating) and control (self-controlling vs. self-freeing). Therapists were categorized on the basis of their introject at worst¹ and fell into three quadrants: Quadrant 2 (self-rejecting and neglecting; $n = 5$), Quadrant 3 (self-indicting and oppressing; $n = 4$), and Quadrant 4 (self-managing and cultivating; $n = 7$).

Patients. Patients were selected from individuals responding to advertisements for low-cost psychotherapy. All patients had interpersonal difficulties judged suitable for a TLDP approach, and none were considered to be in need of an alternate treatment such as drug therapy or hospitalization. Diagnoses, based on the third edition of the *Diagnostic*

and Statistical Manual of Mental Disorders (American Psychiatric Association, 1980), were assigned by a trained interviewing clinician using the computerized version of the NIMH Diagnostic Interview Schedule. Eighty-seven percent of the patients received an Axis I diagnosis and 67% received an Axis II diagnosis, with all patients qualifying for at least one Axis I or Axis II diagnosis. The pre- and posttraining patient samples did not differ significantly on any measure assessed at intake (e.g., symptom status, global functioning, etc.). The mean Global Severity Index *T*-score (outpatient norms) from the SCL-90-R (Derogatis, 1983) was 48.1 ($SD = 5.8$). The mean age of patients was 41 years ($SD = 10.4$), 77% were women, and 95% were White. A total of 84 patients began the study, and 4 dropped out before the fifth session and were not included in the analyses. The mean number of sessions was 21.4 (range = 5–25, $SD = 6.1$).

Patients accepted into the project were assessed for their relative potential for participating effectively in dynamic psychotherapy using the Capacity for Dynamic Psychotherapy Scale (CDPS; Thackrey, Butler, & Strupp, 1985). The CDPS is composed of nine items, with each rated 1–5, and was designed for use by interviewing clinicians or independent raters. It measures a patient's willingness and ability to collaborate therapeutically in addressing problems of an affective and interpersonal nature. Capacities assessed include introspection, insight, verbal fluency, ability to experience affect and discriminate the components of interpersonal events, and the quality of the relationship offered to the therapist. Each therapist was assigned one patient whose capacity was above the median, one who was rated below the median in both the pre- and posttraining phases, and one below-median case during the training phase. Except for this stratification, the patient assignment process was random. The pre- and posttraining patient groups had identical mean CDPS scores (32 out of a possible range of 9–45), and therapists did not differ significantly in the average difficulty of their caseloads.

Training. Training lasted for approximately 1 year and consisted of weekly 2-hr training sessions that were audiotaped for research purposes. Four groups of 4 therapists each were formed randomly. Two senior members of the project staff (hereafter referred to as Trainer A and Trainer B), each trained two of the four groups of therapists using a basic curriculum developed jointly by the research team as a whole. Therapists first received didactic lectures on TLDP principles and techniques, accompanied by readings in the treatment manual, which had been jointly authored by the two senior trainers. All technical aspects of TLDP (e.g., initial assessment, formulation of a CMP, analysis of resistances, interpretations, termination) were illustrated by clinical examples drawn from transcripts and audio- or videotapes. Next, each therapist received small-group supervision while treating a training case. Audio- and videotaped recordings of the training cases were discussed in detail by the trainers to highlight differences between the therapists' usual approach and TLDP. Training groups were terminated when all members had completed supervised treatment of their training cases.

Measures. The effects of the training program on therapists' behavior were assessed with two independently rated process scales: (a) the Vanderbilt Therapeutic Strategies Scale (VTSS; Butler, Henry, & Strupp, 1992), which comprises two subscales: Interviewing Style (IS), which measures the quality of general psychodynamic technique, and Specific Strategies (SS), which measures specific adherence to the TLDP protocol; and (b) the SASB (Benjamin, 1974), which measures moment-by-moment interpersonal process using a circumplex sys-

¹ Introject at worst was chosen because, rated "at best," all therapists reported similar introject states in Quadrant 4 (self-managing and cultivating).

tem.² Raters who were independent of the research team, unfamiliar with the training status of the therapists, and unaware of the study's hypotheses were used to rate third-session process on both instruments. Further details of the process measures and rating and reliability procedures are reported in Henry et al. (1993).

Results

Training Group Differences

A check for possible pretraining differences between the groups of Trainers A and B on interviewing style and specific strategies (or TLDP adherence) was made as an initial step. Between-groups *t* tests revealed no significant pretraining differences. Effect sizes (raw change divided by pretraining standard deviation) were then calculated for each training group for interviewing style and specific strategies change.³ Raw score means, standard deviations, and effect sizes are reported in Table 1. Effect sizes indicate that Group 1 showed much higher levels of change and that this effect was more pronounced with their low-potential patients.

To evaluate statistical significance of these differences, two 2 × 2 repeated measures analyses of variance (ANOVAs; Pre- to Posttraining × Training Group; within-cells *df* = 14) were performed, treating the pre- to posttraining variable as a within-subjects repeated measures observation of the therapist (see Table 2). Results for the interviewing style variable indicate a significant overall increase pre- to posttraining, $F(1, 14) = 6.22$, $p < .03$, but insignificant effects of training group, $F(1, 14) = 0.09$, and an insignificant interaction for differential change by training group, $F(1, 14) = 2.7$, $p < .12$.⁴ TLDP adherence (as measured by the SS) increased significantly from pre- to posttraining, $F(1, 14) = 26.07$, $p < .000$, and also showed overall differences by training group, $F(1, 14) = 6.24$, $p < .03$, as well as differential pre- to posttraining change by training group, $F(1, 14) = 13.3$, $p < .003$. The significant interaction effect, coupled with an examination of means and effect sizes, indicated that the bulk of the overall training effect (in terms of technical adherence) was accounted for by only one of the training groups.

Exploratory item analyses of the nine SS items were performed to investigate whether the Group × Time interaction was a general phenomenon or based on several specific items. A similar 2 × 2 repeated measures ANOVA was performed for each item ($N = 16$).⁵ Significant differences (Time × Group interaction) were obtained on five of the nine items covering a number of core TLDP techniques. These results indicate that the training group differences were broad and not due to differential adherence in a narrow technical domain.

Effects of Therapist Variables

A number of therapist variables⁶ were examined for their relation to training response as measured by posttraining IS and SS scores as well as residual IS and SS change.⁷ Between-groups *t* tests revealed no significant differences in posttraining IS and SS scores or residual IS and SS change as a function of either therapist sex or professional affiliation (MD vs. PhD). However, previous training and existing competence (prior to training)⁸ did correlate significantly with posttraining changes

(see Table 3). Existing competence was strongly related to positive changes in dynamic interviewing style, even after the effects of initial level of IS were removed, $r = .58$, $p < .01$. More hours of previous supervision were associated with less technical adherence to the TLDP model, as measured by the SS scale ($r = -.48$, $p < .06$). Interestingly, the correlation matrix indicated that hours of previous supervision had a stronger negative effect on technical changes as compared with years of experience per se.

Two simultaneous multiple regressions using hours of previous supervision and pretraining competence as predictors (years of experience was dropped as a predictor when preliminary regressions revealed insignificant contributions to the equations) and IS residual change and SS residual change as the criterion variables were significant, $F_s(2, 13) = 10.13$ and 4.66, $p_s < .003$ and .03, respectively. Both predictors had significant beta weights in both regression equations that accounted for 65% of the variance in IS residual change ($R = .81$) and 46% of the variance in TLDP adherence ($R = .68$). These results indicate that both pretraining competence and amount of previous supervision contributed independent variance in predicting technical changes after training.

To investigate the effects of therapists' intrapsychic structure on training responses, we performed two ANOVAs using introject quadrant as the independent variable, amount of residual IS and SS change as the dependent variables, and training group as a covariate. Therapists with self-indicting Quadrant 3 introjects showed the greatest residual change in IS (Quadrant 2 = -13.94, Quadrant 3 = 38.58, and Quadrant 4 = -12.44), but the difference failed to reach significance, $F(2, 14) = .84$, *ns*. Similar but significant results were obtained, with specific TLDP technical adherence being highest among the Quadrant 3 therapists (Quadrant 2 = -14.73, Quadrant 3 = 43.89, Quadrant 4 = -14.56), $F(2, 12) = 4.54$, $p < .04$.

² The Vanderbilt Psychotherapy Process Scale (VPPS) used in our previous study (Henry et al., 1993) was not included in these analyses because of the failure to find statistically significant pre- to posttraining differences at the subscale level.

³ Because of between-groups pretraining differences in standard deviations in much of the data reported in this article, we report effect sizes in two ways: a separate effect size based on each individual training group's standard deviation and a pooled effect size based on the two groups' combined standard deviation.

⁴ The between-groups difference in pooled effect size was nonetheless striking (1.20 vs. 0.25).

⁵ Because of the exploratory nature of item analyses performed in this study, we did not correct for familywise error rate, in concordance with the advice of several statistical experts. However, it should be noted that using the adjusted alpha of .006 would not alter the interpretation of these analyses.

⁶ Initial analyses indicated that the two training groups were statistically equivalent on all therapist variables explored in this section.

⁷ Residual change was calculated by removing the variance from the post- minus pretraining raw change scores that was accounted for by the pretraining score.

⁸ Competence was rated on a 1–5 Likert-type scale by the training supervisors on the basis of their impression of the therapist's general therapeutic skill prior to time-limited dynamic psychotherapy (TLDP) training and independent of the use of TLDP specific techniques.

Table 1
VTSS Group Means Pre- and Posttraining

Source	Pretraining		Posttraining		Group effect size	Pooled effect size
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>		
Interview style						
Grand mean	296.0	51.8	333.5	61.4		0.72
Training Group 1	280.0	48.2	342.2	66.4	1.29	1.20
Training Group 2	312.1	53.4	324.9	59.3	0.24	0.25
High CDPS	301.7	80.9	330.1	71.0	0.35	0.55
Low CDPS	289.6	41.7	337.0	77.6	1.14	0.91
Group 1 high	290.9	68.9	327.2	77.6	0.53	0.70
Group 1 low	269.1	40.0	357.2	74.5	2.20	1.70
Group 2 high	312.5	94.9	332.9	69.0	0.21	0.39
Group 2 low	313.1	31.3	316.8	80.1	0.12	0.07
TLDP adherence (SS)						
Grand mean	113.2	21.5	153.0	42.2		1.85
Training Group 1	112.9	19.1	181.2	35.3	3.58	3.18
Training Group 2	113.4	25.0	124.8	27.4	0.46	0.53
High CDPS	117.6	35.9	147.2	40.9	0.83	1.38
Low CDPS	109.3	17.6	158.8	51.1	2.82	2.31
Group 1 high	119.3	34.4	173.7	34.8	1.58	2.53
Group 1 low	106.6	11.1	188.8	48.4	7.41	3.82
Group 2 high	115.9	39.6	120.7	27.7	0.12	0.22
Group 2 low	112.4	23.6	128.8	34.6	0.69	0.76

Note. VTSS = Vanderbilt Therapeutic Strategies Scale; CDPS = Capacity for Dynamic Process Scale; TLDP = time-limited dynamic psychotherapy; SS = Specific Strategies scale.

To explore the relation between therapist introject and the problematic posttraining changes in interpersonal process noted by Henry et al. (1993), we performed four one-way ANOVAs, with the therapist introject quadrant as the independent variable. Raw and residual pre- to posttraining changes in both the frequency and percentage of complex communications as measured by the SASB were the dependent variables.⁹ The level of specific posttraining TLDP adherence was used as a covariate in order to remove the potential confound caused by the fact that therapists with different introject states showed different levels of technical adherence. As shown in Table 4, three of the four analyses were significant, with the fourth (residual change in frequency) showing a similar trend. An examination

of the means showed that therapists with self-affiliative introjects actually decreased slightly in the frequency and percentage of complex communications. Thus, the group increase in complex communications after training was based on therapists with disaffiliative introjects (Quadrants 2 and 3).

Effects of Patient Characteristics

Data for the two CDPS groups were segregated and analyzed separately because of different change predictions for technical adherence and general dynamic technique made for high- and low-CDPS patients, respectively. As predicted, paired *t* tests indicated that therapists changed significantly on TLDP adherence with both high-CDPS patients, $t(15) = 2.34, p < .03$, and low-CDPS patients, $t(14) = 3.61, p < .003$. Additionally, there was no significant relation between level of posttraining technical adherence (SS) and patient difficulty ($r = -.11$), a finding that runs counter to some earlier research (Rounsaville et al., 1988). General dynamic technique improved significantly only with the low-CDPS patients, $t(14) = 2.39, p < .03$, consistent with our original expectation. Again, there was no relation between general technique (IS) posttraining and patient difficulty ($r = -.17$).

⁹ Both raw change and residual change were analyzed because we believe that these measures bear on different questions where Structural Analysis of Social Behavior process variables are concerned. Our previous research has suggested that even relatively low frequencies of complex communications can be damaging. Thus, raw frequency change is clinically important. Residual change scores indicate differential changes after the initial level is equated.

Table 2
*ANOVA Summary: Pre- to Posttraining
 VTSS Scores by Training Group*

Source	<i>M</i>	<i>F</i> (1, 14)	α
Interview style			
Time (pre- to posttraining)	11,240.3	6.22	.026
Training group	436.9	0.09	.766
Time \times Group	4,879.7	2.70	.123
TLDP adherence (SS)			
Time (pre- to posttraining)	12,691.9	26.07	.000
Training group	6,263.8	6.24	.026
Time \times Group	6,475.5	13.37	.003

Note. ANOVA = analysis of variance; VTSS = Vanderbilt Therapeutic Strategies Scale; TLDP = time-limited dynamic psychotherapy; SS = Specific Strategies scale.

Table 3
Correlation of Therapist Variables and
Technical Change ($N = 16$)

Therapist variable	IS post-training	IS change	SS post-training	SS change
Previous supervision hours	-.257	-.324	-.481*	-.484*
Years of experience	.054	.104	-.290	-.373
Existing competence	.664**	.578**	.330	.262

Note. IS = Interview Style scale; SS = Specific Strategies scale.
* $p < .06$. ** $p < .01$.

Finally, a correlation matrix was constructed containing posttraining IS and SS scores and the patient variables of level of global symptomatology (as measured by the SCL-90-R), age, and education. All correlations were small and insignificant, with the exception that quality of general dynamic technique was positively correlated with level of education ($r = .48$, $p < .006$). Because no such relation was obtained pretraining ($r = -.07$), this finding (if not a statistical artifact) may indicate a differential improvement in general technique with more educated patients. Specific TLDP technical adherence, however, was not related to patients' age, education, or symptom status.

Discussion

In a previous report, Henry et al. (1993) presented results that demonstrated the complex nature of therapists' responses to training. In addition to the expected technical adherence, a number of unintended and potentially countertherapeutic process changes were observed. This study further demonstrates the potential complexities underlying a manualized training program designed to achieve adherence to a treatment protocol. Changes in technical interventions, as well as changes in the interpersonal process associated with these interventions, were found to vary as a function of a variety of training, therapist, and patient variables. The process and effects of manualized training appear to depend on an intricate interaction of factors, many of which have not been previously considered in the literature on protocol therapy. These results have important implications for future training efforts, as well as the evaluation of the effect of training on treatment outcomes.

Training Group Differences

Among the most striking findings were differences in effects of training associated with Trainer A versus Trainer B. This

finding, if generalizable, has implications for manualized therapy research, especially in multisite trials. Just as researchers must recognize the contribution of the individual therapist to the treatment, researchers may also have to recognize the contribution of the individual trainer, even when the curriculum is standardized with a manual.

Why should individual trainers, using a uniform curriculum and format, have produced the divergent training results that were found across training groups? The trainers were both veteran teachers and supervisors who had jointly authored the treatment manual and designed the training program. To explore this question, a senior member of the research team listened to 10 hr of training sessions for each of the four groups (total of 40 hr) and catalogued observations about the two trainers' interventions. Each trainer intervention was noted and categorized according to a simple scheme of educational activities (discussed shortly). These observations revealed several differences in the teaching methods used by Trainer A as compared with Trainer B. The observations were then reported to Trainers A and B for cross-validation. Each trainer immediately recognized his individual training style in the collected observations and validated the accuracy of the following summarization, grouped by educational activity:

1. *Specificity of learning task.* Trainer A's approach was directive, and he presented the therapists with specific learning tasks during each supervision session (e.g., listening for allusions to the transference). Trainer B's style was relatively less task specific and focused on the patient-therapist interaction from a number of perspectives as they emerged.

2. *Patient versus therapist dynamics.* When Trainer A stopped the tape for discussion, he was likely to focus on the therapist and to pose specific questions. Often, these questions addressed the therapists' own thought processes and systematically reviewed and re-reviewed core concepts. For example, he might ask, "What is the interpersonal theme here?" or "What were you thinking when you asked that?" Thus, Trainer A prompted exploration of alternative methods of inquiry and hypothesis generation, attempting to make the therapists more aware of their ongoing thought processes.

Trainer B, by contrast, tended to encourage the therapists to formulate their own questions *after* listening to a segment of audiotape rather than stopping the tape periodically and questioning the therapist. Additionally, he emphasized the traditional supervisory approach of focusing on patient dynamics and behavior as they affected the therapeutic process. He did

Table 4
Complex Communication Change as a Function of Therapist Introject

Source	Introject Quadrant 2		Introject Quadrant 3		Introject Quadrant 4		$F(2, 14)$	p
	M	SD	M	SD	M	SD		
Frequency								
Raw change	8.8	6.6	9.3	4.6	-0.9	7.3	3.99	<.05
Residual change	4.3	9.5	2.6	4.4	-3.4	5.6	1.89	<.20
Percentage								
Raw change	0.05	0.05	0.08	0.05	-0.05	0.10	4.22	<.04
Residual change	0.06	0.08	0.01	0.04	-0.03	0.04	3.85	<.05

periodically review TLDP principles and techniques, but the focus remained on understanding the patient and commenting on the therapeutic process in broad terms that did not directly address the therapists' momentary thought processes.

Both trainers often presented examples from their own clinical experience, and they both focused attention on the trainee's in-session transactions with particular patients. However, when Trainer A discussed patient dynamics, they were framed in the context of their implications for further specific exploration and intervention. By contrast, Trainer B discussed patient dynamics in broader theoretical terms within the context of the entire treatment, not as they related to a potential specific intervention.

3. *Feedback to therapists.* Both trainers freely offered supportive comments and praise to their therapist trainees, but their style of reinforcement differed. Trainer A spelled out precisely what the therapist had done and said that was desirable, whereas Trainer B made more global positive comments. When therapists offered resistance to particular concepts or suggestions, Trainer A was more likely to be confrontational or challenging, albeit respectfully so. In general, Trainer A tended to emphasize the fact that despite their advanced professional status, the therapist trainees were novices to TLDP, thus presumably requiring close and directive supervision. Trainer B tended to be more respectful of trainee autonomy and avoided confrontation. He proceeded on the assumption that the therapist trainees were already expert clinicians familiar with basic psychodynamic therapy principles. Therefore, his role tended to be that of a consultant to fellow professionals rather than a preceptor to novices. Our results appear to support the role adopted by Trainer A, suggesting the wisdom of treating even experienced clinicians as relative novices for purposes of training them in a new approach.

Therapist Variables

In some respects, it seems a foregone conclusion that different therapists, as trainees in a learning situation, will respond differently. Nonetheless, some of the systematic relationships observed among therapist variables, technical adherence, and changes in interpersonal manner have important ramifications for manualized therapy training. To begin with, it appeared that therapists with more prior supervision were more reticent to change their accustomed style of intervention. It is particularly interesting to note that the relation between prior experience and technical changes appeared to be more a function of amount of previous supervision rather than years of experience per se. This suggests that early training may leave a more lasting mark than the amount of experience accrued during therapists' posttraining career and that therapists with extensive previous supervision are more resistant to training in manual-guided therapy.

The finding that therapists with hostile and controlling introjects showed the greatest technical adherence is both intriguing and potentially problematic. The fact that this relationship was obtained makes sense because these were the therapists who theoretically would be most likely to monitor their own behavior tightly and fear external disapproval (resulting in higher adherence). However, earlier research (Henry et al.,

1990) has shown that these are also the same therapists who are most prone to engaging in countertherapeutic interpersonal process. These related findings suggest the possibility that personal qualities that lead some therapists to "perform the best" (in terms of technical adherence) may also present problems in other, unrecognized ways. If this is true, it would work against any linkage between manualized adherence and improved therapeutic outcomes. Indeed, the research community has by and large failed to demonstrate improved outcome via protocol adherence.

In a previous report, Henry et al. (1993) noted that therapists as a group became more active after training. The absolute frequency of complex communications rose substantially as a result, although the relative percentage did not. Therapists with hostile introjects were found to be largely responsible for the posttraining increase in negative and complex interpersonal communications. These findings suggest that this subset of therapists may be particularly vulnerable to countertherapeutic training effects.

Patient Variables

As we had hoped, therapists showed greater improvements in general dynamic technique when working with patients traditionally deemed less suitable for short-term dynamic treatment. These were patients who were less verbally fluent, less psychologically minded, and less able to quickly form good working alliances. After training, better general dynamic technique was also found to be correlated with educational level, suggesting that the training might have had its greatest effects when therapists were working with difficult but well-educated patients. Unlike Rounsaville et al. (1988), we did not find that technical adherence dropped off with more difficult patients. This could have been attributable to possible differences in the range of patient difficulty in the two samples or to differences in the two therapies, with TLDP being somewhat less technically prescriptive than interpersonal therapy (IPT). Additionally, interventions such as transference interpretations that may mark adherence to TLDP would be considered deviations in IPT.

Conclusion

In attempting to measure the effects of manualized training in TLDP on the therapeutic process, we examined a range of variables: the absolute level of posttraining technical adherence, relative posttraining adherence level of different subgroups of therapists, pre- to postchanges in general psychodynamic technique, and changes in the underlying interpersonal process between patient and therapist. What has emerged is a complex set of relations among factors such as the amount of therapists' previous supervision, therapist introject structure, style (as opposed to content) of manualized instruction, and level of patient difficulty.

These findings suggest the following guidelines for maximizing positive manual-guided training effects: (a) Select competent but relatively less experienced therapists; (b) measure relevant therapist personality characteristics and try to avoid selecting therapists vulnerable to negative training effects; (c)

assume that even seasoned therapists are novices in the approach to be learned; and (d) structure the learning experiences to provide specific directive feedback and to focus on the therapists' internal thought processes.

In conclusion, the results of this study, as is so often the case, raise more questions than can be answered. So far, there has been a dearth of systematic studies exploring the effects of therapists' training on the process and outcome of treatment. We hope that the present line of research underscores the proposition that research on the process of training is as important as the study of various therapeutic modalities themselves. To guide such research, the field may profitably draw on concepts not only from the clinical literature but from cognitive and educational psychology as well. In particular, studies focused on the nature and development of *expertise* may provide a promising background (Chi, Glaser, & Farr, 1988; Schacht, 1991). Researchers must take seriously the proposition that therapists are not interchangeable units who "deliver" a standard treatment even while they move to develop a more standardized and higher quality of care.

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Received March 18, 1992

Revision received October 27, 1992

Accepted November 17, 1992 ■