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CHAPTER 1

# Current Issues in Psychotherapy Theory, Practice, and Research

## *A Framework for Comparative Study*

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This book presents the core theoretical and applied aspects of essential psychotherapies in contemporary clinical practice. In our view, essential psychotherapies are those that form the conceptual and clinical bedrock of psychotherapeutic training, practice, and research rather than those that may generate momentary enthusiasm but are soon likely to fade from the therapeutic scene. We believe there are two fairly distinct categories of essential psychotherapies. There are those approaches whose origins are found early in the history of psychotherapy, although all of these have been revised and refined considerably over time. Examples of such foundational and time-honored approaches are Freudian-derived psychoanalytic psychotherapy; existential–humanistic and person-centered models; traditional behavior therapy; and group therapy. Then there are the more recently developed psychotherapies that have had a strong influence on practice, training, and research, and are likely to have staying power. Examples are the relational/psychodynamic, cognitive and cognitive-behavioral, third-wave cognitive-behavioral, family, couple, brief, and integrative therapies.

The first three editions of *Essential Psychotherapies* have become a primary source for comprehensive presentations of the most prominent contemporary influences in the field of psychotherapy. Although there are literally hundreds of differently labeled "psychotherapies," the great majority are only partial methods, single techniques, or minor variations on existing approaches. We believe they can be subsumed by about a dozen quite distinguishable types.

As editors, we have challenged our contributing authors to convey not only what is basic and core to their ways of thinking and working but also what is new and forward-looking

in theory, practice, and research. Our demographically and professionally diverse group of contributors, all eminent scholars, practicing clinicians, and clinical educators, have helped to forge a volume that is well suited to exposing advanced undergraduates, graduate students, and advanced trainees in all the mental and behavioral health professions to the major schools and methods of modern psychotherapy. Because the chapters were written by cutting-edge representatives of their therapeutic approaches, there is something genuinely new in these presentations that will be of value to more experienced therapists as well.

As in the first three editions, each chapter offers a clear sense of the history, current status, assessment approach, techniques, and research on the therapy being discussed, along with its foundational ideas about personality and psychological health and dysfunction. However, each of these sections now pays greater attention to cultural factors. Furthermore, in keeping with current trends, attention is paid to the ways in which each approach is consistent with the evidence-based practice (EBP) movement, and applicable to not only mental/behavioral health concerns but also general physical health care. As academicians, psychotherapy trainers, and practicing psychotherapists ourselves, we endorse the adage that "there is nothing so practical as a good theory" (Lewin, 1951, p. 169). Each chapter balances the discussion of theory and practice, and emphasizes the interaction between them.

Before detailing our organizing framework for the chapters in this book, three comments about its contents are in order. First, while *Essential Psychotherapies* provides substantive presentations of the major schools of psychotherapeutic thought and general guidelines for practice, it does not emphasize, per se, treatment prescriptions for specific disorders or "special populations." Included, however, are examples of such applications. Whereas forces in the contemporary world of psychotherapy support a rather broad movement to specify particular techniques for particular problems and types of persons (although see below for some recent changes in this regard), we continue to believe that the majority of practitioners approach their work from the standpoint of theory as it informs general strategies and techniques of practice. Optimally, such techniques and interpersonal stances have survived in the crucible of systematic research and can be considered supported or validated. In other words, we believe that there is an interplay among theory, practice, and research that encompasses what we know about evidence-based treatments and techniques (e.g., American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006), as well as those aspects of the psychotherapy relationship that have a marked effect on the success of therapy (e.g., Messer & Fishman, 2018; Norcross, 2011; Norcross & Wampold, 2018).

Second, there is considerable energy being devoted to the development and refinement of integrative approaches to psychotherapy (see Gold & Stricker, Chapter 13, this volume). While valuing the search for integrative principles and common factors that transcend particular therapies (e.g., Goldfried, 2019; Laska, Gurman, & Wampold, 2014), we support the continuing practice of teaching relatively distinct schools or systems of psychotherapy. We agree with Feldman and Feldman (2005) that "for therapists to offer a truly balanced and systematic integration, they need to be well versed in the core concepts and techniques of a variety of orientations and conscious of the strengths and limitations of each perspective" (pp. 398–399).

Third, we believe that therapists' personalities increase their attraction to certain approaches and diminish their interest in others. Fortunately, the field of psychotherapy provides enough variety of concepts and modes of practice to match the personal predilections of any aspiring clinician.

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## THE EVOLUTION OF PSYCHOTHERAPY AND OF "ESSENTIAL PSYCHOTHERAPIES"

Although the essential approaches are largely the same as when this volume first appeared in 1995, there have been some important changes in the landscape of psychotherapy. Gestalt therapy and transactional analysis have left their imprint on current models, and were popular and prominent therapies in earlier times, but they are less so today. As a result, there are no separate chapters devoted to them. Gestalt therapy, however, is addressed (Bohart & Watson, Chapter 7, this volume) in a discussion of person-centered and emotion-focused approaches. Due to the growth of various offshoots of behavior and cognitive therapy, such as dialectical behavior therapy, acceptance and commitment therapy, and mindfulness-based cognitive therapy—known as the "third wave" of behavior therapy—we now have a chapter on these and other related innovations (Masuda & Rizvi, Chapter 6, this volume). The chapter on brief psychotherapy from previous editions has been reconfigured to focus on its two most prominent forms, namely, interpersonal psychotherapy and brief psychodynamic therapies.

The various models of psychotherapy appearing here stem from different views of human nature, about which there is no universal agreement. Working from alternative epistemological outlooks (e.g., introspective [from within] vs. extraspective [from the outside]), these schools of therapy embrace quite different ways of getting to know clients/patients. In addition, these therapies encompass distinct visions of reality or combinations thereof, such as tragic, comic, romantic, and ironic views of life (Messer & Winokur, 1984), which influence what change consists of and how much is considered possible. We believe it is important for the field to appreciate and highlight the different perspectives and visions exemplified by each model or school of therapy, while simultaneously respecting both the search for common principles in theory and practice and the emphasis on integration across approaches.

## A FRAMEWORK FOR COMPARING THE PSYCHOTHERAPIES

> Our theories are our inventions; but they may be merely ill-reasoned guesses, bold conjectures, hypotheses. Out of these we create a world, not the real world, but our own nets in which we try to catch the real world.
>
> —KARL POPPER

> I think psychotherapy saves lives and is hugely meaningful and I think that one of the unfortunate aspects of prescription drugs working well is that people tend to think that's enough.
>
> —KAY REDFIELD JAMISON

As in the earlier editions of *Essential Psychotherapies,* we have provided the authors with a comprehensive set of guidelines (presented below). These have proven useful in facilitating readers' comparative study of the major models of contemporary psychotherapy and also may be used by the student as a template for studying therapeutic approaches not included here. These guidelines include the basic and requisite elements of an adequate description of any type of psychotherapy.

In offering these guidelines to our authors, we aimed to steer a midcourse between providing the reader with sufficient anchor points for comparative study, while not constraining authors' expository creativity. We are pleased that our contributors succeeded in following

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the guidelines, while describing their respective approaches in an engaging fashion. Authors were encouraged to sequence their material within chapter sections according to their own preferences. They were also advised that they did not need to limit their presentations to the matters raised in the guidelines or address every point identified therein, but to address these matters if they were relevant to their treatment approach. Authors were also free to merge sections of the guidelines if doing so helped them communicate their perspectives more meaningfully. We highlighted those features we considered essential to include. (See italics below for required content.) We believe the authors' flexible adherence to the guidelines helped to make clear how theory organizes clinical work and facilitates case conceptualization. The inclusion of clinical case material in each chapter serves in a concrete and engaging way to illustrate the constructs and methods described previously.

Although most of our author guidelines remained unchanged from those in the third edition, we have made a few additions and modifications. We asked the authors to be sure to address cultural factors such as ethnicity, race, religion/spirituality, social class, gender, and sexual orientation. We also asked them to consider health-related issues, applications to serious mental illness, ethical considerations, and psychotherapy integration. We again requested suggestions of videos that illustrate their approach. We now present these author guidelines, along with our rationale for, and commentary on, each area. In this fashion, we hope to bring the reader up to date on continuing issues and controversies in the field.

## HISTORICAL BACKGROUND

> History is the version of past events that people have decided to agree on.
>
> —Napoleon Bonaparte

> The work of today is the history of tomorrow, and we are its makers.
>
> —Juliette Gordon Low

**PURPOSE:** To place the approach in historical perspective within the field of psychotherapy.

*Points to consider:*

1. The *major influences that contributed to the development of the approach* (e.g., people, books, research, theories, conferences). What were the sociohistorical forces or *Zeitgeist* that shaped the emergence and development of this approach (e.g., Victorian era, American pragmatism, modernism, postmodernism)?
2. The therapeutic forms, if any, that were forerunners of the approach (e.g., psychoanalysis, learning theory, client-centered theory).
3. Types of patients with whom the approach was developed, and speculations as to why.
4. Early theory and/or therapy techniques.
5. Ways that cultural factors (e.g., *gender, ethnicity, race, sexual orientation, religion/spirituality, social class) were considered, if at all, in the development of this form of psychotherapy.*

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People's lives can be significantly influenced for the better in a wide range of ways—for example, a parent adopts a new approach toward a defiant adolescent, a member of the clergy facilitates a congregant's self-forgiveness, an athletic coach or teacher serves as a life-altering role model for a student, and so on. Yet none of these, or other commonly occurring healing or behavior-changing experiences, qualifies as psychotherapy. *Psychotherapy refers to a particular process rather than just to any experience that leads to desirable psychological outcomes.* Written five decades ago, Meltzoff and Kornreich's (1970) definition of psychotherapy is still quite apt, although their term *techniques* has to be seen as including relationship factors, and the phrase "judged by the therapist" must be broadened to include the client's/patient's perspective:

> Psychotherapy is . . . the informed and planful application of techniques derived from established psychological principles, by persons qualified through training and experience to understand these principles and to apply these techniques with the intention of assisting individuals to modify such personal characteristics as feelings, values, attitudes and behaviors which are judged by the therapist to be maladaptive or maladjustive. (p. 4)

Given such a definition of psychotherapy, we believe that developing an understanding and appreciation of the professional roots and historical context of psychotherapeutic models is an essential aspect of one's education as a therapist. (Norcross, VandenBos, & Freedheim [2010] provide the most comprehensive accounts of the histories of all the major psychotherapy approaches to date.) Lacking such awareness, a particular therapy might seem to have evolved from nowhere and for no known reason. A key factor in a therapist's ability to help people change lies not only in the therapist's belief in the more technical aspects of the chosen orientation, as in the aforementioned definition, but also in the worldview implicit in it. Having some exposure to the historical origins of a therapeutic approach helps clinicians comprehend its worldview.

In addition to attending to the professional roots of therapeutic methods, it is enlightening to understand why particular methods, or sometimes clusters of related methods, appear on the scene in particular historical periods. The intellectual, economic, and sociopolitical contexts in which therapeutic approaches arise often provide meaningful clues about the emerging social, scientific, and philosophical values that frame clinical encounters. Such values may have a subtle but salient impact on whether newer treatment approaches endure. For example, until quite recently, virtually all the influential and dominant models of psychotherapy were derived from three broad outlooks: psychoanalysis, humanism, and behaviorism.

In the last few decades in particular, however, two newer conceptual forces have shaped the landscape of psychotherapy in visible ways. The systems-oriented methods of couple, family, and group therapy have grown out of an increasing emphasis on the contextual embeddedness of all human behavior (Gurman & Snyder, 2010). Indeed, even the more traditional therapeutic approaches, such as those grounded in psychoanalytic thinking or behavioral therapy, have become more relationally focused. Likewise, emerging integrative and brief psychotherapeutic approaches have gained recognition and stature in the last three decades, in part as a response to increased societal and professional expectations that psychotherapy demonstrate both its efficacy and its efficiency (see, in this volume, Farber, Chapter 12, and Gold & Stricker, Chapter 13; Messer, Sanderson, & Gurman, 2013).

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## THE CONCEPT OF PERSONALITY

> Children are natural mimics—they act like their parents in spite of every attempt to teach them good manners.
>
> —Anonymous

**PURPOSE:** To describe within the therapeutic framework the conceptualization of personality, such as the patterns of behaviors, thoughts, feelings, emotions, and social adjustments that are consistently exhibited over time and that influence one's expectations, self-perceptions, values, and attitudes.

*Points to consider:*

1. What is the *theory of personality development* (or related constructs) in this approach?
2. What are the *basic psychological concepts used* to describe and understand people (e.g., schemas, traits, character types, behaviors, emotions, motivations)?

Although there are different definitions of what constitutes personality, three elements are usually included:

1. Personality is not merely a collection of individual traits or disconnected behaviors, but is structured, organized, and integrated.
2. This structural criterion implies a degree of consistency and stability in personality functioning. Behavioral manifestations of that structure may vary, however, according to the situational context. This is due to behavior being a function of the interaction of personality and situational factors.
3. There is a developmental aspect to personality that takes into account childhood and adolescent experience; that is, personality emerges over time out of a matrix of biological and social influences.

There exists an intimate connection between personality theory and the factors posited to bring about change by any theory of psychotherapy. Psychoanalysis, for example, emphasizes unconscious aspects of human functioning, including disguised motives, ambivalence in all human relations, and intricate interactions among the structures of mind, namely, id, ego, and superego. Thus, it is not surprising that an essential curative factor in this theory is interpretation of motives, defenses, conflicts, and other relatively hidden features of personality. A cognitive theory of personality, by contrast, is based on the assumption that mental structures determine how an individual comes to evaluate and interpret information related to the self and others. In particular, this theory posits that "schemas" (Neisser, 1967) organize and determine individuals' behavior, affect and experience. Psychotherapy, within this approach, involves cognitive reeducation, in the course of which old, irrational, or maladaptive cognitions are unlearned and replaced by new, more adaptive ones. As well, areas of deficiency are remedied by the learning of new cognitive skills. On the flip side of the coin, some theories of therapy are not linked to a specific theory of personality. A good example

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is behavior therapy, which accounts for consistency in people's behavior with concepts such as conditioned and operant learning, stimulus generalization, and modeling.

In a meta-analysis, Roberts et al. (2017) investigated the extent to which personality traits changed as a result of interventions, especially clinical interventions. These interventions were found to be associated with fairly large changes in personality trait measures, regardless of the therapy employed in a particular study (e.g., supportive therapy, cognitive-behavioral therapy (CBT), and psychodynamic therapy). Such changes took place over an average of 24 weeks, which were maintained in longitudinal follow-ups.

## PSYCHOLOGICAL HEALTH AND PSYCHOPATHOLOGY

> All my writing is about the recognition that there is no single reality. But the beauty of it is that you nevertheless go on, walking towards utopia, which may not exist, on a bridge, which might end before you reach the other side.
>
> —Marguerite Young

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**PURPOSE:** To describe the way in which psychological health and pathology are conceptualized within the approach.

*Points to consider:*

1. Describe any formal or informal system for *diagnosing or categorizing individuals.*
2. *How do symptoms or problems develop? How are they maintained?*
3. *To what extent does the approach diagnose and treat individuals with serious mental illness?*
4. Is there a concept of the *ideal* or *healthy personality* or optimal functioning within this approach?

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Much can go awry in the developing personality due to biological or psychosocial factors. Symptoms can result from contemporaneous stresses and strains or, more typically, from the interaction of a personality disposition with a current event that triggers emotional disturbance or maladaptive interpersonal behavior (the diathesis–stress model; Ingram & Luxton, 2005). *Although some theories avoid the use of language and labels that pathologize human experience, they still speak clearly about what constitutes maladaptive behavior.* Thus, even schools of therapy that do not formally judge the health of a person based on external criteria, such as symptoms or interpersonal difficulties, do attend to the consequences of behavior in terms of that person's welfare and interest. In addition, there is mounting appreciation of the need to conceptualize personality not just in terms of diathesis and stress, but in a broader social–ecological framework, in which human development is understood as a bidirectional interaction between individuals and the multiple systems in which they are embedded (Bronfenbrenner, 1979).

It should be noted that psychological disorders possess no natural boundaries, only loose categorical coherence. This is not an instance in which nature is carved at its joints. In fact, there is a recent proposal to conceptualize psychopathology along a single dimension, called *p,* parallel to the *g* factor of general intelligence. It is an effort to unite all mental

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disorders. "Studies show that the higher a person scores on *p,* the worse that person fares on measures of family history of psychiatric illness, brain function, childhood developmental history, and adult life impairment" (Caspi & Moffitt, 2018, p. 831).

All efforts to date have failed to identify objective features that underlie the various mental disorders as characterized by DSM-5 (American Psychiatric Association, 2013) and ICD-11 (World Health Organization, 2018). What people seem to agree on is their undesirability, which is more a moral than a scientific valuation (Woolfolk, 1998). In fact, *a therapy may reveal its esthetic and moral values by how it conceptualizes mental health and psychological well-being.* For example, "Psychoanalysis puts forth the ideal of the genital personality, humanistic psychology the self-actualized person, and cognitive-behavior therapy, the objective problem-solving human being" (Messer & Woolfolk, 1998, p. 257).

In other words, the terms of personality theory, psychopathology, and the goals of psychotherapy are not neutral. They are embedded in a value structure that determines what is most important to know about and change in an individual, couple, family, or group (Woolfolk, 2015). Even schools of psychotherapy that attempt to be neutral with regard to what constitutes healthy (and, therefore, desirable) behavior, and unhealthy (and, therefore, undesirable) behavior inevitably, if unwittingly, reinforce the acceptability of some kinds of client strivings more so than others.

Ways of assessing personality and pathology are closely linked to the underlying theory. If the latter focuses on unconscious factors, for example, asking about dreams and early memories may be considered a more fertile mode of assessment than self-report questionnaires (Messer & Wolitzky, 2007). In the following chapters, the reader is encouraged to look for the links among personality theory, the description of psychopathology, the manner of assessing these dimensions, and the kinds of changes that are sought.

## THE PROCESS OF CLINICAL ASSESSMENT

> If you are sure you understand everything that is going on, you are hopelessly confused.
>
> —WALTER MONDALE

> I was a keen observer and listener. I picked up on clues. I figured things out logically, and I enjoyed puzzles. I loved the clear, focused, feeling that came when I concentrated on solving a problem and everything else faded out.
>
> —SONIA SOTOMAYOR

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**PURPOSE:** To describe the methods used to gain understanding of an individual's (or couple's or family's) style or pattern of interaction, symptoms, and adaptive resources.

*Points to consider:*

1. What, if any, *is the role of standard psychiatric diagnosis* in your assessment? Does it influence treatment planning, or is it used primarily for administrative purposes?
2. *At what unit level(s) is assessment made* (e.g., individual, dyadic, system)? *At what psychological levels is assessment made* (e.g., intrapsychic, behavioral, interpersonal, systemic)?

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3. To what extent and in what ways are *cultural factors (e.g., gender, ethnicity, race, sexual orientation, religion/spirituality, social class)* considered in your assessment?
4. Are any tests, devices, questionnaires, *or* structured observations typically used?
5. Is assessment separate from treatment or integrated with it (e.g., what is the temporal relationship between assessment and treatment)?
6. Are the patient's strengths/resources a focus of your assessment? If so, in what way?
7. What other dimensions or factors are typically involved in assessing dysfunction?

*The practicality of a good theory of psychotherapy, including ideas about personality development and psychological dysfunction, becomes evident as the therapist tries to make sense of both problem stability (how problems persist) and problem change (how problems can be modified).* As indicated earlier in Meltzoff and Kornreich's (1970) classic definition of psychotherapy, the therapist is obligated to take some purposeful action in regard to an understanding of the nature and parameters of whatever problems, symptoms, complaints, or dilemmas are presented. Therapists typically are interested in ascertaining what previous steps clients/patients have taken to resolve or improve their difficulties, and what adaptive resources they, and possibly other people in their world, have for doing so.

Moreover, the therapist pays attention to the cultural (ethnic, racial, religious, social class, gender) context in which clinically relevant concerns arise. Such contextualizing factors can play a critical role in how the therapist collaboratively defines the problem at hand and selects a general strategy for addressing the problem therapeutically. The 2017 Multicultural Guidelines set forth by the American Psychological Association (2017) highlight the necessity of incorporating an ecological framework when conducting interviews and assessments with culturally diverse clients/patients. Similarly, mounting attention has been paid to cultural variations in assessing various forms of psychopathology and culture-bound syndromes in forms of evaluation ranging from neuropsychological to personality assessment (Paniagua & Yamada, 2013; Smith & Krishnamurthy, 2018).

How therapists actually engage in clinical assessment varies from one approach to another (Eells, 2007), but all include face-to-face clinical interviews. The majority of therapists emphasize the immediate therapist–client/patient conversation as the source of such understanding. A smaller number of therapists also opt to complement such conversations with direct observations of the problem as it occurs as in family and couple conflict situations, or in cases involving anxiety-based avoidance of specific stimuli. In addition, some therapists regularly include in the assessment process a variety of patient self-report questionnaires or inventories, and may also use structured interview guides, which are usually research-based instruments. Generally, therapists who use such devices have specialized clinical practices (e.g., focusing on a particular set of clinical disorders for which such measures have been specifically designed) or come from specific theoretical traditions.

The place of standard psychiatric diagnosis in the clinical assessment phase of psychotherapy likewise varies widely. The overwhelming majority of psychotherapists of different theoretical orientations routinely consider the traditional diagnostic, psychiatric status of patients according to the criteria of the current edition of DSM (American Psychiatric

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Association, 2013) and/or the ICD-11 (World Health Organization, 2018), at least to meet requirements for financial reimbursement, maintenance of legally mandated treatment records, and other such institutional necessities. Although engaging in such formal diagnostic procedures may provide a useful orientation to the general area of a patient's/client's concerns, every method of psychotherapy has developed and refined its own, more fine-grained, idiosyncratic ways of understanding each individual patient's/client's problem. Moreover, some approaches to psychotherapy argue that "diagnoses" do not exist "out there" in nature but merely represent the consensual labels attached to certain patterns of behavior in particular cultural and historical contexts. Such therapy approaches see the use of diagnostic labeling as an unfortunate and unwarranted assumption of the role of "expert" by therapists, which may inhibit genuine collaborative exploration between therapists and "patients" or "clients" (e.g., see Bohart & Watson, Chapter 7, this volume). For such therapists, what matters more are the fluid issues with which people struggle, not the diagnoses they are given (e.g., see Schneider & Krug, Chapter 8, this volume).

All things considered, one primary dimension along which clinical assessments vary is the intrapersonal–interpersonal one. Some therapy models emphasize intrapsychic processes, whereas others emphasize social interaction. In fact, there is a constant interplay between people's inner and outer lives. Emphasis on one domain versus another reflects an arbitrary punctuation of human experience that probably says as much about the perceiver's theory as it does about the client/patient who is perceived. Another dimension on which such assessments vary relates to the extent to which attention is paid to affects, behaviors, or cognitions.

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## THE PRACTICE OF THERAPY

> In theory, there is no difference between theory and practice. In practice, however, there is.
>
> —Anonymous

> We delight in the beauty of the butterfly, but rarely admit the changes it has gone through to achieve that beauty.
>
> —Maya Angelou

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**PURPOSE:** To describe the typical structure, goals, techniques, strategies, and process of a particular approach to therapy and their tactical purposes.

*Points to consider:*

A. Basic Structure of Therapy

1. *How often* are sessions typically held?
2. Is therapy *time-limited or unlimited*? Why? How long does therapy typically last? How long are typical sessions?
3. Who is typically included in therapy? Are combined formats (e.g., individual plus family or group sessions) ever used?
4. How structured are therapy sessions?
5. Are individuals with more serious disorders (e.g., schizophrenia, bipolar

disorder, personality disorders such as borderline personality disorder) treated within this approach? What, if anything, is different in treating them? (See also the section on “Treatment Applicability.”)

B. Goal Setting

1. Are there *treatment goals that apply to all or most cases* for which the treatment is appropriate (see the sections “Treatment Applicability” and “Ethical Considerations”) regardless of presenting problem or symptom?
2. Of the number of possible goals for a given client/patient group, *how are the central goals selected*? How are they prioritized? Who determines the goals of therapy? Are therapist values involved in goal setting?
3. *Do cultural factors (e.g., gender, ethnicity, race, sexual orientation, religion/spirituality, social class) typically influence the setting of treatment goals and, if so, how?*
4. Do you *distinguish between intermediate or mediating goals and ultimate goals?*
5. Is it important that treatment goals be discussed with clients/patients explicitly? If yes, why? If not, why not?
6. At what level of psychological experience are goals established (are they described in overt behavioral terms, in affective–cognitive terms, etc.)?

C. Process Aspects of Treatment

1. *Describe and illustrate with brief case vignettes major commonly used techniques and strategies.*
2. How is the decision made to use a particular technique or strategy at a particular time? Typically, are different techniques used in different phases of therapy?
3. Are homework or other out-of-session tasks used? If so, give examples.
4. *How are cultural considerations addressed in the therapeutic/intervention process?*
5. What are the most commonly encountered forms of *resistance to change*? How are these dealt with?
6. What are both the most common and *the most serious technical errors* a therapist can make operating within your therapeutic approach?
7. Are psychotropic *medications ever used* (either by the primary psychotherapist or in collaboration with a medical colleague) within your approach? What are the indications–contraindications for their use?
8. On what basis is termination decided, and how is termination effected?
9. Have recent findings in neuroscience influenced important process aspects of your therapeutic approach?
10. Is there a *trend toward integrating features* of other therapies? If so, are there particular approaches that are most often integrated and how does this integration occur?

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*Psychotherapy is not only a scientific and value-laden enterprise but also part and parcel of its surrounding culture. It is a significant source of our current customs and worldviews* and thus possesses significance well beyond the interactions between clients/patients and therapists. For example, when laypeople refer to Freudian slips, defenses, guilt complexes, conditioned responses, existential angst, identity crises, codependency, an enabling partner, or discovering their true self, they are demonstrating the impact of psychological and psychotherapeutic categories on their vocabulary and cultural conversations. Similarly, when they explain their problems in terms of childhood occurrences such as parental neglect, repressed memories, conditioned emotional reactions, family dysfunction, lack of unconditional positive regard, or maladaptive behavior or thoughts, they are affirming that the institution of psychotherapy is much more than a technical, medical, or scientific endeavor. It helps to shape the very terms in which people think, and even constitutes the belief system they use to explain and make sense out of their lives (Messer & Woolfolk, 1998).

Recent years have witnessed growing support for cultural competency in psychotherapeutic interventions. Although some have argued for the cultural universality of psychotherapies, others have underscored the importance of cultural modifications or adaptations to ensure effective treatment of individuals from diverse backgrounds (Bernal & Domenech Rodriguez, 2012). A meta-analysis that included 14,000 participants, 95% of whom were non-European Americans, revealed that culturally adapted interventions are more effective than other interventions or no intervention (Hall, Ibaraki, Huang, Marti, & Stice, 2016). Similarly, in another meta-analysis that compared culturally adapted with unadapted psychotherapy, the former was more effective on measures of psychological functioning (Benish, Quintana, & Wampold, 2011). It has been argued that the therapist's cultural competence is relevant to effective psychotherapeutic practice because it leads to a better relationship, enabling the client/patient to feel empathically understood and empowered (Chu, Leino, Pflum, & Sue, 2016a).

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Not surprisingly, psychotherapy is a sensitive barometer of cultural customs and outlooks to which the different modes of practice are responsive and incorporate within their purview. The relation between psychotherapy and culture, then, is one of reciprocal influence (Messer & Wachtel, 1997). For example, two currently important cultural phenomena affecting the practice of psychotherapy are the medicalization of how psychological disorder is treated and the technology revolution.

Regarding the medicalization of mental health treatment, the language of medicine has long been prominent in the field of psychotherapy. We talk of "symptoms," "diseases," "disorders," "psychopathology," and "treatment." Many medications have been at least moderately successful in treating the full array of psychological disorders. These medications are actively promoted on television and via social media directly to the consumer, with the promise of the pill removing a person's worries and blues. Thus, the pharmaceutical companies have played their part in promoting a biological approach to mental disorder. This is despite the fact that psychological treatments are often at least as effective as pharmacotherapy. For example, a recent review of hundreds of randomized controlled trials (RCTs) of the effects of psychological treatment of adult depression concluded that such interventions are evidence-based and have comparable benefits to those found with antidepressant medications (Cuijpers & Gentili, 2017). The authors went on to note that the positive outcomes for psychotherapy may be of longer duration than those for pharmacological interventions.

What about the combination of medication and psychotherapy in the treatment of depression? In a meta-analysis of 23 RCTs in which combined treatment was compared to

either psychotherapy or antidepressant medication alone, Karyotaki et al. (2016) reported that in the acute phase of major depressive disorder, the combination of medication and psychotherapy outperformed antidepressants alone. In the maintenance phase, combined psychotherapy with antidepressants resulted in better sustained treatment response compared to antidepressants alone. Psychotherapy alone was as effective as both treatments combined at 6 months posttreatment or longer. Furthermore, Dunlop (2016) concluded that the sequential addition of psychotherapy for individuals whose depression does not remit following a trial of antidepressant medication shows the most support in terms of improving remission rates and reducing relapse and recurrence rates over time. There is also evidence from a recent meta-analysis that the combination of the two interventions is most likely to be associated with improvements in functioning and quality of life (Kamenov, Towmey, Cabello, Prina, & Ayuso-Mateos, 2017). In our view, these results argue for the importance of psychotherapy in the treatment of depression either alone or often in combination with medication.

The growing appreciation of a biopsychosocial–cultural framework has had an impact on the practice of psychotherapy. Individuals who present for psychotherapy and their therapists are more likely to consider having medication prescribed. Psychologists and other nonmedical therapists collaborate more frequently with physicians in treating their patients. Courses in psychopharmacology are now routinely offered or even required in training programs for various behavioral health professionals. Relatedly, recent advances in neuroscience, especially in the realm of "affective neuroscience" (e.g., Panksepp, 2013) and "interpersonal neurobiology" (e.g., Solomon & Siegel, 2017), have demonstrated the brain's capacity for plasticity and change, providing a basis for some broad principles to guide psychotherapy with individuals (Cozolino, 2017), couples (Fishbane, 2013), and groups (Kinley & Reyno, 2016). Levenson (2017), however, advises caution about prematurely concluding "that we can identify specific neurological processes and brain structures to explain precisely why and how our therapeutic interventions work" (p. 121). From our standpoint, it would be unfortunate if the range of essential therapies described herein were not taught and practiced, if the psychological outlook these essential therapies convey were not respected, and if the important kind of psychological help these therapies offer were made less available because of excessive biologizing of our understanding of psychological suffering and change.

It should be noted that controlled comparisons among therapies typically result in a finding of "no difference" (Lambert, 2013). For instance, when CBT was compared to psychodynamic therapy for adult outpatient depression on measures of psychopathology, interpersonal functioning, pain, and quality of life, no significant differences were found (Driessen et al., 2017). About 45–60% of the individuals who completed posttreatment assessment showed clinically meaningful change for most outcome measures regardless of intervention condition. Much more study is needed before we can conclude which psychotherapies are best for which individuals with which diagnoses or problems. Such investigations must take into account not only the different psychotherapeutic approaches being compared but also the clients'/patients' preference for a particular modality, given that such preferences are associated with lower levels of dropout and more positive treatment outcomes (Swift, Callahan, Cooper, & Parkin, 2018).

In terms of the technology revolution, technology has increasingly become integrated into psychotherapy delivery in the past 15 years. Technology-based psychotherapy has surfaced as an alternative approach to in-person psychotherapy services when these are not

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accessible. Initially, the focus was on the use of telephone technology in psychotherapy, which has been found to be effective for a range of psychological disorders, as well as for individuals with medical problems (Alvandi, Van Doorn, & Symmons, 2017). Building on the use of the telephone has been videoconferencing for psychotherapy. Recently, guidelines have been developed to address the provision of such telepsychology services including psychotherapeutic interventions (Joint Task Force for the Development of Telepsychology Guidelines for Psychologists, 2013).

Concomitant with the recent dramatic proliferation of a range of Internet technologies (e.g., Internet digital gaming, virtual reality, robotics) for health promotion and intervention (i.e., eHealth) has been the proliferation of mobile device use (e.g., smartphones, tablets, personal digital assistants, wearable devices) within the health care context to support the promotion, maintenance, and intervention of health-related concerns (i.e., "mHealth"; Luxton, McCann, Bush, Mishkind, & Reger, 2011). mHealth includes mobile phone applications (apps), text messaging systems, personal digital assistants, social media usage, ecological momentary assessment (EMA) and ecological momentary intervention (EMI), and sensory technology (Borrelli & Ritterband, 2015). Apps are the most common form of mHealth, and a plethora of them have been developed to increase the accessibility, convenience, and effectiveness of mental health treatment (Crooks, Mack, Nguyen, & Kaslow, in press; Luxton et al., 2011). mHealth technologies are convenient, portable, and readily accessible, and thus have the potential to bypass stigmatizing attitudes toward the seeking of behavioral health. Such resources also help reduce disparities in mental health care (Crooks et al., in press). Despite preliminary evidence that mobile apps and other forms of mhealth technology are acceptable to patients/clients and effective in treating behavioral health symptoms (Lindhiem, Bennett, Rosen, & Silk, 2015), the limited research investigating their efficacy means that it is premature to conclude that they are effective for behavioral health treatment (Clough & Casey, 2015).

In keeping with the advancement of technology usage in psychotherapy, there has been an explosion in the number and variety of technologies in psychotherapy supervision and training (e.g., videoconference supervision, cloud-based file sharing software, clinical outcome tracking software; Rousmaniere, 2014; Wolf, 2011). Research on technology-assisted supervision and training (TAST) demonstrates that it enhances the education and training process (Rousmaniere, Abbass, & Frederickson, 2014).

## THE THERAPEUTIC RELATIONSHIP AND THE STANCE OF THE THERAPIST

> Remember that the best relationship is one in which your love for each other exceeds your need for each other.
>
> —The Dalai Lama

> Walking with a friend in the dark is better than walking alone in the light.
>
> —Helen Keller

**PURPOSE:** To describe the stance the therapist takes with clients/patients.

*Points to consider:*

1. *To what extent is the therapeutic alliance prioritized in this approach?*
2. How does the therapeutic relationship influence the outcome of therapy?

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3. What techniques or strategies are used to *create a treatment alliance (e.g., warmth, empathy, acceptance, coaching, accurate interpretations especially of the therapist–patient interaction). Describe and illustrate the nature of the therapeutic alliance.*
4. How are cultural factors taken into account, if at all, in the formation and/or maintenance of the alliance?
5. To what degree does the therapist overtly control sessions? *How active/directive is the therapist?*
6. Does the therapist assume responsibility for bringing about the changes desired? Is responsibility left to the client/patient? Is responsibility shared?
7. Does the therapist use self-disclosure? What limits are imposed on therapist self-disclosure? In general, *what role does the "person" of the therapist play* in this approach? *Describe and illustrate.*
8. Does the therapist's role change as therapy progresses? Does it change as termination approaches?
9. Is *countertransference or the therapist's experience of the client/patient* recognized or employed in any fashion?
10. How are *ruptures in the alliance handled and repaired?*
11. What *clinical skills or other therapist attributes are most essential* to successful therapy in your approach?

---

In recent years, a great deal of effort has been expended to identify EBPs among the many existing forms of psychotherapy (e.g., Nathan & Gorman, 2015). Although such efforts can be useful for important public policymaking decisions, they tend to focus heavily on one particular domain of the therapy experience—the role and impact of *therapeutic techniques*. Increasingly, evidence-based therapy-oriented efforts have been counterbalanced by efforts to investigate and understand the essential characteristics and effects of *evidence-based therapy relationships* (Norcross, 2011; Norcross & Wampold, 2018; Wampold & Imel, 2015). Regarding the latter, as far back as 1913, Freud understood that collaboration and cooperation between therapist and patient required a certain degree of rapport between them. For a patient to be receptive to their interventions, Freud posited, therapists had to show a serious interest in the patient, be sympathetic, avoid moralizing and not take the part of a third, contending party (Messer & Wolitzky, 2010). Since that time, hundreds of studies have confirmed that there is a moderate correlation between the strength of the therapeutic alliance and therapy outcome (e.g., Crits-Christoph, Connelly Gibbons, & Mukherjee, 2013) regardless of the specific type of psychotherapy. The elements of the relationship that have garnered the most empirical support include the alliance (in individual, couple, and family therapy), collaboration, agreement about goals, cohesion (group therapy), empathy, positive regard and affirmation, and client/patient feedback (Norcross & Wampold, 2018).

Different therapies, however, make use of the therapeutic relationship (TR) (or therapeutic alliance) in different ways. Messer and Fishman (2018) present a two-by-two model to map these differences: One dimension is the establishment of a relationship in order to have more leverage when using techniques to bring about therapeutic change versus the TR itself as the hub of the treatment. The second dimension pertains to how directly the therapist's actions address the TR: Are the therapist's interventions designed to address it directly

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or are they not, even if the interventions nevertheless impact the TR. For example, in CBT, the TR is considered necessary but insufficient to bring about change, but how the therapist's actions are implemented has an indirect impact on the TR. By contrast, in psychodynamic therapy, the TR is part and parcel of the treatment itself, and the therapist's actions are designed to address the TR directly. In family systems therapy, the TR is necessary but insufficient, as in CBT, but different from CBT, in that the therapist's actions are designed to address the TR directly. As Messer and Fishman demonstrate, other therapies in a similar fashion can be placed in one of the four cells created by this matrix.

Another way of understanding the role of the alliance has been proposed recently by Zilcha-Mano (2017). She differentiates between the alliance as trait-like—that is, the person's ability to form satisfactory relationships with others, including the therapist—and the alliance as state-like, which changes during treatment and is an active ingredient in bringing about change. She posits that in some treatment models the alliance may be "predominantly a precondition for therapeutic change whereas in other orientations it may also be curative in itself" (p. 320). Although they were developed independently, there is clearly overlap between the Messer and Fishman (2018) and Zilcha-Mano (2017) models.

Work on the alliance or relationship provides a solid empirical basis for arguing that *the therapist as a person exerts at least moderate effects on the outcome of psychotherapy, and that these effects often outweigh those that are attributable to treatment techniques per se* (Wampold & Imel, 2015). Even symptom-focused therapy encounters, which rely substantially on the use of clearly defined change-inducing techniques, occur in the context of human relationships characterized by support and reassurance, persuasion, identification, and the modeling of active coping.

The kind of TR required by each approach to psychotherapy affects the overall "stance" the therapist takes to the experience (how the working alliance is fostered, how active and self-disclosing the therapist is, etc.). Thus, different therapeutic orientations appear to call forth (and call for) somewhat different therapist attributes and interpersonal inclinations. For example, therapists with a more "take charge" personal style may be better suited to practicing therapy approaches that require a good deal of therapist activity and structuring than to those therapies requiring a more reflective style.

Given the presumed outcome equivalence of the major modes of psychotherapy (Lambert 2013), it is not surprising that idiosyncratic personal factors influence therapists' preferred ways of practicing. Thus, it has been found that therapists generally do not advocate different approaches on the basis of their relative scientific status but are more influenced by their own direct clinical experience, personal values and philosophy, and life experiences (Norcross & Prochaska, 1983; Stewart & Chambless, 2007).

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## CURATIVE FACTORS OR MECHANISMS OF CHANGE

> The road is not the road, the road is how you walk it.
>
> —Juan Ramón Jiménez

> Here are the values that I stand for: honesty, equality, kindness, compassion, treating people the way you want to be treated and helping those in need. To me, those are traditional values.
>
> —Ellen DeGeneres

**PURPOSE:** To describe the factors (i.e., mechanisms of change that lead to change) and to assess their relative importance. Include key research findings if possible.

*Points to consider:*

1. What are the proposed *curative factors or mechanisms of change* in this approach?
2. Do patients *need insight or understanding* in order to change and, if so, describe. Are interpretations of any sort important and, if so, do they take history into account? If interpretations of any kind are used, are they seen as reflecting a psychological "truth," or are they viewed rather as a pragmatic tool for effecting change?
3. How important is the learning of new interpersonal skills as a curative element of change? When important, are these skills taught in didactic fashion, or are they shaped as approximations that occur naturalistically in treatment?
4. Does the therapist's personality or psychological health play an important part in bringing about change?
5. How important are *techniques as opposed to relational factors, such as the therapeutic alliance, for the outcome of therapy*?
6. Are corrective emotional or cognitive experiences considered curative?
7. To what extent does the management of termination of therapy determine outcome?
8. What aspects of your therapy are *not* unique to your approach (i.e., are common to all or most psychotherapies)?

*A current controversy in the psychotherapy research literature is whether change is brought about largely by specific ingredients of therapy or factors common to all therapies.* The former usually refers to specific technical interventions, such as biofeedback, systematic desensitization, *in vivo* exposure, cognitive reframing, interpretation, or empathic responding, which are said to be the ingredient(s) responsible for client/patient change. In some therapies, these techniques are set out in detail in manuals to which the practitioner is expected to adhere in order to achieve the desired result. The specific ingredient approach has some similarities to the medical model insofar as it treats a particular disorder with a psychological technique (akin to administering a pill or employing a surgical technique), producing the psychological equivalent of a biological or physical effect. Its proponents tend to fall in the behavioral, cognitive, and cognitive-behavioral camps, but at least in theory could hail from any of the psychotherapy schools. Followers of the EBP movement are typically adherents of this approach, advocating specific modes of intervention for different forms of psychopathology.

*Common factors* are relevant to all therapeutic approaches and are not anchored in any specific model of treatment. Because outcome studies comparing different individual therapies have found few between-group differences (Lambert, 2013), it has been argued that common factors are key change elements and the curative elements responsible for

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therapeutic success in individual therapy, as well as in couple and family therapy (e.g., Sprenkle, Davis, & Lebow, 2009). The following are the key categories of variables that have been shown to be common factors:

- *Client/patient factors* that have been deemed to be common to positive outcomes across psychotherapies include a genuine motivation to and readiness for change, active participation in the therapeutic process, requisite skills and confidence to change, and a belief that change will be beneficial (Bohart & Tallman, 2010).

- *Therapist factors* include the capacity to create a healing setting; listening and conveying presence, empathy, and warmth; affirming the client's/patient's feelings and experiences; treating the client/patient as an individual and a human being; highlighting the client's/patient's strengths, abilities, and resources; and instilling hope and positive expectations for change (Blow, Sprenkle, & Davis, 2007; Moix & Carmona, 2018; Wampold, 2012).

- *Therapeutic relationship/alliance factors* include collaboration, mutuality, cohesions, a trusting bond, cultural respect, a consensus about therapeutic goals and tasks, and development of an explanatory framework and belief shared by both parties (Moix & Carmona, 2018; Wampold, 2012).

- *Therapeutic interventions* that have been subsumed within the common-factors approach include reflective listening, use of "I" statements, varied use of questions, provision of feedback, and efforts to help the client/patient acquire mastery (Weinberger & Rasco, 2007). Recently, it has been purported that the common-factors perspective offers an additional evidence-based approach for understanding the mechanisms of change in psychotherapy (Laska et al., 2014).

Drawing on the common-factors approach, Wampold (2001) developed what he refers to as a *contextual model*. In it, "the purpose of specific ingredients is to construct a coherent treatment that therapists believe in, and this provides a convincing rationale to clients. Furthermore, these ingredients cannot be studied independently of the healing context and atmosphere in which they occur" (Messer & Wampold, 2002, p. 22). In a sense, this is a common factors model that also takes account of the context in which those factors occur, namely, a healing atmosphere and the employment of a specific theoretical model. Wampold (2001) has made a case for the centrality of common factors such as the therapy alliance, the therapist's allegiance to his or her theory or rationale for treatment, and the personality qualities and skills of the therapist. He reviews the evidence for the specific ingredients model and finds it wanting (see also Wampold & Imel, 2015). Nevertheless, proponents have also presented convincing evidence in favor of the specific ingredients model (e.g., Baker, McFall, & Shoham, 2009; Chambless & Ollendick, 2001; Yulish et al., 2017).

A third approach has been to challenge the dichotomy of relationship and technique, to show that they are partly overlapping categories (Lundh, 2017) and that neither approach can exist without the other (McAleavey & Castonguay, 2015). In a similar vein, Lin (2016) presents a framework for integrating common and specific factors in therapy. Consistent with this outlook, there have been mounting calls for the benefits of teaching and practicing therapy-specific models alongside common factors approaches with individuals, as well as with couples and families (Karam, Blow, Sprenkle, & Davis, 2015).

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## TREATMENT APPLICABILITY AND ETHICAL CONSIDERATIONS

> All who drink this remedy recover in a short time, except those whom it does not help, who all die and have no relief from any other medicine. Therefore, it is obvious that it fails only in incurable cases.
>
> —GALEN

> Our motto, E Pluribus Unum, of many one, signals our appreciation that we are the richer for the religious, ethnic, and racial diversity of our citizens.
>
> —RUTH BADER GINSBURG

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**PURPOSE:** To describe those patients for whom your approach is especially relevant and any health-related applications.

*Points to consider:*

1. For what *kinds of clients/patients* is your approach particularly relevant?
2. For whom is your approach either *not appropriate* or of uncertain relevance?
3. Are there either inherent or likely advantages and/or limitations in the applicability of your approach to people of *diverse cultural backgrounds (e.g., as a function of gender, ethnicity, race, sexual orientation, religion/spirituality, social class)?*
4. When, if ever, would a referral be made for another (i.e., different) type of therapy?
5. Are there *applications of your approach to general health care* (e.g., smoking, pain, weight loss, psychosomatic symptoms, exercise)? Give examples.

**PURPOSE:** To describe ethical issues that are particular to your approach.

*Points to consider:*

1. Are there features of your approach that can lead to *specific ethical issues? If so, describe them.*
2. *Provide a vignette* of an ethical issue that has arisen and how it was resolved.

Questions about the applicability, relevance, and helpfulness of particular psychotherapy approaches to particular kinds of symptoms, problems, psychopathology, and issues are best answered through careful research on *treatment efficacy* (as determined via randomized clinical trials) and *effectiveness* (studies in practice or other real-world settings). Testimonials, appeals to established authority and tradition, and similar unsystematic methods are insufficient to the task. Psychotherapy is too complex to track the interaction among, and impact of, the most relevant factors in therapeutic outcomes on the basis of only individual participants' perceptions. Moreover, the contributions to therapeutic outcomes of therapist, client/patient, the relationship, and technique factors probably vary from one therapeutic method to another.

When Galen's observations (in the opening epigraph) about presumptively curative medicines are applied to psychotherapy nowadays, they are likely to be met with a knowing

chuckle and implicit recognition of the inherent limits of all our treatment approaches. Still, *new therapy approaches rarely make only modest and restrained claims of effectiveness, issue "warning labels" for "customers" for whom their ways of working are either not likely to be helpful or may possibly be harmful, or suggest that alternative approaches may be more appropriate under certain conditions.* In fact, Meichenbaum and Lilienfeld (2018) have developed a "Psychotherapy Hype Checklist" that comprises 19 warning signs that point to exaggerated claims of a therapy's effectiveness.

If therapy methods continue to grow in number (and we see no reason to predict otherwise), the ethical complexities of the psychotherapy field may grow commensurately. There are generic kinds of ethical matters with which therapists of all orientations must deal: for example, confidentiality, adequacy of recordkeeping, duty to warn, respect for personal boundaries regarding sexual contact and dual relationships, and so forth. Yet more recent influential approaches, especially those involving multiperson clientele (e.g., couple, family and group therapy), raise practical ethical matters that do not emerge in more traditional modes of practice—for example, balancing the interests and needs of one person against the interests and needs of another, while also trying to help maintain the very viability of the client/patient system (e.g., couple or family; Gottlieb, Lasser, & Simpson, 2008).

Such potential influences of new perspectives on ethical concerns in psychotherapy are perhaps nowhere more readily and saliently seen than when matters involving cultural diversity are considered. Certainly, all psychotherapists must be sensitive in their work to matters of race, ethnicity, social class, gender, sexual orientation, and religion, adapting and modifying both their assessment and treatment-planning activities, and perspectives and active intervention styles as is deemed functionally appropriate to the situation at hand. To do otherwise risks the witting or unwitting imposition of the therapist's values onto the patient, such as in the important area of setting goals for their work together.

To begin with, the American Psychological Association has offered a series of guidelines for working with specific client/patient populations based on age, gender, sexual orientation, gender identity, etc. The initial *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* crafted by the American Psychological Association (American Psychological Association, 2003) recently were updated with an eye toward the transformation that has occurred with regard to diversity and multiculturalism since the publication of the original guidelines, combined with a greater appreciation of the intersectionality, that is, the overlapping and interconnected nature, of various social identities and categories (American Psychological Association, 2017). These updated guidelines, entitled *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality,* which became the policy of the organization in 2017, encourage psychologists and other psychotherapists to attend to developmental and contextual antecedents of identity and to adopt a richer and more complete appreciation of diversity and human differences and their impacts across individuals and communities (American Psychological Association, 2017).

A rapidly growing number of books and articles on culture and diverse topics such as race, feminism, immigration, religion and spirituality, sexual orientation, and gender identity, as they pertain to psychotherapy and counseling, have appeared, putting multiculturalism closer to the center than the periphery of practice (Chu, Leino, Pflum, & Sue, 2016b; Hook, Davis, Owen, & DeBlaere, 2017). Research has followed suit, producing results such as a positive association between clients'/patients' perceptions of their therapists' multicultural competence and their ratings of the therapeutic alliance, satisfaction

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with the psychotherapy, and view of the therapist's overall competence as well as with their treatment outcomes (Tao, Owen, Pace, & Imel, 2015). That psychotherapy is at least as much a socially and culturally situated activity as a biologically driven one is elaborated in a series of papers on psychotherapy as practiced internationally (Wachtel, 2008).

## RESEARCH SUPPORT AND EBP

> If all the evidence as you receive it leads to but one conclusion, don't believe it.
>
> —MOLIÈRE

> The process of being scientific does not consist of finding objective truths. It consists of negotiating a shared perception of truths in respectful dialogue.
>
> —ROBERT BEAVERS

---

**PURPOSE:** To summarize existing research that supports the efficacy and/or effectiveness of your approach and generally to describe the role of research in the typical practice of your approach.

*Points to consider:*

1. Describe the *nature and extent of empirical research that supports the efficacy and/or effectiveness* of your approach.
2. *If supportive research is not abundant*, *on what other bases* can the effectiveness of your approach be argued?
3. Do research findings on your approach typically get incorporated into clinical practice? If so, how?
4. How does your approach regard the movement toward EBP?

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### Psychotherapy Process and Outcome Research

Each chapter in this volume provides a snapshot of the *outcome research* backing its particular model of therapy. *The many hundreds, if not thousands, of studies on the outcome of psychotherapy* are testament to investigators' efforts to place the field on a firm scientific footing. In recent times, a statistical process known as *meta-analysis,* which statistically compiles the results across a number of studies, has become very prominent. This procedure compares the efficacy of a particular therapy to a waiting-list control group, to another therapy, or to other treatment modalities, such as medication. Two major findings have emerged from these meta-analyses. The first is that being treated in psychotherapy is helpful to roughly 40–60% of clients (Lambert, 2013), which is higher than many evidence-based medical practices that are much costlier and come with side effects. The second is that there is little comparative difference in the effectiveness of the therapies that have been extensively practiced and researched, such as the ones discussed in this volume. Time and again, the results of comparative studies have shown that when pitted against one another, each therapy is more effective than being on a waiting list, but not better than any other standard therapy (e.g., Lambert, 2013; Wampold & Imel, 2015).

The other major kind of psychotherapy research is known as *process research.* Rather than focusing on the question of whether therapy works, it studies what takes place during

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the therapy, such as the nature of the techniques employed, and frequently their impact. A subset of process research is process-to-outcome research, which attempts to answer the question of how therapy works; that is, it relates process variables to change within a session or to therapy outcome. For example, the effects of client/patient factors (e.g., race, age, defensiveness, motivation), therapist factors (e.g., warmth, attunement, experience), types of interventions (reflection, cognitive reframing, interpretations), and the interaction among these and other variables and their relation to outcomes are all part of process research. Thousands of such studies cannot be as neatly summarized as the field's outcome results. However, after their extensive review of process-to-outcome research, Crits-Christoph et al. (2013) concluded that the strongest association between process and outcome is the therapeutic alliance. Lambert (2013) concurs that a positive affective relationship and positive interpersonal encounters that characterize most forms of psychotherapy "loom large as stimulators of patient improvement" (p. 206). The reader will find further examples in the research sections or elsewhere in the body of the individual chapters.

## EBP: The Science and Practice of Psychotherapy

There is a long history of disconnection between psychotherapy practitioners and psychotherapy researchers (e.g., Norcross, Klonsky, & Tropiano, 2008). The latter typically criticize clinicians for engaging in practices that lack empirical justification (e.g., Baker et al., 2009), and clinicians characterize researchers as being out of touch with the complex realities of conducting psychotherapy (e.g., Zeldow, 2009). Unfortunately, such criticisms are not entirely unwarranted.

As already noted, the world of psychotherapy has seen increased pressure placed on the advocates of particular therapeutic methods to document both the efficacy of their approaches through carefully controlled clinical research trials and the effectiveness of these methods via evaluations in uncontrolled, naturalistic clinical practice contexts (Nathan & Gorman, 2015). This movement to favor empirically supported treatments (ESTs) has been challenged by a complementary movement of psychotherapy researchers who assert the often overlooked importance of evidence-based relationships in therapy (Norcross, 2011; Wampold & Imel, 2015). Messer (2016), in an article on EBP, of which ESTs are a component, spelled out the advantages and disadvantages of ESTs. Among the advantages are a shared language regarding psychopathology via use of the DSM; ability to draw causal conclusions about the efficacy of a therapy; possibility of replication of the procedures in a standardized way by use of a manual; and the measurement of outcomes (e.g., symptom change, psychosocial improvements) to ensure that we are not fooling ourselves when we say that a therapy works.

Among the disadvantages of ESTs are that diagnosis is excessively narrow and mechanistic, encompassing a limited view of the person, and does not apply to couples and families; RCTs are subject to researcher allegiance effects in which researchers' theoretical persuasion affects outcomes; exclusion of many people from RCTs or high dropout rates that lead to overestimates of the value of the therapy for everyday practice; and deemphasis of individual characteristics of clients/patients (e.g., cultural background) and of therapists who are known to differ markedly in the outcomes they achieve. ESTs also tend to minimize the crucial role of the therapist–patient relationship.

Whereas the term EST refers to the results of research affirming the positive outcomes of a specific therapy, the prestigious Institute of Medicine (2001) defined the broader construct of EBP as the integration of research (the emphasis in ESTs) with clinical expertise

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and patient values. Following suit, a report of an American Psychological Association Presidential Task Force on Evidence-Based Practice (2006) defined EBP as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences" (p. 273). As the document explains, ESTs focus on each specific psychotherapy and its efficacy for specific disorders or problems under specified circumstances, whereas evidence-based psychological practice (EBPP) has as its starting point the client/patient and addresses the empirical evidence (including data from RCTs) that will enable the mental health professional to attain the optimal outcome. This definition is far friendlier to the essential roles of therapists and clients/patients, and to the kinds of therapy that put more emphasis on relationship factors than techniques (e.g., psychodynamic, experiential and other humanistic therapies).

At the risk of oversimplification, those who advocate an EST perspective tend to be associated with certain theoretical orientations (e.g., behavioral, cognitive, and cognitive-behavioral), whereas those who adopt an evidence-based relationships perspective tend to be associated with other theoretical orientations (contemporary Freudian psychoanalytic, relational psychoanalytic/psychodynamic, person-centered and emotion-focused, existential–humanistic). Other dominant approaches (e.g., couple, family, group, integrative) stand somewhere in the middle, akin to an EBP perspective.

In recent years, the American Psychological Association has begun to promulgate clinical practice guidelines. For example, there are now guidelines for posttraumatic stress disorder, and obesity and overweight in children and adolescents, and many more are in the pipeline (e.g., for depression). These guidelines offer information about strongly but conditionally recommended ESTs and medications for these various psychological disorders and are designed to serve as resources for practitioners as well as clients/patients and their families. While these guidelines can be useful in informing psychotherapeutic practice and other clinical interventions, and are in keeping with the emphasis in health care on EBP, many practitioners have expressed concerns about the constraining nature of the clinical practice guidelines and their overemphasis on ESTs as opposed to evidence-based relationships or culturally informed psychotherapeutic practice.

Regarding their role in daily practice, Zeldow (2009) points out that clinicians will always have to deal with uncertainty and uniqueness as they respond during therapy sessions in a moment-to-moment way, and will have to rely on not only empirical research but also their clinical judgment and values. Wolf (2009) sums it up well, stating that "both a scientific knowledge base and a model of clinical practice that value the judgment of the expert are necessary for psychology to be a learned profession" (p. 11). Can the field of psychotherapy foster more EBP without unduly constraining the kinds of evidence and expertise that are needed to inform it? That is, *can we create a truly scientific practice that is truly practice-friendly?*

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## CASE ILLUSTRATION

A good example is the best sermon.

—Yankee Proverb

**PURPOSE:** To illustrate the clinical application of this model by detailing the major assessment, structural, technical, and relational elements of the process of treating a person–couple–group viewed as typical, or

representative, of the kinds of clients/patients for whom this approach is appropriate.

*Points to consider:*

1. *Relevant case background (e.g., presenting problem, referral source, previous treatment history, sociodemographic factors).*
2. *Description of relevant aspects of your clinical assessment: functioning, structure, dysfunctional interaction, resources, and individual dynamics/ characteristics, including how you arrived at this description.*
3. *Description of the process and content of goal setting.*
4. *Highlight the major themes, patterns, and so forth, of the therapy over the whole course of treatment. Describe the structure of therapy, the techniques used, the role and activity of the therapist, and so forth.*

NOTE: *Do not describe the treatment of a "star case,"* in which therapy progresses perfectly. Select a case that, while successful, also illustrates the typical course of events in your therapy.

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The first psychotherapist to use case illustrations was none other than the founder of modern psychotherapy, Sigmund Freud. Here is what he wrote about the case history approach:

> It still strikes me as strange that the case histories I write read like short stories and that, as one might say, they lack the serious stamp of science. I must console myself with the reflection that the nature of the subject is evidently responsible for this, rather than any preference of my own. . . . A detailed description of mental processes such as we are accustomed to find in the works of imaginative writers enables me, with the use of a few psychological formulas, to obtain at least some kind of insight into the course of that affliction [i.e., hysteria]. [The case histories provide] an intimate connection between the story of the patient's suffering and the symptoms of his illness. (Breuer & Freud, 1895/1955, p. 160)

There are several advantages to the case report as a method for presenting the process of therapy. The therapist is in a privileged position to know what has happened over the course of therapy. A *case study* summarizes large quantities of case material in a richly textured, narrative fashion. Well-written cases bring material alive in a compelling way and bring us in on the unfolding sequence of events, major emergent themes, and results of the therapy. The treating therapist permits readers to participate in the discovery process and share in the excitement in elaborating new ideas and techniques (Messer & McCann, 2005). Case reports offer a more in-depth understanding of a particular approach to psychotherapy and, as such, have unique educational value (Nissen & Wynn, 2014).

There are disadvantages to the case report as well, particularly from a scientific standpoint. First, it is one person's view only, albeit that of a trained observer. What is not recorded may be technical mistakes that are not remembered or are simply omitted to avoid guilt or shame (Spence, 1998). We cannot assume that accounts prepared for publication are veridical, because we know memory is affected by wishes and confirmatory bias. The summary report is therefore not a substitute for the recording of actual dialogue between client/patient and therapist, because the data are selected in terms of both what is reported and the inferences that are drawn by the reporting therapist. Furthermore, it may be more

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challenging to generalize from case reports than from RCT data; it is difficult to determine a cause-and-effect relationship; and there may be a danger in overinterpreting findings (Nissen & Wynn, 2014).

Nevertheless, there have been several creative endeavors to employ case studies in such a way as to partially overcome these obstacles. One such effort employs a "hermeneutic single-case efficacy design" (Elliott et al., 2009; Elliott & Widdowson, 2017), which incorporates a combination of quantitative and qualitative data to create a rich report that offers evidence in support of and counter to the hypothesized causal influence of psychotherapy on client/patient outcomes (Elliott et al., 2009); that is, it searches for negative evidence to rule out competing explanations as to how events external to therapy might have resulted in client/patient improvement. It has been argued that this approach offers researchers a viable alternative to between- and within-group experimental designs (Benelli, De Carlo, Biffi, & McLeod, 2015).

A second approach, called the "pragmatic case study method" (Fishman, 2013), refers to systematic, qualitative case studies that capture the process and outcome of psychotherapy as practiced, and that are written up under standardized headings. Such cases also include, where possible, a comparison of the individual with others via intake and outcome data on standardized quantitative measures. (See the volume by Fishman, Messer, Edwards, & Dattilio, 2017, for case examples derived from RCTs that combine qualitative and quantitative methods). The overall aim is to maintain the clinical richness and creativity of the case study, while generating a database that permits cross-case comparisons and more generalized rules of psychotherapeutic practice. The pragmatic case study has been developed in an Internet-based journal called *Pragmatic Case Studies in Psychotherapy* (*pcsp.libraries.rutgers.edu/index.php/pcsp/about/pcspabout*), allowing open access and sufficient space for a rich narrative case exposition and expert commentary on the cases.

In a review of the Fishman et al. (2017) volume, Bohart (2017) summarized the advantages of case studies as follows:

- Identifying therapist and client/patient factors that may help determine success or failure.
- Ascertaining extratherapeutic factors, such as the role of parents.
- Examining how mismatches between client/patient and therapy can affect outcome.
- Determining the role of culture.
- Examining how the process of a specific therapy works.

For other rigorous and systematic methods that enhance the scientific value of case studies, see McLeod (2010) and Yin (2014). It remains to be seen to what extent such clinical, single-case research efforts will be generative and supplement more typical group-based empirical approaches in the future.

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## SUGGESTIONS FOR FURTHER STUDY

**PURPOSE:** To aid the instructor in assigning relevant readings and/or videos as supplements to the text.

*Points to include (plus one- or two-sentence annotation for each reference):*

1. *Two articles or accessible book chapters that provide detailed, extensive clinical case studies.*

2. *Two research-oriented articles or chapters, preferably one of which includes an overview of research findings or issues pertinent to your approach.*
3. Two videos that demonstrate your therapeutic approach.

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