Psychotherapy has come a long way from its humble beginnings as a “new movement” at the beginning of the 20th century and continues to be a field characterized by changing emphases, new developments, and considerable controversy. It receives considerable attention from the news media, has a place in the popular media such as TV, novels, movies, the Internet (Barkham, Stiles, Connell, Twigg, Leach & Angus, 2008), and its methods feature prominently in the “self-help” industry. It is widely regarded as an indispensable form of treatment for a variety of mental health problems and personal crises, and remains a popular endeavor in which a growing number of professionals and paraprofessionals are actively involved. Its evolution has been nicely summarized in The History of Psychotherapy: Continuity and Change by Norcross, Vandenbos, and Freedheim (2011).

In contrast, research into the processes and effects of psychotherapy remains much less known and, to some degree, a minor aspect of the endeavors falling under the rubric of psychotherapy with its emphasis on theory and practical application. Nevertheless, a search of ISI Web of Knowledge (an Internet journal search engine) reveals that around 60,000 academic papers have been published on psychotherapy research in just the past 30 years. If each of these papers took 1 hour to read, a comprehensive reading of the literature would take about 13 years (working at one paper per hour nonstop for 12 hours a day) and that is not including all the book chapters, reports, and papers in nonacademic journals. The field of psychotherapy research is also a vital and evolving enterprise, which supplements the theory-based activities of therapists, and is quickly becoming the foundation for treatment guidelines and “best practices” common in today’s world.

The forms that research has taken over the years have evolved in many of the same ways as psychotherapy itself—moving in the direction of precisely understanding the factors that lead to patient improvement. This evolution has been nicely summarized in past editions of this handbook (Bergin & Garfield, 1971, 1994; Garfield & Bergin, 1978, 1986; Lambert, 2004).

Before discussing current trends and issues in psychotherapy research, an historical overview is presented for the purpose of putting current research in the context of past research practices and changes in society at large. This overview includes comments on trends in practice, basic training of providers, payment systems, and issues of general interest. Finally, an overview of the book’s contents is provided.

**HISTORICAL BACKGROUND**

From the end of the 19th century to around 1960, the dominant influence in psychotherapy was Freud and his notable colleagues. Even after his death in 1939, Freud’s followers persisted in defending psychoanalysis and in creating variations and significant modifications of his original scheme. Adler, Jung, Horney, and Sullivan, among others, while offering important modifications, retained traditional features of Freud’s thinking, such as the importance of early life experiences, repressed conflict, unconscious motivation, defenses, and the like.

Research on these methods was published as early as 1924 (Bergin, 1971). Following the emergence of the Freudian influence, other approaches
to psychotherapy began to appear. Client-centered therapy as developed by Carl Rogers (1942) was a significant departure from Freudian views where the therapist was considered the expert on the client. Rogers emphasized the client’s potential for self-healing through the positive directional tendency found within, and the need for the therapist to provide an environment rich in respect, warmth, and empathic connection. Positive personality change was viewed as inevitable in such an environment. The use of interpretations common in Freudian treatment was seen not only as unhelpful, but potentially damaging.

Other more radical developments included the growth of learning-based approaches that appeared as early as the 1920s (Jones, 1924; O. Mowrer & Mowrer, 1938). Learning-based procedures emphasized patient behaviors, situational contingencies, and an active/directive role for the therapist. These approaches did not begin to have a dramatic impact on psychotherapy until the publication of Wolpe’s *Psychotherapy by Reciprocal Inhibition* in 1958. Since then psychologists have been extremely influential in the development of learning-based approaches to behavior change.

Both the Rogerian position and that of the learning-based approaches placed greater emphasis on the importance of formally evaluating the effects of therapy than had been true of other orientations. Roger’s research groups applied sound-recording techniques of actual sessions, allowing researchers to carefully examine the moment-by-moment encounter, thereby reducing the mystery of the therapeutic hour and identifying correlates of positive and negative change. Learning-based approaches put major emphasis on monitoring treatment response and its connection to therapist-guided interventions. Both methods were relatively brief (lasting weeks or months) as compared with psychoanalysis and related techniques (often taking years), a factor that increased the feasibility of research inquiries.

The emergence of cognitive therapy was a natural outgrowth of the limitations of the learning-based approaches with their emphasis on behavior at the expense of thought, but also represented dissatisfaction with the effects of psychodynamic treatments. Cognitive therapy was most notably advocated by Ellis (1962) and Beck (1970) and came to the forefront of theory-driven treatments by the mid-1970s with the publication of Beck’s (1976) *Cognitive Therapy and the Emotional Disorders*. These and related developments, such as the emergence of social learning theory (Bandura, 1969), provided rich contrasts between cognitive theories and treatment methods and carried with them a strong research emphasis.

The decades of the 1950s and 1960s were an exciting and innovative period for the field of psychotherapy and mental health in general. The community mental health movement, along with additional forces from within psychology itself, resulted in further declines in the popularity of long-term treatments, with many psychodynamic assumptions about behavior change interventions being further challenged. These challenges were largely based on social forces that provided pressure to make affordable treatments widely available to all segments of the population. The necessity of reducing treatment length continue to this day and have even become more accelerated in the past two decades due to economic pressures and the costs involved in making therapy widely available. Within psychology, theoretical issues have been a strong driving force toward changes in treatment (DeLeon, Kenkel, Garcia-Shelton, & VandenBos, 2011), but research results have also been important and, as of this writing, have become a dominant force (e.g., *Evidence-Based Psychotherapy: Where Practice and Research Meet*, Goodheart, Kazdin, & Steinberg, 2006). Practical necessity aside, theoretical battles about the causes and cures of psychopathology have been prominent in the history of psychotherapy practice and research.

The brewing theoretical controversy between systems of treatment with their underlying assumptions and practices was crystallized in a controversial article published by British psychologist Hans Eysenck. He published an early review of 24 studies, concluding that there was no research evidence to support the effectiveness of psychotherapy compared to groups receiving no therapy, and that psychoanalysis was less effective than no treatment (Eysenck, 1952). This provocative conclusion was strongly criticized by numerous psychologists (e.g., Bergin, 1971; Lambert, 1976). Nonetheless, the Eysenck article was important in sparking considerable interest in scientific investigations of psychotherapy. Since that time there has been a dramatic increase in both the quantity and quality of research on psychotherapy, with the emerging conclusions that are the focus of this and the previous handbooks.

Since Eysenck’s (1952) review, most reviews evaluating the efficacy of psychotherapy have
been much more positive. By 1970 there were enough studies on the outcome of treatments that it took “the patience of Job and the mind of a bank auditor” to integrate the information (Meltzoff & Korneich, 1970). This job was undertaken by several reviewers (Bergin, 1971; Bergin & Lambert, 1978; Meltzoff & Korneich, 1970). With the emergence of meta-analytic statistical techniques, reviews of the growing literature were subjected to quantitative analysis, with large bodies of information summed across studies. Smith, Glass, and Miller’s (1980) book was the most extensive reanalysis of the psychotherapy literature that dealt with treatment effects. Through an analysis of more than 475 studies it reaffirmed the findings of the earlier scholarly reviews. The effects of therapy are superior to no-treatment and placebo control conditions, and therapies appear to have equivalent effects when compared with each other across a variety of disorders (see Chapter 6, this volume, for an elaboration of this point). Since the Smith et al. (1980) review, the number of studies on psychotherapy has increased dramatically and, consequently, meta-analytic reviews are so numerous that just reviewing the reviews is a daunting task. Although not attempting to be comprehensive, the chapters in this book provide integrations of the effects of psychotherapy with an emphasis on recent research findings. They rely heavily on findings based on quantitative reviews. Meta-analytic reviews of the effects of psychotherapy have gone from rare in the 1980s to commonplace, providing more precise estimates of both the effects of psychological treatments and the contributing factors.

Several other developments have taken place in the field and are worthy of note here. The number and types of psychotherapy have expanded. The practitioners of psychotherapy have increased in number and diversity along with training programs. Reimbursement systems have changed dramatically and emerged as a powerful force in practice, and research, and great emphasis is being placed on providing the right treatment for the right disorder. All of these topics merit further discussion and are highlighted here as well as focused on by chapter authors.

**Issues**

A central issue for contemporary practice and research is the failure of clinicians to respond to and integrate research findings into daily activities and for researchers to make efforts to translate their findings into clinically useful recommendations for practice.

**Integration of Research and Practice**

Historically, the importance of research in guiding clinical practice has been limited. Theories that guide interventions have typically been developed and disseminated independent of research investigations. Despite considerable lip service to the importance of research for practice, many practitioners have not found treatment research, as reported in scientific journals, to be particularly useful to them. Research articles reporting clinical trials have not been rated highly among important sources of information on treatment (Cohen, Sargent, & Sechrest, 1986; Morrow-Bradley & Elliott, 1986). However, several dynamic forces have resulted in a renewed interest in outcome research and its integration into routine practice. These forces are both theoretical and economic. The emergence of cognitive-behavioral treatments and the increasing specificity of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association (2000) have led to increased interest in developing specific treatments for specific disorders. In recent years we have seen more interest in what form of therapy is most effective within diagnostic classifications. Thus, research and practice have moved from an early emphasis on viewing symptoms as superficial, to considering the removal of symptoms as a central goal of treatment. This trend can be noted in both research designs that include only patients with a specific disorder as well as increased use of dependent measures that operationalize outcomes for specific disorders (as noted by Ogles, Chapter 5, this volume). The result has been unambiguous evidence for the efficacy of some treatments that are transportable from the laboratory to clinical settings (Burns & Hoagwood, 2005).

Changes in reimbursement systems in the form of managed care organizations have also had an impact on both practice and research. These organizations have emphasized the development of clinical guidelines that are intended to make treatment more uniform across practitioners and settings and, presumably, more effective. Despite a major emphasis placed on cost reductions (rather than treatment quality) by these organizations, they clearly have rekindled the need for evidence-based practice. Irrespective of an emphasis on financial considerations the resulting attention to acquiring more research-based
evidence for effective and efficient practice promises to benefit patients in the long run if the evidence is translated into policy and practice.

**From Empirically Validated Psychotherapies to the Emergence of Evidence-Based Practice**

Based on the assumption that society is in need of treatments with known effects, and that behavioral health care specialists agree on the necessity of providing a firm base of empirical support for their activities, numerous efforts have been made to solidify evidence to guide practice. The most notorious of efforts in this area were those developed by Division 12 of the American Psychological Association (The Division of Clinical Psychology), which created criteria for what constitutes empirical support for treatments. The agenda of the original Task Force on Promotion and Dissemination of Psychological Procedures (1995) was to consider methods for educating clinical psychologists, third-party funders, and the public about effective psychotherapies. This Task Force (now called the Standing Committee on Science and Practice) generated and disseminated criteria for levels of empirical support, identified relevant treatment outcome studies, and weighed evidence according to defined criteria. This resulted in highly controversial lists of treatments that met criteria for different levels of empirical support, and lists of resources for training and treatment manuals (Woody & Sanderson, 1998), along with the phrase, empirically validated, to describe these treatments (Chambless, 1996; Chambless et al., 1996; Chambless & Hollon, 1998).

The controversies generated from the initial report came mainly from practitioners who saw the report as rigid, if not dogmatic, and as having an agenda that was biased in favor of a small number of therapies that were promoted by Task Force members (e.g., criteria were set up that would give an advantage to highly structured short-term behavioral and cognitive-behavioral treatments advocated by many Task Force members). But strong criticism came from psychotherapy researchers as well (Garfield, 1996; Nathan, 1998; Strupp, 1997). For example, Gavin Andrews (2000) who produced some of the first treatment guidelines stated his view of empirically supported treatments in a commentary:

This is not to deny that identifying empirically supported treatments carried out by a profession does not have important political advantages for the profession. Funders, providers, and consumers all like to pretend that efficacy is the same as effectiveness, and lists of empirically supported treatments feed this delusion. (p. 267)

Beutler (2000) among others provided an overview of the early efforts to set scientific standards both in the United States and abroad. He notes, however, that scientific standards for practice have been typically based on the subjective impressions of committee members rather than on the evidence itself (e.g., Nathan, Gorman, & Salkind’s 2002 *Treating Mental Disorders: A Guide to What Works*; Roth & Fonagy’s 2005 *What Works for Whom? A Critical Review of Psychotherapy Research*). The Task Force’s initial response to these criticisms appeared defensive to many—they insisted on retaining terms such as empirically “validated” therapies (later changed to empirically supported therapies, Chambless, 1996) and seemed to lack the humility of recognizing the limitations of their own work, while being especially harsh on practitioners whose practices were often seen as not being based on empirical knowledge. This “methodological” did not seem like a hopeful way of bridging the gap between practice and research, creating greater distance rather than greater consensus.

Since the earlier efforts, the task of identifying effective treatments has become more sophisticated, but the job of privileging certain psychotherapies undertaken by committees is a difficult one that will never be completed because treatments are constantly being modified, and new treatments invented. Treatments evolve, as do research strategies, and the search for final conclusions that is being undertaken by committees must always recognize the tentative nature of the results that are forthcoming from research and practice. The ensuing efforts by American Psychological Association (APA) committees appear to be mindful of this reality and much more circumspect in its assertions than the original committee (Weisz, Hawley, Pilkonis, Woody, & Follette, 2000). Nevertheless, the committee continued toward the goal of developing “a single list of empirically supported treatments” and setting “standards of practice” (Weisz et al., 2000, p. 249). But this Committee on Science and Practice also pursued a three-part agenda (Weisz et al., 2000): (1) increasing the reliability
of review procedures through standardization and rules of evidence; (2) improving research quality; and (3) increasing relevance and dissemination to the professions and public.

Given the number of disorders, treatment research paradigms, and means of measuring treatment effects, a valuable service would be to inform both practitioners and the public of developments in the field based on current research. Lists of “empirically supported treatments” are static and seem to offer only a false guarantee of effectiveness. Some would argue that even efforts at softening the term validated for the more modest term supported has not gone far enough.

More recently there have been additional attempts to further bridge the gap between practice and research. Perhaps the most important of these was undertaken by Alan Kazdin while president of the American Psychological Association (Kazdin, 2008). He helped to illuminate the various positions taken by researchers and practitioners with regard to empirical evidence noting that psychology as a discipline has increased its emphasis on what is commonly referred to as evidence-based practice in psychology (APA Presidential Task Force on Evidence-Based Practice, 2006). Key terms that are used to discuss treatments and the use of evidence reflect the differences and priorities of the various parties involved. For example, empirically supported or evidence-based treatment (EBT) refers to the specific interventions or techniques (e.g., exposure-based therapy for phobic disorders) that have produced therapeutic change in controlled trials. Evidence-based practice (EBP) is a broader term and refers to clinical practice that is informed by evidence about interventions, clinical expertise, and patient needs, values, and preferences and their integration, to make decisions about individual care (e.g., American Psychological Association [APA], 2005). In 2010 the American Psychological Association initiated a process for developing evidence-based practice and evaluation with treatment guidelines developed by a variety of organizations (Kurtzman & Bufka, 2011). In this effort a distinction is made between the narrow term treatment guideline and that of practice guideline.

Kazdin (2008) also notes that: “In the evolution of attempts to place psychotherapy practice on a stronger empirical footing the discussion of preferred treatment and delivery of services has moved into the public domain as part of the larger health-care landscape. There is an effort to provide resources that inform and make available current evidence-based interventions.” For example, on web-based sites a single link can encompass more than 30 federal, state, professional, and university sites that enumerate these interventions (http://ucoll.fdu.edu/apa/lnksinter .html). The Substance Abuse and Mental Health Services Administration (http://www.nrepp .samhsa.gov) has provided an active and ever-expanding Web-based site that regularly evaluates and adds new treatment options.

One can applaud efforts to provide resources to agencies and practitioners for the purpose of improving services; but it is also clear that some are eager to be more forceful in insisting evidence-based treatments be exclusively used. There are efforts among third-party payers and states to prescribe what treatments are to be allowed and reimbursed. According to the Campaign for Mental Health Reform—a national group of mental health organizations including among others the American Psychiatric and Psychological Associations—the only remaining impediment to widespread use of evidence-based treatment is, “resistance to change by entrenched and threatened organizational structures, outdated reimbursement rules, lack of effective provider training, and, most importantly, lack of resources” (http://www.mhreform.org).

Serious questions can be raised about who (professionals, managed-care agencies, government agencies, or administrators) should be empowered to make treatment decisions when the evidence applies to a specific client. Researchers, practitioners, and health-care policy advocates continue to debate the merits of the evidence in behalf of various interventions, what counts as evidence, and how the evidence is to be used and integrated (e.g., Burns & Hoagwood, 2005; Goodheart et al., 2006; Hunsley, 2007; Tanenbaum, 2005; Wampold, 2001; Westen, Novotny, & Thompson-Brenne, 2004). Most would agree that the final decision must rest with practitioners.

From the point of view of many practitioners and researchers, another problem with evidence-based treatment guidelines is that reliance on the prevailing research paradigm (randomized clinical trials) has had the organizational effect of distancing some therapies and specific interventions from being considered as “evidence-based” because they have not relied on these procedures. This has a self-perpetuating effect, as research funding goes increasingly to research groups
who have already completed large grant projects successfully. Some treatment procedures become set in stone, while others languish. Funding decisions and research evidence work together to shorten the list of treatments considered to be empirically supported. Although some might argue that ignoring treatments that do not have a strong evidence base is justified, they miss the real sociological and epistemological complexity of the scientific undertaking and such a view dooms regulatory and advisory bodies to marginalize some psychosocial interventions and remain restrictively focused on pharmacological interventions and on particular therapies and particular problems and client groups. This is a great loss of potential to maximize learning and uptake of learning for the benefit of the full population of people with mental health needs.

Although many practitioners and the public may be comforted by the notion that they are offering or receiving an empirically supported psychotherapy that works best, the fact is that success of treatment appears to be largely dependent on the client and the therapist, not on the use of “proven” empirically based treatments (see Chapters 6, 7, and 8, this volume). Proof of effective treatment needs to be based on the measurement of treatment response rather than merely provision of the “right” treatment (Lambert, 2010). We cannot be satisfied with providing the right treatment for the right disorder as a means of exercising our duty to patients who are suffering from the pain of psychological problems.

CONTINUING DOMINANCE OF INTEGRATIVE/ECLECTIC PRACTICE

A clear trend in psychotherapeutic interventions since the mid-1960s has been the proliferation not only of types of practitioners, but of the types and numbers of psychotherapies used alone and in combination in day-to-day practice. Garfield (1982) identified 60 forms of psychotherapy in use in the 1960s. In 1975 the Research Task Force of the National Institute of Mental Health, estimated that there were 125 different forms. Henrick (1980) listed more than 200 separate approaches, while Kazdin (1986) noted 400 variants of psychotherapy. Research on the effectiveness of each and every emerging form of therapy is nonexistent. As far back as the 1980s Parloff (1982), pointed out that “a systematic approach to dealing with a matrix of 250 psychosocial therapies and 150 classes of disorders would require approximately 47 million comparisons” (p. 723). Clearly the invention of separate psychotherapies took place independent of research evidence, and research results have not slowed the development and advocacy of various treatment methods. Note that Parloff made his comment more than 30 years ago and that what he said then holds even more so today: It is impossible for comparative testing of every existing or new therapy to be conducted even if the resources to make comparisons were available.

This dilemma becomes ever more problematic because the proliferation of therapies has been accompanied by the continuing trend for therapists to disavow allegiance to a single system of treatment in the form of a purely theoretically based approach. Eclecticism, representing the use of procedures from different theoretical systems, and integrationism, representing the theoretical joining of two or more positions into a consistent approach, has replaced the dominance of major theories in therapeutic practice. Surveys of practitioners repeatedly indicate that one half to two thirds of providers prefer using a variety of techniques that have arisen from major theoretical schools (e.g., Jensen, Bergin, & Greaves, 1990; Norcross, Karg & Proshaska, 1997). Those therapists who identify with an eclectic orientation feel free to select techniques from any orientation that they deem to be in the best interest of a particular patient. Although taking great liberties in applying mixed interventions in routine practice is done to maximize therapist responsiveness to individual patient needs, such seemingly unsystematic practice bolsters the need for treatment guidelines.

Unfortunately, there appears to be little consensus among eclectic therapists about the specific techniques that are most helpful, and thus there is little likelihood that two eclectic therapists would use the same techniques with the same client. Garfield and Kurtz (1977) who studied 154 eclectic psychologists found 32 combinations of theoretical orientations were in use. Jensen et al. (1990) found comparable results but also a trend toward differences in preferred combinations across professional disciplines, with dynamic orientations more often used in psychiatry, systems theories in social work and marriage and family therapy, and cognitive and behavioral approaches in psychology. Preferences for certain types
of theory-directed interventions appear to be largely based on traditions rather than empirical considerations.

Nevertheless, eclecticism reflects the fact that there are many diverse theoretical orientations with varying strengths. These strengths are widely recognized and occasionally supported by research evidence from the study of single theory approaches. The movement to combined use and integration of these approaches is likely to continue and appears inevitable given the diversity of concerns manifest in people who come for help. Consider for example the clear trend of cognitive-behavior therapy (CBT) to incorporate psychodynamic, client-centered/experiential approaches, along with mindfulness practices that come from Eastern religious traditions. It is readily observed that even "single school" approaches such as CBT are far more eclectic than the name implies, with substantial variations in CBT practices across the globe and over time. Even within the eclectic practice of CBT there are strong disagreements among theoreticians about the necessity and importance of specific procedures; it does not seem farfetched to suggest that two patients entering CBT treatment offered by different providers might receive nearly nonoverlapping treatments. Newer variations displace older ones for reasons that are sometimes just as much about human and social needs for identity, change and novelty, as the empirical evidence itself.

Eclectic and integrationist treatment approaches might also be explained in part by the diversity of individuals who are treated, even within specific diagnostic categories. Kazdin (2008), for example, notes that given the criteria for diagnosing conduct disorder, there are more than 32,000 combinations of symptoms that individuals can have and still meet the diagnosis. The same can be said for other disorders such as agoraphobia. Williams (1985) notes that: “The configuration of fears in agoraphobics is so highly idiosyncratic that it is substantially true that no two agoraphobics have exactly the same pattern of phobias and that two people with virtually no overlapping areas of phobia disability can both be called agoraphobic” (p. 112).

The integrative movement, which parallels eclectic practice, has the ambitious goal of being more systematic than eclecticism. Early attempts at theoretical integration of psychodynamic and behavioral procedures by Wachtel (1977) and the early work of Goldfried (1991) are fine examples of blending theoretical diversity. Integrationist activity and growth can also be noted by the formation and success of the Society for the Exploration of Psychotherapy Integration (SEPI). In addition to these movements, process research aimed at examining the in-session behavior of therapists across different theoretical orientations indicates that the distinctiveness of approaches in practice is less pronounced than it is at the abstract level of theory (Ablon & Jones, 1999; Norcross & Goldfried, 1992). Thus, theories of change are somewhat independent of the actual activities that therapists engage in and these activities show a large degree of overlap across theoretically diverse treatments. The overlap in behaviors are also a part of what has commonly been referred to as common factors in psychotherapy dealt with more extensively in Chapter 6 of this volume. These common factors can be shown to account for a significant amount of patient change. They include the facilitation of hope, the opportunity for emotional release, exploration and integration of one’s problems, support, advice, and encouragement to try out new behaviors and ways of thinking.

Emphasis on common factors as central to the changes made in psychotherapy, a phenomenon that is distinct from eclecticism has the potential for reducing conflicts between particular theoretic views. Polarization based on claims of unique effectiveness for specific theoretical orientations has resulted in conflict within the field that has had positive consequences (e.g., stimulation of research studies), but has also caused considerable defensiveness and slowing of progress (e.g., through the overstatement of claims of success, and attempts to create exclusive lists of effective treatment). Eclectic and integrationist movements reflect similar attempts by many practitioners to be flexible in their approach to working with patients.

This handbook has been eclectic from its inception in 1967 and first publication by Bergin and Garfield in 1971. Empirical findings from all approaches are considered potentially important. Being open to research findings on any approach, both positive and negative, is the central mission of the handbook. This focus is consistent with the ideal goals of eclecticism—fostering what works for the patient. Openness to methods of investigating psychotherapy is also valued and represented by inclusion of chapters representing not only traditional research paradigms but diverse and competing methods that search for
“practice-based evidence” from practice research networks, as well as a variety of qualitative methods that are now covered in the handbook (see Chapters 3 and 4, this volume).

THE PRACTITIONERS OF PSYCHOThERAPY

The practitioners of psychotherapy are becoming more numerous and diverse. This phenomenon can be seen across other professions as well. In medicine, for example, many services, such as writing prescriptions or administering anesthesia, were once performed solely by MDs, but are now offered by nurses, medical assistants, and related personnel. Since Freud’s time, the practitioners of psychotherapy were primarily physicians, and prior to World War II, clinical psychology was a relatively small and undeveloped profession with a major emphasis on the administration of psychological tests. After the war the shortage of psychiatrists, coupled with the unmet demand to care for veterans who had developed psychological disorders, led to government-supported graduate training in clinical and counseling psychology with psychotherapy becoming an important part of this training. Despite subsequent conflicts with organized medicine, the independent practice of psychotherapy by psychologists became a reality (Garfield, 1983).

Social work, school psychology, nursing, pastoral counseling, marriage and family therapy, licensed professional counseling, substance abuse counseling, as well as a host of paraprofessionals also participate in a variety of psychotherapeutic practices. The professionals responsible for training across disciplines as well as regulatory boards disagree about the type and extent of training needed to safely and effectively engage clients in psychological treatments. One might think that if we were able to agree on the most effective practices then there might be some agreement as to the training and qualification of providers—but this is not the case.

In the United States, as much as 60% of the psychotherapy that is conducted is now provided by social workers whose master’s degree training in psychotherapy, at least from the point of view of psychology, is inadequate. A common practice in Europe and the United Kingdom is to license professionals within psychotherapy training programs that are single theory-based rather than profession-based and typically require a master’s degree (in these training models the focus of training and credentialing is entirely on the practice of psychotherapy). Given such diverging views about ideal or even adequate training and necessary qualifications (in the United States and abroad) confusion reigns supreme, with regulatory bodies and a public unsure about differences and advantages that might come from selecting an available provider.

Selecting a provider based on knowledge of that provider’s treatment effects is emerging as a possibility (Okiishi et al., 2006), but it is as rare in psychotherapy as it is in medicine to know the likely consequences of being treated by a particular provider. The kinds of professions involved in psychotherapeutic services has risen to meet the demands for service, especially as demands for service came from the needs of underserved populations such as the poor, substance abusing individuals, those in the criminal justice system, and the seriously and persistently mentally ill. The established professions both resisted and facilitated such developments. Because of fears about the negative consequences to the patient who would be treated by minimally trained persons and fear of competition from less trained providers, resistance was (and often is) the most common reaction from within the professions to new classes of providers.

However, the forces at work in society and within individuals appear to stretch the boundaries of who can be considered a trustworthy provider. Besides the needs of the underserved, and the fact that many treatments, once developed, can be routinely offered through the use of treatment manuals, economic forces play a large part in the movement toward using less trained persons (Bright, Baker, & Niemeyer, 1999; Weisz, Weisz, Ham, Granger, & Morton, 1995). Nowhere is this more evident than in recent developments in the United Kingdom where access to specialized mental health service has been characterized by long waitlists and immediate service provision in the hands of general practitioners who often simply prescribe medications (Carey, 2010; Carey & Spratt, 2009). Despite the fact that many mental health practitioners were available and could provide prescribed treatment an initiative titled Improving Access to Psychological Treatments (IAPT), which targets anxiety and depression through the use of circumscribed CBT, began in 2008. “CBT Workers” who do not need to be mental health professionals provide “low” and “high” intensity
CBT after a year of training. They carry a very heavy active load of 45 clients, seeing between 175 and 250 cases per year. Using 4-session CBT protocols, National Institute of Health and Clinical Excellence Guidelines (NICE), and a stepped-care approach to their patients that relies on the individual's self-management of their problems, a whole new profession was created (see http://www.iapt.nhs.uk, 2011).

Some of the more promising (and disturbing?) conclusions of psychotherapy research arose from its investigation of the effects of training on patient outcome. Within this context research has not shown a strong link between level or kind of training that typifies the separation between professions and the paraprofessionals whom they train and employ as extensions of their influence. If taken seriously such findings support the widespread application of psychotherapeutic services and will ensure that they remain widely available. On the basis of research evidence no monopoly on superior service can be claimed by any one profession, and the thoughtful use of paraprofessionals should be encouraged not only for economic reasons, but because they have been found to be effective in a variety of circumscribed roles when properly supervised. A repeated finding of research studies aimed at satisfaction with service, suggests satisfaction is equal across mental health specialties, with 46% of more than 1,500 respondents indicating that psychotherapy made things “a lot better” and 45% said things were “somewhat better” (Consumer Reports, 2010). The current large-scale experiment being undertaken in the United Kingdom (IAPT) will become an important source of information over the next decade.

Perhaps one reason for the lack of difference between professions on psychotherapy outcome is that the training in psychotherapy that is received is highly diverse even within professions. Psychiatrists are trained first in medicine, and second in pharmacological solutions, with psychotherapy being a distant third in emphasis. Psychologists have typically been trained in academic departments of psychology, but now are often trained in freestanding professional schools as well. Both types of programs differ within and between themselves in the amount and intensity of didactic and supervised experience. One cannot distinguish the training (or its quality) a particular psychologist has received by virtue of knowing the type of degree that has been attained. Since the various programs may emphasize different theoretical orientations and different practicum experiences, the diversity in training can be extensive.

In addition, knowledge about professionals’ credentials is not informative about their participation in widely available postdoctoral institutes, continuing education programs, workshops, professional meetings, and the like. The personal qualities of those who provide treatment can also be of great importance, but are seldom studied. Nevertheless, psychotherapy research has illuminated the widespread effectiveness of psychological interventions across a wide range of practitioners that offer services, and this effectiveness is highlighted in many of the chapters that follow, particularly Chapters 7 and 19.
Managed Care and Dose-Effect Research

For the first half of the 20th century effective psychotherapy was considered to be a long-term process, with briefer therapy considered superficial. Early providers of psychoanalytically oriented therapy prescribed years of treatment that was very costly. Voth and Orth (1973), for example, reported an average length of 835 sessions from their study of psychoanalysis. A clear trend in practice has been the movement toward relatively brief treatments, although a preference for longer treatment persists in some parts of the world, it certainly does not represent current practice patterns in the United States and many other countries. In a recent dinner conversation with a group of psychoanalysts from Germany, where the health system continues to support long-term therapy, the discussion turned to a recent controversy within psychoanalytically oriented providers, with some advocating three sessions per week instead of the traditional four sessions per week.

This less intense therapy was viewed by the more traditional providers as undermining the best interests of the patient. The author was a complete outsider in such a discussion, because in the United States brief therapy has become acceptable to most practitioners and certainly the common experience for most patients. In fact, most research is conducted on therapy offered once a week for no more than 14 to 20 weeks, and in most practice settings treatment actually averages closer to five sessions (Hansen, Lambert, & Forman, 2002). Earlier editions of this handbook included a chapter dedicated to brief therapy. Organized brief therapy programs tended to use interventions that lasted 6 to 10 sessions and generally reported positive results (Koss & Shiang, 1994). In the 2004 and current edition, no such chapter was included because it was seen as redundant with the study results reported in most other chapters, which seldom summarize long-term treatments. Almost all therapies that are studied (particularly in the United States) are “brief,” lasting less than 20 sessions. For an understanding of longer-term treatments, one must consider older studies that were reviewed in earlier editions of the handbook, examine research from European countries where patients continue to receive treatments that last for years (that is often not available in English) or consult Chapter 12 of this volume.

One of the most profound developments in recent years that affects the length of treatment has been the advent of managed care organizations. Most health insurance plans place limits on the number of treatment sessions they will reimburse (hovering around eight sessions), and often instigate evaluative procedures to make certain that coverage does not extend beyond what they advocate as the basic necessary treatment length. This practice is undertaken with little regard for the fact that a majority of studies of empirically supported psychotherapy is based on at least weekly psychotherapy that extends over an average of 14 weeks. Because many people cannot afford self-paid treatment that goes beyond an insurance coverage limit, managed care organizations determine the length of treatment received by a large number of Americans and this same trend can be found in other countries.

Patients, for the most part, prefer to be helped as quickly as possible, and efficiency is also favored by funding services such as insurance companies and the government. Managed care itself arose, at least partially, as a response to spiraling health care cost in general. Limiting sessions is an obvious and relatively simple way of reducing costs. The amount of treatment available to those in need is often determined by the costs of providing services. Obviously, if as much can be gained from 10 sessions of treatment as 30, then curtailing the amount of therapy makes good economic sense. Brief therapy is an option that responds to the issue of efficiency, a topic that is on the minds of many. At this point in time psychotherapy researchers have not devoted much attention to cost-effectiveness studies that would simultaneously consider cost and outcome, although they have begun to investigate the relationship between “dose” of treatment and response with its obvious correlation with costs.

Early investigations within this latter topic were focused on demonstrating that brief therapy was as effective as longer therapies (e.g., Luborsky, Singer, & Luborsky, 1975). Contemporary studies have been more interested in understanding the dose–response relationship (how many sessions are needed for a meaningful treatment outcome?). This research has important implications for social policy and insurer decision making as well as client suffering. Howard, Kopta, Krause, Merton, and Orlinsky (1986) were the first to report data in a form that estimated the dose response relationship.
meganalysis of data from 2,431 patients drawn from previously reported studies using pre- and postchange, they used statistical modeling techniques to estimate the number of sessions needed to meet a defined standard of improvement. Their analysis suggested that positive gains made early in treatment were followed by less dramatic changes across later sessions. They also suggested that 75% of patients had improved after 26 treatment sessions (nearly 6 months of once-weekly psychotherapy).

Later research following this same paradigm, but using data from patients who rated their functioning on a weekly basis (obviating the need for statistical procedures that estimate weekly change), found the same general relationships—rapid change early in therapy is followed by smaller per session increments, but more therapy increases the likelihood of improvement and recovery in individual patients (e.g., Anderson & Lambert, 2001; Kadera, Lambert, & Andrews, 1996). It appears from this research and related studies summarized in Chapter 6 of this volume, that 50% of patients who enter treatment in clinical settings will show clinically meaningful change after 13 to 18 sessions of treatment. An additional 25% will meet the same standards after approximately 50 sessions of once weekly treatment (an estimate of sufficient dosage that exceeds that provided by Howard et al., 1986). More recently, researchers studying care in naturalistic settings have suggested that patients tend to withdraw from treatment when they have reliably improved or recovered. Barkham et al. (2006), for example, suggest that the impact of sessions does not diminish as dosage increases, a finding supported by Percevic, Lambert, and Kordy (2006).

These studies suggest that the movement toward briefer treatment is justified on empirical grounds for some patients; but that close to 50% of patients will not be well served by therapies that are intentionally limited to less than 18 sessions. They also suggest that the more disturbed a patient is when they begin treatment, the longer therapy will need to last for the patient to return to normal functioning. Limiting treatment duration to eight sessions serves the interests of those patients who are least disturbed, but cannot be considered a fair and equitable practice for a majority of patients. Some recognition of this reality and its social consequences needs to find its way into the minds of the U.S. public, employers, and government, and be integrated into third-party payer guidelines and future social policy decisions as well as theoretical suppositions about effective psychotherapy.

The Emergence of Evidence-Based Outcome Monitoring

There are several trends in psychotherapy research and practice that appear to be highly promising for patients beyond the provision of evidence-based treatments and treatment practices. These promising new practice/research strategies are likely to make research more useful to providers and will probably have more impact on patients than offering “empirically supported treatments.” Two distinct but potentially overlapping research paradigms hold this potential: patient-focused research and practice-based research.

Patient-focused research. Initial efforts to apply this alternative psychotherapy research paradigm were described in a special section of the Journal of Consulting and Clinical Psychology (Lambert, 2001). Variously termed, patient-focused research, quality management, and outcome management, this research strategy makes use of actuarial methods for modeling expected patient treatment response in relation to actual treatment response, feeding back this information to therapists, supervisors, and the patient. Thus the results of research become imbedded in routine care that includes session-by-session monitoring of mental health vital signs. Although most research has depended on statistical tests of differences between a treatment group and a control group, with differences reported through the use of group-based inferential statistics, patient-focused research uses clinically meaningful change criteria such as those elaborated upon by the late Neil Jacobson and his colleagues (Jacobson, Follette, & Ravenstorf, 1984; Jacobson & Truax, 1991) for the individual patient to inform the clinician when the patient has reliably improved or recovered. Outcome management research strategies are aimed at helping clinicians formally monitor patient treatment response, and make adjustments to treatments in real time. In contrast to other research strategies, outcome management makes empiricism a viable part of routine practice on a case-by-case basis, rather than a distant abstraction that practitioners find difficult to incorporate in practice. At this point in time enough research evidence has accumulated to show such methods significantly enhance
patient outcomes (Lambert & Shimokawa, 2011; Shimokawa, Lambert, & Smart, 2010), but these methods are relatively new and they are in need of replication. In addition, there is considerable resistance among clinicians to making regular assessments of outcomes a routine practice (Jensen-Doss & Hawley, 2010).

*Practice-based evidence.* Barkham and Margison (2007) have provided a definition for this term: “Practice-based evidence is the conscientious, explicit, and judicious use of current evidence drawn from practice settings in making decisions about the care of individual patients.” (Barkham & Margison, 2007, p. 446). These authors suggest that practice-based evidence results from integrating both individual clinical expertise and service-level parameters, with the best available evidence drawn from rigorous research activity carried out in routine clinical settings. Practice-based research examines how and which treatments or services are provided to individuals within service systems and evaluates how to improve treatment or service delivery at the clinic level. The aim is not so much to isolate or generalize the effect of an intervention across settings, but to examine variations in care and ways to implement research-based treatments.

Much of the work in this area has been summarized by Barkham, Hardy, and Mellor-Clark (2010). The focus of their edited book is to show how practice-based evidence starts with a focus on the individual patient through monitoring treatment response, and then extends the use of this systematic data collection to providers, groups of providers, and systems of care. In the end, very large data sets become available and can be used in a wide variety of ways, from providing benchmarks that can be compared across services and within services over time, to identifying practices that are working and those that are not (Stiles, Barkham, Connell, & Mellor-Clark, 2008). Good examples of benchmarks can be found in a special issue of *Counselling & Psychotherapy Research* (2006), including completion rates for measures, frequency of unilateral termination, recovery and improvement rates, and waiting times (Trusler, Doherty, Grant, Mullin, & McBride, 2006). Benchmarking can also take the form of comparing effectiveness in a particular clinical setting against the outcomes obtained in efficacy studies (e.g., Barkham et al., 2008; Merrill, Tolbert, & Wade, 2003; Minami, Wampold, Serlin, Kircher, & Brown, 2007). Weisz and colleagues (2005) indicate that the most valid answers to questions about treatment outcome and change processes are more likely to come from research in “real-world” service settings than from controlled lab studies.

Based on the initial applications of these research methods it is clear that practice-based evidence research can be integrated into routine practice, thus narrowing the gap between practice and research, while improving treatment outcomes (see Chapter 4, this volume, for a more complete discussion).

**ETHICS IN RESEARCH**

Interest and concern over the ethics of research activities connected to psychotherapy have a long-standing history. For example, in the 1950s Rogers and Dymond (1954) raised concerns about the use of a no-treatment control group in their study of client-centered psychotherapy because it was clear that psychotherapy had been shown to be effective. The current climate for conducting studies of psychotherapy, and psychology in general, abounds with ethical and legal considerations aimed at protecting the participants in studies. The protection of “subjects’” rights and welfare has been a positive development, notwithstanding the sometimes-obvious inhibition on creativity and slowing of progress in the field. These protections have obvious impact on design and conduct of studies and have led to reductions in the use of no-treatment and placebo control groups as well as the rise in use of “standard treatment” or “usual treatment” control groups to overcome the problems associated with depriving individuals who need treatment with bona fide interventions (Spielmans, Gatlin, & McFall, 2010).

Other standards for conduct of research studies have remained more stable. Objectivity and honesty in recording, tabulating, analyzing, and reporting results are mainstays of all scientific endeavors. It is important to maintain such principles if the research enterprise is to exist and flourish. So far psychotherapy research has avoided notoriety for the kind of fraud that has been exposed in some fields (e.g., data tampering or even the creation of false data). One notable case in the field of psychotherapy recently involved accusations of filing false information involving discrepancies between the number of subject volunteers that were reported on progress reports that William Fals-Stewart submitted to the National Institute for Drug Abuse relating to grants for which he was...
the Principal Investigator, and his subsequent actions aimed at covering up this fraud. Such intentional deception as well as mishandling of data and its variations must be perceived as simply intolerable. However, within the field, instances of biased interpretation of data have been noted (e.g., Bergin & Garfield, 1994) and such activities can be harmful to patients, the status of scientific information, as well as the reputation and careers of those who are involved.

Some related problems are more subtle and complex, but nonetheless important to the field. For example, the presentation and interpretation of data by researchers leaves considerable wiggle room for partial truths to be presented as the entire picture. In fact, journal review procedures encourage routine summaries of procedures that make it all but certain that research reports will present the strongest possible case for rigor with little mention of significant limiting information. In the competitive world of publishing in the most respected journals, where editors and reviewers search for design and performance flaws and reject 85% of manuscripts, researchers are likely to emphasize the strengths of their research procedures and methods rather than providing a complete list of problems. Even the most rigorously executed research is imperfectly conducted but little is to be gained by elaborating on problems when submitting manuscripts for review.

For example, a common demand in clinical trials research is to test the effects of treatment on a single disorder. In the context of writing about selection and exclusion criteria for study patients, researchers are prone to emphasize the inclusion of homogeneously diagnostic patient samples. When being criticized for the lack of relevance of such research (with such carefully selected patients) for practice, however, these same researchers are likely to present a picture of these patients that is quite different when this criticism is raised. They argue that the patients are, after all, just like the patients seen in everyday practice. It is generally understood by avid readers of scientific reports that the politics of publishing influences the presentation of methods, and that these presentations are not an entirely accurate picture of all the findings that could be reported. Fortunately, the discussion of results by the authors (and the use of peer review) often point out many limitations of the research and soften the expression of implications for practice that might otherwise be made.

In addition, replication studies, as well as exposure of research to public scrutiny, eventually correct many of the important errors that find their way into the field. But this corrective action often takes years. The American Psychological Association has gone to great lengths to provide reporting standards (APA Publications and Communications Board, 2008). Aside from these remedies, it behooves readers of research to use caution in drawing more than tentative conclusions from any particular study. In the area of interpreting research findings, meta-analytic reviews present an opportunity to increase objectivity. Although such procedures are not entirely free of biasing choices (compare, for example, Anderson & Lambert, 1995; Crites-Christoph, 1992; Svartberg & Stiles, 1991; or results presented by Prioleau, Murdock, & Brody, 1983; Smith et al., 1980). Although meta-analytic procedures are not free from biasing choices, the decision rules are made explicit and made public, and thus a step in the direction of reducing biases in reviews of psychotherapy outcome literature can be achieved (see Chapter 2, this volume).

Psychotherapy researchers have considerable awareness that values are central in the therapeudic process as well as in the research that they conduct. An emphasis on values and their impact on research are often obscured by the focus on effective technologies and their evaluation in standard research paradigms. Yet researchers are well aware that their choices about what and how to study the changes that result from psychotherapy guide the phenomena that they seek to investigate. Psychotherapy and psychotherapy research are in fact guided by a host of value choices. Change in humans is so complex that it is difficult to study the full meaning of the changes that take place in treatment. Symptomatic changes often have a meaning component that is seldom studied in traditional research. The errors and oversimplification that inevitably arise in psychotherapy research often come from the complexity of a research task that is very daunting, rather than from carelessness, ignorance, or naiveté. Few studies even attempt to examine the full range of consequences of entering treatment at a propitious moment in the life of a client who is enmeshed in a family and social context. The research summaries in this book attempt to reduce the myriad methods and results of psychotherapy into a cohesive picture that has implications for practice, but in so doing, the values of reviewers effect the conclusions that are drawn.
Out of necessity, the chapters in this text, like the research studies that informed them, sometimes emphasize relatively narrow domains of personal functioning and include research studies that vary widely in sophistication and rigor. Though there are limitations in the research summaries that follow, they provide a foundation for broadening inquiries into the effects of psychotherapies that will enable future studies to move forward with questions of greater precision if not importance. Even with these limitations, the research summaries included in this volume have important implications for the practice of psychotherapy and thereby the fabric of social life in the fullest sense of the word.

**Overview of the Book**

This handbook is divided into four sections. As in the previous five editions, each chapter can be read by itself and makes an independent contribution to the literature. The first five chapters focus on broad methodological issues. Following the present introductory chapter, Comer and Kendall summarize important principles and contemporary methods applied in traditional experimental research designs. The chapter helps the reader understand terminology, procedures, statistical methods, and what types of designs are suitable for answering particular research questions. The information in Chapter 2 is essential to understanding and evaluating the nuances of existing research findings. Chapter 3 (McLeod) provides an emphasis on qualitative methods, and their use in illuminating the subjective experience of research participants and in formulating research questions—and stands in stark contrast to the methods focused on in Chapter 2. The fourth chapter (Castonguay, Barkham, Lutz, and McAleavey) exposes the reader to relatively new research strategies aimed at improving service delivery and outcomes with an emphasis on research in routine care. The emphasis is on bridging the gap between psychotherapy research and psychotherapy practice. It has the important goal of greater cooperation between scientists and practitioners with positive consequences for patients. Chapter 5 (Ogles) focuses on an essential aspect of the scientific study of psychotherapy: methods of measuring the outcomes of psychotherapy. By reviewing contemporary measurement strategies and methods, this chapter brings clarity to how the variables of greatest interest are operationally defined and handled within empirical evaluation. It is an especially important chapter for those who are planning research on behavior change and trying to understand its meanings.

The second section of this handbook moves away from methodological issues by examining findings in a broad context. Chapter 6 (Lambert) provides an overview of the general effects of therapy (efficacy and effectiveness) and deals with questions that are central to practice outside of specific treatments. Chapter 7 (Bohart and Wade) focuses on the patient’s contribution to psychotherapy outcomes. Chapter 8 (Baldwin and Imel) summarizes the impact of the therapist on psychotherapy outcome. The final chapter (Crits-Christoph, Gibbons, and Mukherjee) in this section evaluates the role of processes and outcomes (activities and impacts) as studied simultaneously within single investigations. Together these five chapters, while overlapping to some degree, provide a broad picture of the most basic and general findings of psychotherapy research.

The third section of this handbook reviews research findings as they have arisen within four major schools of psychotherapy (and their variants). It includes chapters on behavioral therapy (Emmelkamp), cognitive and cognitive-behavioral therapy (Hollon and Beck), psychodynamic psychotherapy (Barber, Murran, McCarthy, and Keefe) and experiential/humanistic interventions (Elliot, Greenberg, Watson, Timulak, and Freire).

The fourth and final section of the handbook—“Research on Applications in Special Groups and Settings”—is the longest section, with six chapters. Included are chapters on psychotherapies with child and adolescent patients (Weisz, Ng, Rutt, Lau, and Masland), couple and family therapies (Sexton, Datchi, Evans, LaFollette, and Wright) group psychotherapies (Burlingame, Strauss, and Joyce), behavioral medicine and health psychology (Smith and Williams). Chapter 18 (Forand, DeRubeis, and Amsterdam) reviews research on treating psychological problems with medications alone and in conjunction with psychotherapy. The psychotherapeutic practices in these chapters represent, to a certain extent, specialty areas that are distinct from each other, but also overlap, both in the patient problems that are addressed, and the interventions that are used. The final chapter (Hill and Knox) considers what we know from research about training, and supervision and their effects.
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