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Introduction

Sarah is a 21-year-old cisgender college student suffering many symptoms of generalized anxiety disorder and major depressive disorder.[1] Sarah grew up in a dysfunctional, rural, low socioeconomic status family with significant interpersonal violence between her parents (e.g., pushing and shoving, throwing objects at each other, accompanied by angry outbursts). Although Sarah was not the object of abuse, she finds the family environment aversive and spends as much time as she can away from home, which she accomplishes by working diligently at school and participating in as many school activities as possible. She is dedicated to attending college and "never returning home." However, she finds that she feels alienated from the other students at the urban liberal arts college she attends because they are from cosmopolitan upper middle-class and

[1]This case is fictitious.

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The Basics of Psychotherapy: An Introduction to Theory and Practice, *Second Edition*, by B. E. Wampold

upper-class homes and do not share much in common with her. Sarah's social life is sparse and she spends most of the time studying by herself. She is motivated to change, and she and her therapist have focused on increasing social activities. Sarah has made some friends during the course of therapy and is feeling better, displaying fewer symptoms and reporting greater well-being.

Sarah presented to the sixth session agitated and reported that she had not completed the homework that had been assigned. When the therapist noted her agitated state, Sarah responded, "I don't want to talk about it." The therapist had several thoughts: "Has something happened to Sarah, such as a sexual assault?" "Is she ashamed that she did not complete the homework?" "Is our relationship not sufficient for Sarah to disclose more difficult material?" "Was the focus on interpersonal relationships with other students not optimal?" "Was Sarah simply being compliant with therapy because she is motivated to accomplish any task?" "Was the progress noted previously superficial?" But the most urgent question was: "What do I say to her at this moment and how do I say it?"

This brief vignette poignantly illustrates how complex the task of therapy can be and typically is. There is much important background knowledge needed: a firm understanding of biological, social, ecological, cultural, affective, and cognitive bases of behavior. But what is most important in psychotherapy is a good road map of how therapy unfolds—a guide to action. A map is a representation of reality, and one would not set out across country without one. In psychotherapy, the representation of reality used to guide therapy is theory. Theory provides the framework for therapeutic action: which questions to ask, what to attend to, how to respond to client verbal and nonverbal behavior, when and how to intervene, and how to assess progress. Every aspect of therapy is saturated with the theoretical perspective of the therapist. As will become apparent, there is no one "best" road map for therapy; there are a plethora of viable theories from which to choose.

This series is devoted to introducing you to psychotherapy theories. This is a dynamic process in an important way. You meet the theories, but they do not simply represent information to be learned. The goal is not to

be a well-versed and conversant theorist; rather, the goal is to use theory to be an effective therapist. In the process of becoming a therapist, you will need to master a few of these theories as your road map. Some of the theories will feel more comfortable and logical to you than others. Similarly, some theories will be more compatible with the client, as well. So, it is not simply a case of which theory is best for you. The most important issue is that the choice of theory ultimately is about what is most effective with this client—as *used* by you. Again, the process is dynamic and complex.

A short introduction to psychotherapy as a healing practice is presented in this chapter. Later chapters examine the history of psychotherapy, role of theory in psychotherapy, and research about how psychotherapy works.

PSYCHOTHERAPY AS A HEALING PRACTICE

The number of people receiving mental health care across the world has been increasing over the past 3 decades (Druss, 2010). Psychotherapy is widely accepted as a legitimate and beneficial healing practice in the United States and in many other countries (Angermeyer, van der Auwera, Carta, & Schomerus, 2017). It is estimated that more than 10 million Americans receive psychotherapy annually (Olfson & Marcus, 2010; Olfson et al., 2002; Wang et al., 2005). About 3% of the U.S. general population uses outpatient psychotherapy services (Olfson & Marcus, 2010), but of those who use outpatient services, the percentage who use *only* psychotherapy has been declining—from 15.9% in 1998 to 10.5% in 2007 (Olfson & Marcus, 2010). The percentage of those who use psychotherapy and psychotropic medications together also has been declining (from 40.0% to 32.1% in the same time frame), whereas the use of psychotropic medication alone has increased (from 44.1% to 57.4%). Also decreasing during this time period has been the number of psychotherapy visits in the United States per patient (from a mean of 9.7 to a mean of 7.9), as well as the mean cost per visit (from $122.80 to $94.59). Total expenditures on psychotherapy in the United States also dropped from $10.94 billion to $7.17 billion from 1998 to 2007. These declines

are taking place even though worldwide acceptance of mental health services has been increasing, stigma of mental health disorders has been decreasing, and psychotherapy is increasingly preferred to medication (Angermeyer et al., 2017). Nevertheless, career satisfaction of therapists remains high (Norcross & Rogan, 2013).

Of those who avail themselves of services for psychological distress in the United States, about 40% receive psychotherapy from a psychologist, social worker, or counselor; the remainder receive services from a psychiatrist (13%), a general practice physician (9%), human services professional (e.g., religious or spiritual advisor or counselor not in a mental health setting; 9%), or a complementary or alternative medicine provider or group (e.g., chiropractor, self-help groups, 32%; Druss et al., 2007). Although psychotherapy faces a number of challenges worldwide and in the United States, there is little doubt that it is one of the primary treatment modalities for a range of mental disorders. Yet, many questions need to be addressed by the field.

The first question is whether or not psychotherapy works. The answer, which is explored in more detail in Chapter 4, is a resounding *yes*. The benefits of psychotherapy are clear: Those receiving psychotherapy achieve much better outcomes than they would have had they not received psychotherapy (Lambert, 2013; Wampold & Imel, 2015). Indeed, psychotherapy is more effective than many accepted but expensive medical practices, and is without aversive side effects. In clinical trials, psychotherapy has been shown to be effective for the treatment of depression, anxiety, marital dissatisfaction, substance abuse, health problems (e.g., smoking, pain, eating disorders), obsessive-compulsive disorder, eating disorders, posttraumatic stress disorder, personality disorders, and sexual dysfunction, and with various populations, including children, adolescents, adults, and elders (Chambless et al., 1998; https://www.div12.org/psychological-treatments). Psychotherapy stacks up well against medications for various mental disorders, most notably, depression and anxiety disorders, and is more enduring (i.e., less prone to relapse) and less resistant to additional courses of treatment (Hollon, 2016; Hollon, Stewart, & Strunk, 2006; Imel, Malterer, McKay, & Wampold, 2008;

Leykin et al., 2007). It has been found that psychotherapy, as practiced in the real world, is as effective as psychotherapy delivered in the controlled conditions of randomized clinical trials (Minami & Wampold, 2008; see also Chapter 4, this volume).

Despite the acceptance and effectiveness of psychotherapy, there are concerns to note. First and foremost, most people who need mental health services do not receive care of any kind. A national survey in the United States found that fewer than 40% of people who would be classified as having a mental disorder (e.g., a *Diagnostic and Statistical Manual of Mental Disorders* [*DSM*] disorder) received mental health treatment (Druss et al., 2007). The conclusion from such national surveys is that "most people with mental disorders in the United States remain either untreated or poorly treated" (Wang et al., 2005, p. 629). Moreover, this problem is worse for clients most in need: "Unmet need for treatment is greatest in traditionally underserved groups, including elderly persons, racial-ethnic minorities, those with low incomes, those without insurance, and residents of rural areas" (Wang et al., 2005, p. 629). The problem, it seems, is not that psychotherapy is not effective but, rather, that this practice is not being delivered to the people who need it (see Chapter 4).

Although it is not entirely clear why more people do not use psychotherapy, one important reason is that medications increasingly are used to treat mental disorders as discussed earlier. However, many people who qualify for a mental health diagnosis do not seek any treatment at all (Mojtabai et al., 2011). The major reason given by those with a mental disorder who do not seek treatment is low perceived need, particularly for those experiencing less distress. Even those who perceive a need for help many want to handle the problem on their own. However, stigma, financial barriers, and availability of services also are problems, particularly in the United States (Mojtabai et al., 2011).

There is a perception that psychotherapy is being provided to clients who are not really distressed; that is, psychotherapy is being delivered to the "worried well." Interestingly, of those receiving mental health services, about 40% have experienced the symptoms of a *DSM* diagnosis in

the previous 12 months, 18% have experienced the symptoms of a *DSM* diagnosis in their lifetime, and 13% have or had other indicators of need, such as subclinical symptoms or have or had a stressful life event. Fewer than 4% of those receiving mental health services have had no indicator of need; of those, only 16% are receiving psychotherapy services from a nonpsychiatrist. So, only about one half or 1% of the general population is receiving psychotherapy with no indicator of need, according to the survey criteria (Druss et al., 2007).

One should keep in mind that psychotherapy is a relatively new practice. It was a about a century and a half ago that Sigmund Freud developed the "talking cure," so the use of psychotherapy, relative to the practice of medicine—which has existed since ancient times—is just emerging as a legitimate treatment in the United States and around the world (Pritz, 2002). As the next chapter discusses, psychotherapy is an evolving culturally imbedded practice (see, e.g., Fancher, 1995; Pritz, 2002; Wampold & Imel, 2015). The profession, for better or for worse, has evolved from long-term intensive treatments (i.e., two or three times a week for several years) to, for the most part, a focused and brief intervention (Engel, 2008; Olfson & Marcus, 2010). However, the field continues to emerge and change. Science produces new evidence, policies change, payment mechanisms evolve, and people influence the profession. Only one thing is safe to say: Psychotherapy will change to meet the times.

To this point, psychotherapy has been referenced without a proper definition. So, before continuing, psychotherapy is defined and issues related to that definition are discussed. What will become clear is this: The boundaries of what is considered "psychotherapy" are fuzzy.

PSYCHOTHERAPY DEFINED

Psychotherapy belongs to a class of healing practices that involves talk as the medium to address psychological distress. In many ways, psychotherapy is an amorphous practice because it is delivered by a variety of professionals and paraprofessionals, including psychologists, psychiatrists, counselors, marriage and family therapists, and social workers; it

uses a variety of techniques based on an array of theoretical models; and it is closely allied with a number of related professions and practices, such as personal coaching, support groups, vocational counseling, guidance programs, and self-help programs (Engel, 2008). The focus of this series is on what might be termed "mainstream" psychotherapy, although issues related to practices on the margins are discussed at important junctures.

Keeping in mind that no definition of psychotherapy is entirely adequate, the following definition is offered to define the practice:

> Psychotherapy is a primarily interpersonal treatment that is (a) based on psychological principles, (b) involves a trained therapist and a client who is seeking help for a mental disorder, problem, or complaint, (c) is intended by the therapist to be remedial for the client disorder, problem, or complaint, and (d) is adapted or individualized for the particular client and his or her disorder, problem, or complaint. (Wampold & Imel, 2015, p. 37)

Examining aspects of this definition helps clarify the boundaries of psychotherapy vis-à-vis other similar practices, but keep in mind that there are aspects of the definition, boundaries, and practices about which many will quibble. Yet, as various theories are presented, it is important to confine the discussion to the practice of psychotherapy.

First, psychotherapy is primarily an interpersonal intervention and, as such, has been characterized as "talk therapy" often in its history. That is, psychotherapy involves an interpersonal relationship between therapist and client, and the conversation between therapist and client *is* psychotherapy in many respects. Of course, the client may enact many behaviors within the therapy session or outside of the session that purportedly are therapeutic, such as an exercise involving exposure in which the client approaches some feared situation (e.g., a person with social anxiety is instructed to talk to a potential romantic partner). Nevertheless, the important aspects of psychotherapy are delivered by means of the verbal interaction (Wampold, 2007; Wampold & Imel, 2015). It is unclear whether some modern practices, such as technology-assisted interventions, should be classified as psychotherapy. Telephone counseling

or video-based interventions clearly involve an interpersonal relationship, although not face-to-face. Many would classify an internet interaction in chat mode as interpersonal and language mediated, and thus that interaction could be classified as psychotherapy, particularly to a generation for whom many important interpersonal relationships transpire electronically. The interpersonal relationship criterion, however, importantly removes various environmental interventions, such as those based on classical conditioning (e.g., token reinforcement programs in the schools), which may effectively change behavior but are not psychotherapy in the sense used in this series. Indeed, any psychological intervention that does not depend primarily on language as the mode of delivery is not psychotherapy as defined here. Thus, clients without cognitive abilities to communicate linguistically (e.g., infants and individuals with severe communication disorders) cannot, in this sense, participate in psychotherapy. Of course, this does not preclude other psychological interventions that may be helpful.

Healing practices generally are imbedded in a belief system (Wampold, 2007; Wampold & Imel, 2015). The belief system of psychotherapy generically is psychological. That is, the underlying rationale for any psychotherapeutic treatment must be psychological. As is apparent in this series, there are many different psychological theories that can be usefully applied to develop various psychotherapies. Again, there are interventions that are on the margins, including, for example, the "body" therapies. The rationale for massage therapy is more physiological than psychological, although other body approaches, including Reichian therapies, have purported psychological bases, albeit controversial ones. In this series, the discussion is restricted to psychotherapies that have cogent psychological bases.

Another commonality of healing practices is that the healer has special characteristics that separate him or her from laypeople, and has an authority based on status and knowledge (Boyer, 2001; Frank & Frank, 1991; A. K. Shapiro & Shapiro, 1997; Wampold, 2007). Accordingly, psychotherapy in this series is restricted to those practices that involve a trained therapist, although it is recognized that whereas most

psychotherapy is practiced by degreed and credentialed therapists, occasionally psychotherapy is conducted by paraprofessionals or others without degrees and credentials but with specialized training (e.g., graduate student therapists, some substance abuse counselors, mental health workers in low- and middle-income countries; see Singla et al., 2017). However, psychotherapy is differentiated from any practices conducted informally (e.g., between friends), as an unofficial part of duties (e.g., hairdressers or bartenders), or not generally sanctioned as professional services (e.g., services provided by a religious figure not otherwise trained and recognized as a therapist). This definition thus excludes indigenous healing practices, although there is a close relationship between such practices and psychotherapy (Wampold, 2007).

Notice that the definition used here refers to a client who has a disorder, problem, or complaint. Intentionally, the definition does not necessarily characterize the distress as a *mental disorder* because many psychotherapies eschew such a classification as unhelpful and even stigmatizing. Nevertheless, psychotherapy is a practice that addresses some felt distress and, in this regard, does not include interventions that are primarily preventive, such as drug prevention programs. This discussion raises a critical issue about whether interventions with individuals who have not presented voluntarily can be classified as psychotherapy. In some contexts, clients are mandated to seek treatment (e.g., by the criminal justice system), are pressured by family members, or are referred by schools; such clients are reluctant participants and often do not engage in therapy in a manner that characterizes psychotherapy (Wampold, 2007). Nevertheless, clients vary in their motivation and readiness for change, and, of course, it is the responsibility of the therapist to engage the client and increase the desire for change (Moyers, Miller, & Hendrickson, 2005; Norcross, Krebs, & Prochaska, 2011). However, as this series makes apparent, psychotherapy depends centrally on the notion of a collaborative relationship in which therapist and client have agreements about the tasks and goals of therapy.

The definition of psychotherapy importantly stipulates that the treatment delivered is intended by the therapist to be therapeutic. Clients in any healing practice expect that the healer believes in the effectiveness of

the practice, and psychotherapy clients are no different. Indeed, research has supported the claim that therapist allegiance to the treatment is associated with psychotherapy outcomes (Wampold, 2001b; Wampold & Imel, 2015). Typically, therapists in practice have allegiance to the treatment delivered, but occasionally treatment protocols are mandated for various reasons, resulting in therapists' delivering a treatment that they do not believe is optimally therapeutic. Although one could classify the delivery of a protocol by a doubting therapist as psychotherapy, the discussion here pertains to treatments faithfully delivered. Moreover, treatments delivered in clinical trials by therapists who are aware that the treatment is not intended to be therapeutic (e.g., supportive counseling) are considered to be sham treatments; this recognition is critical to understanding the evidence about psychotherapy efficacy derived from clinical trials (see Wampold, 2001b; Wampold & Imel, 2015) as is discussed further in Chapter 4.

Another aspect of the definition of psychotherapy is that it is individualized to the client and the client's problems. That is, the therapist listens intently to the client and then shapes the therapy to respond to the client, both in terms of client characteristics and the client's problem. There are a number of programs designed to address particular problems and/or to improve lives that do not involve such individualization, such as fixed relaxation protocols, meditation, and movement programs (e.g., dance therapy). Although these types of interventions may be effective, they are not psychotherapy in the sense used in this series. As discussed later, treatments focused on the client's particular problems are more effective than generic unfocused psychotherapy (Cuijpers et al., 2012; Wampold & Imel, 2015; Yulish et al., 2017).

Psychotherapy often is delivered to more than one client at a time, as is the case in group therapy, couple therapy, and family therapy. These variations often are referred to as *modalities*. Frequently, standard individual protocols, such as cognitive–behavioral treatments, are modified to be delivered in group formats, whereas other times, treatments are unique to the modality (e.g., multisystemic family therapy is necessarily

a family modality). The definition of psychotherapy should be broad enough to encompass various modalities as well as theoretical perspectives.

As mentioned, psychotherapy is a generic term in the sense that the practitioners of psychotherapy belong to a variety of professions including counseling, social work, medicine, and psychology, and within each profession, there are various specialties that take various perspectives on the training and practice of psychotherapy. For example, in psychology, there are specialties in school, counseling, and clinical psychology. Psychotherapy is practiced in a variety of settings, including private practice, community agencies, hospitals and clinics, and counseling centers (Minami & Wampold, 2008; VandenBos, Cummings, & DeLeon, 1992). Moreover, psychotherapists receive payment from a variety of sources, including the client directly, managed care and other insurance companies, institutions (e.g., universities, as in college counseling centers), various governmental agencies (e.g., Medicare in the United States, national health services in many countries), and nonprofit agencies.

PURPOSE OF THE BOOK

This book acquaints the emerging professional with psychotherapy. This volume introduces the Theories of Psychotherapy Series, and many of the monographs in the series are accompanied by videos illustrating the use of theories in action (see http://www.apa.org/pubs/books/theories-series-and-dvds.aspx).

George Santayana (1905) famously noted, "Those who cannot remember the past are condemned to repeat it" (p. 284). The same can be said about psychotherapy: A thorough understanding of how psychotherapy has evolved, the forces that have been and are brought to bear on it, its place in the healing practices, and the scientific evidence that has supported its use is absolutely necessary to train clinicians and researchers to carry the profession forward. The backbone of psychotherapy is theory. An atheoretical collection of techniques is not sufficient; every professional and most craftspeople know much about the underlying principles

of their domains. Theory is the scaffolding that holds the enterprise together. Research evidence, therapeutic techniques, clinical expertise, skill acquisition, and all the rest become amorphous chaos without this scaffolding.

Theories in psychotherapy have evolved, as is discussed in some depth in Chapter 2 (see Cushman, 1992; Fancher, 1995; Wampold & Imel, 2015). Freud introduced psychoanalysis, and it was the predominant model for decades; but the second and third forces of behavioral therapy and humanistic therapy, respectively, entered the arena in the mid-20th century. Recently, a fourth force, multicultural counseling, appeared. However, by most accounts, there are hundreds of theories, some closely aligned with a central theme and others quite different (Dattilio & Norcross, 2006). Making the landscape more complex is that many practicing psychotherapists consider themselves eclectic or integrative (Norcross, Hedges, & Castle, 2002), although fewer have been endorsing an eclectic/integrative approach over the years (Norcross & Karpiak, 2012). Complicating the situation is the development of *transdiagnostic protocols* (Barlow et al., 2011; Wells, 2009), which are treatments designed to be effective for classes of disorders that may have common characteristics. How is a graduate student supposed to make sense of a field with so many options? This series is designed to lend coherence to this diversity.

This foundational book in the Theories of Psychotherapy Series sets the stage in three ways. First, it describes the historical context. Chapter 2 addresses the following questions: How did psychotherapy originate and prosper? What are the key developments and who influenced the field? How did (and does) the cultural context shape the development of psychotherapy as a healing practice?

Second, Chapter 3 discusses the critical question, What role does theory play in the practice of psychotherapy? Theory is absolutely necessary for practice, and theory guides how psychotherapists think about their cases and what they do in psychotherapy. Without theory, there is no psychotherapy. The choice of a particular theory involves a calculus involving both therapist and client, as discussed in Chapter 3. As well, the philosophy of science that forms the basis of various theories is discussed

to demonstrate that determining the relative worth of various theories is problematic.

Third, Chapters 4 and 5 review the research evidence. Psychotherapy is a psychology-based endeavor and, as such, rests on an empirical base to the extent possible. Psychotherapists should be knowledgeable about the relevant research and use it as appropriate to ensure that their clients benefit. Although the review in Chapters 4 and 5 is relatively brief, the following questions are addressed: Does psychotherapy work? Are some psychotherapies more effective than others? What do we know about the delivery of psychotherapy in the real world? How does psychotherapy work? Chapter 6 presents a summary and reiterates the importance of theory in practice.