PRINCIPLES OF PSYCHOTHERAPY
Promoting Evidence-Based Psychodynamic Practice

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Principles of Psychotherapy
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Preface

Psychotherapy has been described as both an art and a science. Those who view psychotherapy as an art note that practice and experience are vital in honing the clinician’s therapeutic skills; those who view therapy as a science point out that, without a firm bedrock of empirical data, clinicians can never be certain which therapeutic techniques are most effective and can be best employed. A central theme of Principles of Psychotherapy is that psychotherapy is neither art alone nor science alone, but both: Effective psychotherapy is an art that rests on science.

Like its two previous editions, this revision of Principles of Psychotherapy is addressed to psychotherapy practitioners and is primarily a manual of principles for conducting psychotherapy in clinical practice. As before, the text provides detailed guidelines for conducting psychotherapy from the initial evaluation interviews through the termination phase of treatment. These guidelines are amplified throughout with illustrations of what therapists should consider saying and doing in various circumstances and why certain interventions are most likely to be effective.

Two key considerations characterize the presentation of principles in this third edition: first, that the conduct of psychotherapy should be conceptually based, and second, that the conduct of psychotherapy should be evidence based. With respect to the conceptual basis of psychotherapy, the text attends not only to what therapists should do in working with patients, which defines their treatment strategies; and not only to when and how they should do what they do, which comprise their treatment tactics; but also to why they should intervene in certain ways at certain times, which consists of conceptual principles that should always guide a therapist’s decisions. Conducting psychotherapy within a conceptual framework that helps identify the goals of treatment and strategies and tactics for achieving these goals enhances clinicians’ capacities to identify appropriate and effective ways of intervening on their patients’ behalf.

With respect to the evidentiary basis of psychotherapy, the text hews closely to the three widely recognized pillars of evidence in professional
practice. First, the presentation of principles in each chapter draws on relevant empirical data wherever such data are available. Second, where adequate research studies do not yet exist, clinical expertise as reported in the literature provides support for the recommendations made. Third, the text attends throughout to formulating interventions that are attentive to patient needs, preferences, and values.

Along with its focus on evidence-based practice, the text includes a case study that illustrates many of the concepts and principles discussed. This case study is presented in two parts, the first of which reviews the background history, clinical evaluation, and treatment planning for Ms. A, a 28-year-old woman with complaints of depression and interpersonal difficulties. The second part describes the course of twice-weekly psychotherapy with Ms. A and includes an annotated verbatim transcript of her 221st session, which took place shortly before termination.

The text has also been updated to keep it current with the literature, especially with respect to the substantial volume of psychotherapy research findings that have been reported in the last dozen years. Of the 667 references cited in the text, 332—about half—have appeared since 1997, when the second edition went into production. Noteworthy in the enriched bibliography of this third edition is the relatively recent but already considerable body of published research demonstrating the impact and effectiveness of psychodynamically oriented psychotherapy.

Any conceptualization of evidence-based practice that balances research findings with clinical experience must acknowledge that scientist-practitioner gaps in defining appropriate practice remain part of the clinical psychology landscape, as was the case when the first and second editions of this book were published in 1975 and 1998. A growing ecumenical spirit in the 21st century is beginning to bridge this gap between practitioners and researchers, but most observers would probably agree there is still a long way to go. It accordingly seems appropriate to restate some comments on this issue from the preface to the previous editions.

Historically in the dialogues between psychotherapy researchers and practitioners, researchers have accused psychotherapy practitioners of ignoring or failing to grasp the implications of empirical findings and being doggedly committed to the values of an in-group of believers who reinforce each other’s dedication to their long-standing practices and disregard data to the contrary. Practitioners have in turn accused researchers of failing to appreciate the complexity of real-life clinical interactions and designing studies more with an eye toward methodological rigor than adequate attention to making these studies reflect accurately the transactions and transitions that occur during psychotherapy.
Both of these accusations are to some extent warranted. In every field, the applications of knowledge tend to lag behind advances in theory and research, and so it is with psychotherapy. At the same time, sophisticated psychotherapy researchers readily admit to unresolved difficulties in translating the intricacies of clinical interactions into meaningful operational definitions and measurement strategies. Yet the shortcomings of both practitioners and researchers should not obscure their substantial contributions to psychotherapy and the complementarity of their efforts. Hypotheses for research studies emerge from clinical practice, and it is in the success and failure of clinicians’ efforts to benefit their patients that conclusions from such studies must be examined for their utility. Clinical practice that is neither subjected to nor influenced by research can detract both from the pursuit of knowledge and the delivery of responsible clinical service.

Lack of unequivocal documentation, however, should not dissuade clinicians from employing procedures they expect with reasonable certainty to benefit the people who have sought their help. Cumulative clinical wisdom must be given its just due, lest uncertainty produce a paralysis of thought and action. In the absence of empirically documented procedures for addressing every contingency, psychotherapists must turn for guidance to conceptual formulations and the advice of experienced clinicians who have found certain techniques helpful in their work.

To be learned, taught, and practiced effectively, psychotherapy must be grounded in a theoretical perspective on the nature of personality functioning and behavior change. A psychodynamic view of the psychotherapy process provides the primary theoretical context for the selection and discussion of topics in this book. Whatever theoretical perspective commands their allegiance, however, psychotherapists will benefit from some degree of eclecticism. Useful contributions to understanding the ingredients of effective psychotherapy have emerged within numerous theoretical contexts, and research evidence supports hypotheses derived from many different theories of personality and psychotherapy.

Thus, although the chapters that follow reflect primarily a psychodynamic point of view, they also stress numerous principles central to other approaches: that psychotherapy is an interpersonal process defined by the nature of the communication taking place within it; that the capacity of therapists to create a climate of warmth, respect, trust, and genuineness has considerable bearing on the outcome of treatment; that psychotherapy is essentially a learning situation in which the benefit people derive depends on how extensively they learn to understand and control their behavior; that the goals of psychotherapy include positive behavior change
in addition to increments in self-understanding and self-control; and that positive behavior change is measured both in relief from emotional distress and in progress toward fuller utilization of potentials for productive work and rewarding human relationships.

It is widely recognized that the agents of change in psychotherapy include both general and specific factors. General factors promoting change in psychotherapy reside largely in the opportunity it provides patients to express themselves and in the extent to which it fosters an atmosphere of candid self-observation, expectation of change, and amenability to the therapist’s efforts to facilitate such change. Specific factors promoting change consist of the technical procedures employed by therapists to promote progress toward the goals of treatment. A good working alliance and sound therapist technique are thus interacting ingredients in effective psychotherapy. Inept technical procedures limit the benefits that might otherwise accrue from an open and trusting patient–therapist relationship, but even the most polished technical skills are of little avail in the absence of a treatment climate that nourishes receptivity to them. For this reason, the general (relationship) and specific (technique) aspects of psychotherapy are intertwined throughout this presentation.

*Principles of Psychotherapy* is organized in four parts. Part One begins with consideration in Chapter 1 of the nature and goals of psychotherapy. Chapters 2 and 3 address the characteristics of patients and therapists, respectively, with particular attention to the bearing of these characteristics on treatment process and outcome. Chapter 4 presents an overview of theoretical and research considerations relevant to the psychotherapy process as elaborated in the remaining chapters of the book.

Part Two concerns the initial phase of psychotherapy and includes chapters on the evaluation and assessment of persons who seek treatment (Chapter 5); the role of the treatment contract in psychotherapy and procedures for establishing it (Chapter 6); and methods of conducting psychotherapy interviews in ways that maximize patient engagement in the treatment process (Chapter 7). Part Two concludes with Case Interlude I, which describes the evaluation and assessment of Ms. A.

Part Three turns to the middle phase of psychotherapy and delineates methods for communicating understanding through interpretation (Chapter 8); for recognizing and minimizing interferences with communication (Chapter 9); and for identifying and utilizing influences exerted on the course of therapy by the treatment relationship itself, specifically transference (Chapter 10) and countertransference (Chapter 11) dynamics.

In Part Four, attention is given to determining when an appropriate termination point has been reached and bringing therapy to an effective end
(Chapter 12). Part Four concludes with Case Interlude II, which describes psychotherapy with Ms. A.

Finally, IBW would like to acknowledge with deep gratitude the guidance he received from his two main mentors in psychotherapy, Edward Bordin and Paul Dewald. Their sage teaching and sensitive grasp of the human condition are, he hopes, reflected in the pages of this book. RFB would like to acknowledge Joseph Masling, mentor and friend, whose wisdom, empathy, and understanding have had a profound impact on generations of students.

—Irving B. Weiner
—Robert F. Bornstein
PART ONE

INTRODUCTION
CHAPTER 1

The Nature and Goals of Psychotherapy

Psychotherapy is an interpersonal process in which therapists communicate to patients that they understand them, respect them, and want to help them. Most procedures used by trained professionals to treat people with psychological problems involve understanding, respect, and helpfulness, but psychotherapy is unique by virtue of the intentional effort of therapists to communicate their understanding of a patient’s difficulties and help him or her share in this understanding. Whereas other mental health treatment methods like drug therapy, behavior modification, and environmental manipulation may imply to patients that their problems are being understood, this implicit communication is only a peripheral feature of the method, intended primarily to facilitate the psychotherapeutic effects of the drugs, behavior shaping, and environmental manipulations. In psychotherapy the communication of person-related understanding is explicit and constitutes the central feature of the method.¹

Despite their differences, psychotherapy and other current methods for treating emotionally troubled people are not mutually exclusive. Sophisticated use of somatic, behavioral, and environmental therapies usually includes some explicit communication to patients of where their difficulties appear to lie and in what ways the treatment procedures are expected to prove helpful. When therapists communicate this kind of understanding to their patients and involve them as active agents in the treatment, they are providing psychotherapy. In contrast, when therapists shift their focus from the communication of person-related understanding to telling their patients what to do or altering their body chemistry or environment, they are engaging in treatment procedures
that are not psychotherapy, even though these procedures may also be psychotherapeutic.

In actual practice, the treatment of people with psychological problems frequently combines aspects of psychotherapy with aspects of other psychotherapeutic methods, a trend that has accelerated considerably in recent years (see Hartston, 2008; Livesley, 2005; Riba & Balon, 2005). So how can one know whether a given form of treatment might reasonably be classified as psychotherapy? In general, the more therapists concentrate their efforts on explicitly communicating understanding, the more appropriate it is to label what they are doing psychotherapy; the less their focus is on this sort of communication, the more their work should be called something else.

Defining psychotherapy as the communication of person-related understanding, respect, and a desire to be of help raises the question of whether psychotherapy can be conducted by someone who has not been trained as a psychotherapist. For example, can the special kind of communication that constitutes psychotherapy take place between two friends discussing a problem together? If psychotherapy consists of specific kinds of behaviors, it would be illogical to argue that these behaviors constitute psychotherapy when they are performed by a trained psychotherapist but not when they are performed by anyone else. Such an assertion would amount to saying that the same behavior engaged in by different people is not the same behavior. Hence, teaching and learning about psychotherapy as a set of behaviors intended to communicate a special kind of message requires entertaining the possibility that these behaviors may emerge in any interpersonal situation.

However, to say that psychotherapy may take place inadvertently is not equivalent to saying that it is likely to do so. The likelihood of psychotherapy occurring between two people is considerably enhanced if one of them is a trained and knowledgeable therapist who is following a planned procedure of intervention intended to be of help.² Several differences between the professional psychotherapy relationship and other interpersonal relationships account for the greater likelihood that psychotherapy will take place in the former situation, when a trained professional and a troubled patient have agreed to work together on the patient’s problems:

1. Therapist training and experience. The training therapists have received allows them to understand another person’s psychological difficulties more fully than any but the most empathic and knowledgeable nonprofessional (Kemp & Mallinckrodt, 1996). This training also
provides specific techniques for communicating understanding in ways the other person can comprehend and accept. Although naturally intuitive individuals may be keenly sensitive to the thoughts and feelings of others, they usually cannot translate their sensitivity into the communication of understanding as skillfully and as consistently as individuals who have been trained to do so. Whereas professional therapists typically focus their sessions with patients on significant treatment issues, for example, inherently helpful but untrained people from whom others seek counsel tend to engage primarily in informal conversation and advice giving (Gomes-Schwartz & Schwartz, 1978).

2. **Primary focus on the patient.** The professional psychotherapy relationship is not a mutual relationship, at least not in the sense that other kinds of ongoing interpersonal relationships tend to be mutual. In psychotherapy, the interests, needs, and welfare of the patient always come first; therapists rarely ask for consideration of their interests in return. Unlike a friend or acquaintance, therapists do not inject their own problems and preoccupations into the relationship, do not ordinarily respond to anger and criticism by defending themselves or reciprocating in kind, and do not decide whether to continue the relationship on the basis of how pleasant they find the other person’s company.

It is not that professional psychotherapists have no problems and preoccupations, lack feelings toward their patients, or fail to experience waxing and waning enthusiasm during a course of treatment. It is rather that their training helps them prevent such reactions from interfering with their dedication to the task. Trained therapists focus throughout on understanding and helping their patients, and they bring their own feelings and experiences into the situation only when they believe this will facilitate the treatment (see Hilsenroth, 2007; Schlesinger, 2005). By contrast, friends trying to help each other understand personal problems are much more likely than professional therapists to talk about their own ideas and experiences, and less likely to express empathic understanding (Reisman, 1986).

3. **Formal meeting arrangements.** There are certain formal commitments and constraints in the professional psychotherapy relationship that seldom characterize other interpersonal relationships. Therapists and their patients agree to meet at designated times on a regular basis, and to continue meeting as long as doing so serves the patient’s interests. These meeting times are kept as free from interruption as the therapist is able to make them, and except for chance encounters, patient and
therapist do not interact at other times or concerning matters other than a patient's emotional difficulties. These arrangements put a single-minded stamp on professional psychotherapy—helping patients with their problems—that can rarely be maintained in other kinds of interpersonal relationships.

In summary, the training and experience of professional psychotherapists, the nonmutuality of their relationships with patients, and the formal arrangements they make for ongoing treatment maximize the prospects for their consistently communicating understanding, respect, and a desire to help. In interpersonal situations outside professional psychotherapy, however, the lack of training in understanding and communicating the meaning of human behavior; the absence of formal arrangements for working on a defined problem; and the needs of both parties for mutual gratification, respect, and help combine to minimize the likelihood that one person will consistently provide psychotherapy to the other.

**APPROACHES TO PSYCHOTHERAPY**

Although psychotherapy must be distinguished from the broader category of treatment methods that may be in part psychotherapeutic, the task of doing psychotherapy can itself be approached in several ways. First of all, the communication by one person to another that he or she understands, respects, and wants to be of help is not limited to a two-person situation or to any particular setting. It can be communicated by a therapist to several people together, as in group and family therapy, and it can be communicated by more than one therapist at a time, as when cotherapists work together with groups, families, or sometimes even a single patient. It can be communicated to children and adolescents as well as adults, and it can be communicated in such diverse locales as clinics, hospitals, nursing homes, schools, and prisons.

Second, there is no single or uniform approach to how human behavior can best be understood and how this understanding can be communicated most effectively. Instead, there are a number of systems or “schools” of psychotherapy based on different ways of conceptualizing normal and abnormal behavior. Most of these systems fall into the broad categories of psychoanalytic and psychodynamic therapy, behavioral and cognitive-behavioral therapy, and humanistic and experiential therapy. In addition, numerous eclectic and integrative approaches utilize technical procedures derived from diverse methods or employ an overarching formulation that combines concepts from diverse theories.
Aspiring therapists contemplating the vast array of theories and methods that characterize the field of psychotherapy should find it helpful to keep in mind two extensively replicated and thoroughly documented findings in the psychotherapy research literature. First, there is little evidence to suggest that any particular school, method, or modality of psychotherapy produces generally better results than any other. Individual patients may be more responsive to one type of psychotherapy than another as a function of their personality style, preferences, and degree of psychological-mindedness. Moreover, some patients may derive unique benefit from certain technical procedures as a function of their specific symptomatology. For example, cognitive-behavioral techniques have proven particularly effective in treating phobias, whereas psychodynamic interventions are the treatment of choice for many personality disorders (see Bornstein, 2006; Mystkowski, Craske, Echiverri, & Labus, 2006). Generally speaking, however, across a wide range of patients and patient problems, the commonly used psychotherapies are found to be roughly equivalent in their outcomes (Lambert & Ogles, 2004; Norcross, Beutler, & Levant, 2006; Shapiro & Shapiro, 1982; Smith, Glass, & Miller, 1980).

Second, there is considerable evidence to indicate that the major approaches to psychotherapy are all beneficial and prove substantially more helpful to people with psychological problems than receiving no treatment or a placebo intervention. Not everyone is helped by psychotherapy, of course, and close to 10% of patients are found to deteriorate during the course of treatment. However, the data consistently show that the average person treated with psychotherapy is better off than 80% of no-treatment control participants in research studies, and patients who improve in psychotherapy tend to maintain their improvement for extended periods (Lambert, 2007; Lambert & Bergin, 1992; Lambert & Ogles, 2004; Lipsey & Wilson, 1993; Seligman, 1995). The general effectiveness of psychotherapy has been amply demonstrated for children and adolescents as well as for adults (Brems, 2004; Martin, D. G., 2002; Weisz & Hawley, 1998), and there is little basis for challenging Lambert’s (1991) conclusion in introducing a comprehensive review of programmatic research studies in psychotherapy: “So strong is the evidence favoring the general effectiveness of therapy that this question is no longer of interest in many psychotherapy studies” (p. 2).

With this information about the general equivalence and effectiveness of diverse psychotherapies in hand, therapists should be wary of parochial assertions that one form of psychotherapy is inherently superior to others or has a monopoly on the truth. Although ever an advocate for his own preferred methods, Sigmund Freud (1904/1953e) appears to have
anticipated an ecumenical spirit when he expressed the following opinion: “There are many ways and means of practicing psychotherapy. All that lead to recovery are good” (p. 259). As matters have turned out, the comparable results demonstrated by many different approaches in psychotherapy have led in recent decades to an increasingly open exchange of ideas among adherents to different schools of thought, enhancement of cross-disciplinary collaboration, and the emergence of important new lines of pantheoretical conceptualization and research.4

As noted in the Preface, this book addresses psychotherapy primarily from a psychodynamic perspective but stresses principles that are applicable to other approaches as well. These psychodynamic principles are relevant to any form of therapy that is intended at least in part to help people expand their self-awareness and utilize the patient–therapist relationship toward this end. Significantly in this regard, diverse schools of psychotherapy demonstrate numerous similarities in the general atmosphere and sense of purpose they create and in aspects of the treatment relationship they promote. Moreover, there is broad agreement that both an adequately conducive atmosphere and appropriately employed technical procedures play a part in promoting positive change in psychotherapy.5 Accordingly, the principles of psychotherapy presented in this book concern ways of combining a positive treatment relationship with specific methods of intervention to achieve the goals of treatment.

GOALS OF PSYCHOTHERAPY

The goals of psychotherapy are easy to describe but not always easy to achieve. These goals include (1) relieving patients’ emotional distress, (2) assisting them in finding solutions to problems in their lives, and (3) helping them modify personality characteristics and behavior patterns that are preventing them from realizing their potential for productive work and rewarding interpersonal relationships. In terms similar to these, Strupp (1996b) described psychotherapy as “the use of a professional relationship for the relief of suffering and for personal growth” (p. 1017). There are many possible routes to these goals, including treatment procedures other than psychotherapy and fortuitous life experiences that improve individuals’ emotional state and expand their opportunities to find self-fulfillment. As noted, the defining characteristic of psychotherapy as a route to symptom relief and positive personality and behavior change is helping people understand themselves better as a vehicle for pursuing these goals.
At times, the methods of psychotherapy have been confused with its goals, leading to the misperception that this form of treatment is focused on helping people understand themselves with little attention to how well they are adapting to the demands of their lives. Increased self-understanding promoted by effective therapist communication is the \textit{means} by which successful psychotherapy proceeds, but it is not a \textit{goal} of the treatment. Insight in psychotherapy is merely the means to the end of improved adaptation, and insight in the absence of symptom relief and positive behavior change should not be considered a satisfactory treatment outcome (Bohart, 2007). Enhanced self-understanding without improved adaptation indicates that either (1) the insights achieved have not been relevant to the patient’s problems or (2) certain resistances to behavior change remain to be identified and understood. In either case, further or more incisive treatment is indicated, and the patient may require a different therapist or a different form of therapy.

The goals of psychotherapy are discussed in more detail in Chapter 12, which deals in part with identifying when an appropriate termination point has been reached. The next three chapters in Part One examine further the three central elements of psychotherapy: the patient who comes for help, the therapist who attempts to provide this help, and the treatment process to which both of them commit themselves.

\textbf{NOTES}

1. This approach to defining psychotherapy and distinguishing it from the broader category of what may be therapeutic is elaborated by Reisman (1971) in \textit{Towards the Integration of Psychotherapy}. Reisman’s careful synthesis of relevant considerations provides an excellent guide to the essential nature of psychotherapy. As Zeig and Munion (1990) noted, there exist a vast array of perspectives on the nature of psychotherapy. The particular definition offered here, with its focus on the communication of person-related understanding, shares much in common with definitions proposed by Castonguay (2000), Garfield (1995, Chapter 1), Marmor (1990), and Strupp and Butler (1990).

2. S. Freud (1926/1959c) anticipated this possibility and discussed its implications in his well-known essay \textit{The Question of Lay Analysis}. In the end, he concluded that extensive training and clinical supervision were prerequisites for performing psychotherapy effectively but that this training need not—and in fact should not—always be medical in nature, which accounted for his advocacy of psychologists and other nonmedical professionals performing what Freud termed “lay analysis.”
3. The distinction between eclectic and integrated approaches to psychotherapy is subtle, but most clinicians agree that eclecticism involves combining interventions from different therapeutic models to target different problem areas, whereas integration involves blending elements of different models and emerging with a qualitatively different psychotherapeutic approach (see Beitman, Soth & Bumby, 2005; Gold & Stricker, 2006; Messer, 1992; Wachtel, 2008a). Descriptions and comparative reviews of approaches to psychotherapy are provided by Freedheim (1992, Chapters 4–8, 17–20); Holmes and Bateman (2002); Lambert (2004, Chapters 9–11); Mahoney (1995); Messer and Warren (1995); Schneider, Bugental, and Pierson (2001); Sloan (2006); Stricker and Widiger (2003); Wachtel and Messer (1997); and Wallerstein (1995).

4. This historical development and its implications for an integrated theory of psychotherapy are reviewed by Castonguay, Reid, Halperin, and Goldfried (2003); Gold and Stricker (2006); Lampropoulos (2000); Norcross and Goldfried (2005); and O’Leary and Murphy (2006).

5. Threads of communality running through many different approaches to psychotherapy as well as differences among them have been widely discussed by such authors as Beitman (1992); Castonguay and Beutler (2006); Garfield (1995, Chapter 6); Greencavage and Norcross (1990); Ryle (2001); Weinberger (1993); and Weiner (1991).
CHAPTER 2

The Patient

THERAPISTS SHOULD NOT assume that people who consult them know what psychotherapy consists of, are prepared to undertake it, and are likely to benefit from it. These are matters that must be explored before psychotherapy is begun. For all prospective patients, it is important to determine how, why, and with what preconceived notions they have come; what hopes and fears they bring into the treatment situation; and what the implications of their personal characteristics may be for their likelihood of benefiting from psychotherapy.

HOW PEOPLE COME TO PSYCHOTHERAPY

People come to psychotherapy primarily on referral from a physician, often through a managed care organization with which both physician and therapist are affiliated. Other patients are self-referred or are sent by an agency or organization in the community. Some physician-referred patients have specifically asked their doctor for help with a personal or psychological problem, whereas others have presented somatic complaints or other concerns that the physician considers to have a psychogenic component. Patients who are self-referred sometimes have decided entirely on their own to seek psychotherapy, but more commonly they come to this conclusion after discussing a problem or concern with someone close to them, such as a spouse, clergyperson, or friend (see Vogel, Wester, Larson, & Wade, 2006, for a discussion of stages typically involved in a person’s decision to initiate psychotherapy).

Community agencies and organizations that frequently refer people for psychotherapy include family service centers, welfare programs, schools, courts, and places of business. Agency and organization referrals often bring people to psychotherapy on something less than a voluntary basis.
Widespread public recognition and acceptance of psychotherapy has made seeing a psychotherapist a common condition of receiving a suspended or reduced sentence following a criminal conviction, being allowed to return to school after a suspension or expulsion, continuing to receive public assistance, or retaining a job or position of trust subsequent to some episode of inappropriate conduct.

Such involuntary entry into psychotherapy is less immediately apparent in physician-referred and self-referred patients than among people referred by agencies, but it nevertheless occurs. For example, a person may insist that his or her spouse enter psychotherapy as a condition of continuing their marriage, and physicians may use their status and authority to pressure a patient to undertake psychological treatment. These types of involuntary entry into psychotherapy do not preclude successful treatment, but whether people are coming voluntarily or under duress can influence their response to psychotherapy. It is safe to assume that patients who feel coerced into entering treatment are more ambivalent regarding therapy and sometimes even resentful toward the therapist. For these reasons, determining the conditions under which patients come to psychotherapy should always be included in their initial evaluation for treatment, as is elaborated in Chapter 5.

**WHY PEOPLE COME TO PSYCHOTHERAPY**

However people make their way into psychotherapy, they come for many different reasons. Some are troubled by distressing symptoms, such as anxiety, depression, phobias, compulsions, or difficulty thinking clearly. Some are experiencing problems in living, such as work inhibition, school failure, marital discord, or social isolation. Some feel generally dissatisfied with their lives or disappointed with themselves for not having become the kind of person they would like to be. These common reasons for seeking psychotherapy on a voluntary basis parallel the major goals of psychotherapy identified in Chapter 1: symptom relief, problem resolution, and life satisfaction enhancement.

Despite sharing one or more of these common concerns, prospective patients vary considerably in the extent of their psychological distress, and some consult a psychotherapist for reasons other than being particularly troubled. On occasion, relatively untroubled people seek psychotherapy out of curiosity about what it is like, or because they regard being in psychotherapy as a status symbol, or because they believe that psychotherapy can make their already productive and rewarding life even better. People in training to become therapists often enter treatment as a
consequence of being required or encouraged to experience psychotherapy firsthand from the perspective of being a patient. Nevertheless, there is no basis in fact for the sometimes-heard assertion that psychotherapy is a self-indulgent luxury for people who do not in reality have many problems. To the contrary, survey data reported by Kessler et al. (2005) and Olfson, Marcus, Druss, and Pincus (2002) indicate that users of psychotherapy, compared to the general population, have more health problems, higher levels of anxiety and depression, and higher rates of work inhibition.

Ironically, some people come to psychotherapists not because they want to engage with them in productive work but because they do not want psychotherapy. These are people who look to the therapist not for help with psychological problems but for absolution—for professional confirmation of their belief that they have no significant psychological problems or that whatever problems they have are caused by other people or by environmental circumstances. Prospective patients who want to be told they do not need help are very often people for whom psychotherapy has been mandated. Armed with a therapist’s clean bill of health, they could then report to their referring probation officer, school official, or spouse that “I’m all better now” or “See, it’s not my problem, it must be yours.”

Sometimes a psychotherapist’s most appropriate response to an involuntary patient will be to indicate no need for treatment, while at other times initially unmotivated patients can and should be helped to undertake therapy addressing psychological problems they have, even if they do not yet recognize these problems (see Connor, 1996, for advice regarding outpatient psychotherapy with involuntary patients). To proceed effectively in either of these directions, therapists must first ascertain why a particular person has come to see them. This topic, along with the “how” of their coming, is part of the initial evaluation process discussed in Chapter 5.

PRECONCEIVED NOTIONS BROUGHT TO PSYCHOTHERAPY

Except for psychotherapists themselves and patients who have previously been in psychotherapy, most people arrive at a therapist’s office with limited information and preconceived—often inaccurate—notions about what to expect. Self-referred patients are particularly likely to be uninformed, unless they have been briefed by a friend or spouse who has been in psychotherapy. Even after receiving such briefings, however, self-referred patients rarely come without biases and preconceptions. With the visibility of psychotherapy in movies, on television, in magazines and books, and on the Internet, very few people remain innocent of at least literary or theatrical versions of what transpires between patients
and therapists (Orchowski, Spickard, & McNamara, 2006; Vogel et al., 2006).

Among people referred for psychotherapy by a physician, agency, or organization, many are likely to have been prepared by some discussion of their need for psychological treatment. Patients referred in these ways do not necessarily come better informed about psychotherapy than patients who are self-referred, however. Referring persons may have reservations about psychotherapy or know very little about it themselves, and consequently their preparation may not provide a potential patient with much useful information. Additionally, in their efforts to encourage the patient to accept a referral for psychotherapy, referring persons may sometimes foster misconceptions about how rapid, painless, and curative the treatment process is.

The preconceived notions people bring to psychotherapy usually include expectations of what the treatment will consist of and what it will accomplish. Some patients come expecting to talk about themselves and be listened to, whereas others expect to be medicated, hypnotized, advised on how to lead a better life, or presented with a detailed analysis of their psychological makeup. Some patients anticipate that psychotherapy will be an ongoing process involving regular sessions for some indefinite period of time, whereas others anticipate that a few visits will be adequate to meet their needs. Some patients come to psychotherapy expecting it to relieve them of distressing symptoms, whereas others expect it to help them understand themselves better.

Some people approach a first visit with the expectation that they are entering psychotherapy and will continue to work with that therapist; others expect that the initial sessions will constitute an evaluation period to determine whether they should enter psychotherapy and, if so, with whom; and still others begin with no expectations regarding psychotherapy or the particular therapist but see the first meeting solely as a diagnostic consultation for the benefit of a referring physician or agency. Like the how and why of a patient’s coming to psychotherapy, all such notions about it need to be explored before treatment is begun, particularly since success in psychotherapy depends in part on congruity between what patients expect and how their therapist plans to treat them (see Chapter 5).

**HOPES AND FEARS ON BEGINNING PSYCHOTHERAPY**

People rarely enter psychotherapy without mixed feelings about doing so. Even highly motivated patients often have some unspoken reservations about undergoing psychological treatment, and even involuntary patients
usually harbor some interest in the possibility of being helped. Such ambivalent attitudes are seldom expressed in the early stages of psychotherapy, at least not spontaneously. Highly motivated patients hesitate to air their reservations for fear of diminishing the therapist’s interest in working with them, and involuntary patients resist giving others the satisfaction of knowing that they see any possibility of benefiting from psychotherapy.

What most patients hope for when they begin talking to a psychotherapist is to feel better as soon as possible. Consistent with the basic reasons why people come to psychotherapy, “feeling better” for some means relief from specific symptoms, for some it means resolution of certain problems, and for others it means achieving a greater sense of satisfaction and purpose in life. Whatever “feeling better” means, it is a hope shared alike by motivated patients and by those who come to psychotherapy under duress and deny (at least initially) any symptoms, problems, or shortcomings. The fact that involuntary patients are regarded by other people as needing psychological help can be taken as presumptive evidence that their life circumstances are causing them difficulty. Psychotherapy may not be a means of improving these circumstances, but involuntary patients certainly can (and often do) hope it might be.

As for feeling better quickly, almost all patients who enter psychotherapy hope for rapid or painless improvement. Even those who recognize that a satisfactory outcome usually requires months or even years of work may still feel disappointed when the first few sessions do not produce noticeable change. Additionally, many people begin psychotherapy with the hope that it will solve all their emotional problems completely and permanently. When therapists appreciate that their patients are likely to have such hopes—whether expressed or not—they are better prepared to discuss with them the goals of treatment and its possible outcomes.

Patients’ fears may be less apparent than their hopes when they consult a psychotherapist, but apprehension in some form or other is almost certain to be present. Some patients are afraid of being considered crazy and put in a hospital. Some fear being embarrassed and humiliated on revealing their innermost secrets to a total stranger. Some are fearful of learning terrible things about themselves or their past that they were better off not knowing. Some are concerned that entering psychotherapy will undermine their autonomy, interfere with their creativity, or change them and their life in other undesirable ways. And many people, in contrast to those who see psychotherapy as a status symbol, worry about the social stigma of being a “mental” patient.
Concerns about being crazy, bad, or overly dependent put voluntary patients in a particularly difficult bind when they come for a first meeting with a therapist. On one hand, they are motivated to put their best foot forward and demonstrate that they are sane, competent, and worthwhile people capable of managing their own affairs. On the other hand, they are motivated to reveal enough of their emotional problems to ensure that the therapist will recognize and respond to their need for help. An accurate assessment of a potential patient’s current status and needs depends on the therapist’s sensitivity to the influence that these conflicting motivations may have on how patients present themselves in an initial visit.

**PATIENT CHARACTERISTICS AFFECTING OUTCOME**

In earlier times, considerable attention was paid to selecting patients for psychotherapy and developing criteria for identifying “good candidates” for treatment. The search for acceptable psychotherapy patients typically involved the presumption that most failures in treatment can be laid at the patient’s doorstep. Currently, however, clinicians recognize that most types of people can be helped by psychotherapy and that a diverse repertoire of demonstrably effective methods is available for providing help. Thus, rather than attempting to select patients for psychotherapy based on their personal qualities, therapists should focus on choosing treatment techniques that are suited to each patient’s needs and capacities (see Lakey, Cohen, & Neely, 2008; Peebles-Kleiger, Horwitz, Kleiger, & Waugaman, 2006). Patients for whom an indicated treatment approach does not fall within the therapist’s competence or interests should be referred to a colleague better prepared to conduct the appropriate therapy. In other words, people seeking help should not be obliged to suit the preferences of any one therapist or fit the mold of any particular form of treatment. They should instead have access to a wide range of treatment methods and therapists qualified to apply them.

Nevertheless, clinical and research studies summarized by Clarkin and Levy (2004) and Stricker (1995a, 1995b) indicate (1) that failures in psychotherapy are not the property of any particular approach and (2) that patients who do poorly in one form of therapy usually do poorly in other types of treatment as well. As these findings suggest, the personal characteristics that patients bring to the treatment situation have a substantial bearing on psychotherapy outcome. In fact, numerous contributors to the psychotherapy literature argue that the personality style of patients and the way they approach and participate in psychotherapy are the most potent determinants of whether and how they change in response to various