

## **Definitions and Scope of Review**

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The term psychotherapy has been used to refer to a wide variety of treatments employed to ameliorate mental distress, mental illness, and problems of coping with daily life. Psychotherapy is a global term, and one commentator has found at least 40 different definitions in the scientific literature (300). The definitions range from broad and inclusive descriptions of various ways of helping other individuals to more limiting definitions which are very specific as to the nature of the problem and treatment (see, e.g., 118). Differences in the definitions used by those who discuss psychotherapy are a likely reason that discussions of psychotherapy have been so difficult to understand and evaluate. The present review attempts to specify the nature of psychotherapy, so as to avoid some of these problems.

To illustrate some of the difficulties of different views of psychotherapy, consider a broad definition such as "the treatment of emotional and personality problems and disorders by psychological means" (144). This definition refers to treatments that may have either a good or poor scientific basis, as well as to treatments that are delivered by either professionally trained or untrained personnel. In contrast, a more specific definition (which has been favored by some researchers) describes psychotherapy in terms of its techniques, the qualifications of the therapist, and nature of the patient's problem (181):

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

Apart from their level of specificity, definitions vary with regard to what is included as the disorders to be treated by psychotherapy. Al-

though some definitions, like the above, are not specific as to the nature of the disorder (see, e.g., 84), diagnosis is becoming more systematic; viz, the newly developed *Diagnostic and Statistical Manual of Mental Disorders* (63). The new diagnostic manual includes disorders that range from organic brain syndromes, schizophrenic and paranoid disorders, to affective disorders such as depression, anxiety, and disorders such as phobias or posttraumatic stress; also included are behavior aberrations such as kleptomania or pathological gambling, personality disorders, alcohol- and drug-related problems, and interpersonal difficulties such as marital or family disturbances or education and work blockages.

One additional feature of the various approaches to defining psychotherapy is that definitions vary in terms of their underlying theoretical assumptions. These assumptions lead to differences in defining the goal of psychotherapy, the basic techniques, and the role of the patient and therapist. As Hogan (118) has noted, psychotherapy can refer to a wide variety of vaguely defined processes. Attempts to specify the nature of psychotherapy result, in part, in definitions that vary in terms of the practitioners and settings which are included as acceptable. Different definitions require different levels of professional training and experience for psychotherapy practitioners. For example, medical definitions of psychotherapy (see 163) may limit primary responsibility for psychotherapy treatment to physicians, while nonmedical models (e. g., 250) may suggest central roles for psychologists, social workers, and nurses, as well as educational and pastoral counselors. The various forms of psychotherapy are further affected by the variety of settings in which therapy takes place (e. g., psychiatric hospitals, outpatient clinics, private offices) and the variety of modalities that are offered (e. g., individual, family, or group counseling).

In order to adequately summarize psychotherapy research and practice, it is necessary to

reflect components of a number of definitions of psychotherapy. In this report, the definition of psychotherapy is limited only in the sense that an effort is made to view psychotherapy as a field that is both scientific and professional. Thus, our definition will emphasize therapies that have an established scientific base and that are delivered by trained professionals. In addition, although it seems unnecessary (as well as difficult) to differentiate between levels of psychopathology, this report is most concerned with those disorders that cause severe dysfunction. Although psychotherapy may be useful in

aiding individuals' adjustment and improving the quality of life, the primary concern here is with problems that require some form of outside intervention.

The following section briefly describes the scope of psychotherapy practice, in terms of the definitional variables described above. It is hoped that this review will orient readers to the central features of psychotherapy and will identify the central factors that must be accounted for in an assessment of psychotherapy.

## THEORETICAL ASSUMPTIONS

When discussing psychotherapy, one typically refers to differences between treatments based on different underlying theoretical assumptions. There is a wide variety of beliefs about people and pathology, and this has resulted in the development of a number of different psychotherapeutic treatments. The variety of psychotherapeutic treatments, at least in terms of the number of labels used to describe psychotherapies, is somewhat bewildering. Nevertheless, many treatments have similar origins, and it is possible to examine the range of therapies by considering only a few major theoretical perspectives. For present purposes, therapies based on psychodynamic, humanistic/phenomenological, and behavioral theories are discussed as the perspectives that underlie most current practice. These theoretical perspectives do not exist in pure form, but they illustrate the most important differences between treatment approaches (see 259).

**Psychodynamic.** —The psychodynamic perspective, which grew out of the classical psychoanalytic theory of Freud (88), is the oldest and the most complex of the three orientations. Although psychoanalytic theory cannot be described here in detail, the role of unconscious motivation, one aspect of Freud's theory, can provide a basis for understanding the nature of psychodynamic (also called analytic) treatments. The importance of unconscious motivation is central to all of Freud's psychological in-

terpretations. The driving forces of an individual's life are seen as originating in some inner system of which he or she might, at the most, be only vaguely aware. Most of the unconscious cannot be called into conscious awareness; any move in this direction meets with resistance, or censorship.

According to Freud's theory, some unconscious impulses come into conflict with environmental constraints and moral prohibitions. To keep such threatening impulses from coming into consciousness, part of the normal energy of mental life is used to provide a constant defense, or resistance, against the acceptance of such impulses. These impulses, however, are not eliminated by such a defensive reaction; instead, they express themselves in indirect ways, leading to behavior that the individual is sometimes unable to explain. Neurosis occurs when such behavior is especially prominent in the life of an individual.

Thus, the goal of analytic psychotherapy is gradually to promote the patient's insight into his or her underlying motivations and conflicts by repeatedly working through the patient's intellectual and emotional defensive resistances. Acquisition of insight, along with affective understanding, is presumed to be a sufficient and necessary condition for restructuring significant aspects of the patient's personality and for promoting the development of more adaptive behaviors in real life.

The methods that use therapies based on the psychodynamic approach are intended to aid the patient in bringing unconscious material to awareness. The core of therapy lies in transference. Freud suggested that patients inevitably project into the therapeutic situation feelings and attitudes from their past, and that they sometimes reenact with the therapist important situations and traumatic experiences repressed since childhood. By becoming aware of these unresolved conflicts, patients can master them and liberate their energy to develop a mature personality. Therapeutic techniques are designed so as to encourage and to analyze this process of transference.

In Freudian psychotherapy, the therapist also makes timely interpretations of the patient's free associations and dreams and deals with the patient's resistances to the content of this unconscious material. Psychoanalytic therapy has provided the model for most "verbal" therapies (i.e., therapies based on conversations between therapist and patient). Although infrequently practiced in pure form, in part because many of Freud's students (e.g., Adler, Jung) developed their own forms of therapy, psychoanalytic theory has had a major influence on other types of psychotherapeutic treatments.

**Humanistic/Phenomenological.** —The second major orientation that has influenced present day treatment can be called the humanistic/phenomenological perspective. The approach is humanistic because it posits that the basic aim of the individual is the achievement of personal growth. Personal growth is variously conceived of as self-actualization (e.g., 234, 235, 236), meaning in life (e.g., 87), and cognitive complexity (e.g., 137). The perspective is also called phenomenological because it holds that the central focus of treatment should be an individual's "phenomenal field." Thus, a person's perceptions about himself or herself and the world (rather than unconscious thoughts) are believed to be central to understanding. The theory further posits that each person has a fundamental urge to preserve his or her self-concept (i.e., perceptions about self).

This theoretical approach, like psychoanalytic theory, has influenced how psychotherapy is

practiced by a variety of different therapists. A major form of therapy based on this perspective is "client-centered" or "nondirective" psychotherapy. This therapy is grounded in the early theoretical work of Rogers (234; see also 235, 236). According to Rogers, when individuals have needs, impulses, or experiences that are not consistent with their self-concept, tension and anxiety result. More severe problems result when individuals react with defensive mechanisms to avoid awareness of their contradictory responses by ignoring important responses *or* by distorting their thinking about them. The role of the therapist, according to Rogers, is to be an empathetic responder.

A central tenet of client-centered therapy is the belief that each individual has the resources for growth. These resources merely need to be released for the person to resolve a problem and achieve maturity. Thus, therapy facilitates the patient's growth by promoting the free expression of feelings and by refraining from imposing patterns and values. Out of the therapeutic relationship, patients (almost always referred to as clients) evolve a new conceptualization of the self. This view of themselves is more tolerant, especially of their failings, and it resolves the differences between their ideal image and their actual perception of themselves. As a result, anxiety and dysfunctional tendencies are lessened, and there is greater objectivity in the handling of reality. The new self-image should also be accompanied by a more harmonious expression of attitudes and feelings.

Therapists' efforts to interpret, evaluate, or guide the individual (which are central to analytic therapy) are felt by humanistic therapists to hamper patients' emerging sense of self-growth and self-direction. Techniques commonly employed in client-centered therapy are intended to facilitate individuals who seek help in achieving their own insight. These techniques include attentive listening to clients' communications for content and feeling, reflecting or verbally focusing clients' feelings, and encouraging clients in their efforts to manage their *own* problems.

**Behavioral.** —The third major orientation is the behavioral perspective. It developed, at least

initially, from an extensive body of experimental research and theory associated with animal and human learning research. Theorists of behavior such as Skinner (263,264,265), Pavlov, and Hull—who were not psychotherapists or directly interested in the treatment of mental dysfunction—are most responsible for the ideas that underlie this approach. A wide variety of therapeutic approaches derived from these basic research efforts have been developed by later theorists such as Wolpe (302) and Bandura (11).

The basic assumption of behavioral theories is that most persistent pathological behavior is acquired through a process of learning. In essence, experiences in the individual's life instigate patterns of behavior which remain unless other conditioning experiences modify them. Therapies based on behavior theory usually begin with systematic analysis of the problematic situation and an identification of the specific behavioral or situational factors to be modified. Once it is known how and under what conditions these behaviors are maintained in the individual's behavioral repertoire, the therapist interferes directly with this preestablished order. Internal (cognitive) or external (environmental) patterns of behavior contrary to the well-being of the patient are modified by systematic retraining procedures.

Current clinical practice in behavioral therapy is derived from two laboratory-developed theories of learning. The first, operant conditioning, is derived directly from research by Skinner (e.g., 263). Because behavior is presumed to be lawful and predictable, behaviorists believe it is controllable once the relevant reinforcing variables (those that maintain the behavior) have been determined. Operant conditioning includes aversive counterconditioning to eliminate undesirable behaviors and/or positive reinforcement to establish and maintain new adaptive behaviors. Aversive counterconditioning entails pairing the patient's behavioral deviation with an unpleasant stimulus. For example, alcoholism has been treated by administering a substance to patients which would induce violent and uncomfortable physical reactions in the presence of alcohol. Positive reinforcement entails rewarding the patient for pro-

ducing desired behaviors. For instance, positive reinforcement has been used to treat autistic children who are disassociated from reality and unable to engage in gratifying interpersonal relationships. These children are rewarded with verbal approval and cand, when they show any evidence of social responsiveness or interaction.

Another form of clinical practice, developed by Wolpe (302), is reciprocal inhibition. This therapy is an outgrowth of Pavlov's classical conditioning studies and of Hull's learning theory. The theory underlying reciprocal inhibition is that neuroses (in particular, phobias) are characterized by persistent anxiety responses to situations in which there is no objective danger. The neuroses are produced when an individual associates high intensities of anxiety and neutral stimulus events. Therapy based on principles of reciprocal inhibition systematically desensitizes the patient to particular stimulus events. Thus, a patient with neurotic anxiety is taught to relax. Then, in a state of relaxation, he or she is asked to think about a mildly anxiety-provoking situation. This technique is then used with increasingly more disturbing situations. Relaxation inhibits anxiety, and the patient is progressively able to master the situations previously associated with anxiety reactions.

Although many of the behavioral therapies rely directly on learning paradigms tested with laboratory animals, a more recent trend (in part, exemplified by Bandura's work (11,12)) is the development of cognitive behavior therapies. Within such therapies, laws of learning are used as the basis for modifying cognitive processes (see 164, 180). The patient in cognitive behavior therapy takes an active role in identifying problems and working with the therapist to develop mechanisms to control desirable or undesirable thoughts. Bandura's (12) social learning theory is a related approach that emphasizes the role of observing others (models) who are reinforced or punished. There are also a variety of eclectic behavior therapies (e.g., 154) which employ a varying set of learning principles.

**Common Factors.**—Psychotherapy, as should be clear from the above, is derived from a range of assumptions. Although the three theoretical perspectives described above under-

lie most forms of therapy, there is considerable eclecticism in practice. A practitioner is likely to hold some views or use techniques that are consistent with one dominant theoretical perspective and to hold other views and use other techniques that are quite inconsistent with it.

In part, the reason for this eclecticism is that a number of important similarities exist across different theoretical persuasions. Some theorists such as Frank (84,86), in fact, argue that psychotherapeutic change is predominantly a function of factors common to all therapeutic approaches (e. g., 84). The primary ingredients of such common, nonspecific, factors are the ther-

apist's understanding, respect, interest, encouragement, and acceptance. Thus, while the contents and procedures of psychotherapy may differ across theoretical orientations, all forms of psychotherapy share common "healing" functions. All therapists combat the patient's demoralization and sense of hopelessness by the relationship they establish with the patient and by providing an explanation for previously inexplicable feelings and behavior. According to those who maintain that such nonspecific factors are responsible for psychotherapy's effects, one reason for the success of therapy is because it removes the mystery from the patient's suffering and supplants it with hope.

## MENTAL DISORDERS

Although it is true that one source of confusion about psychotherapies is the divergent theoretical assumptions of therapists, it should also be recognized that the nature of the problems dealt with by specific therapies varies widely. Not only are a broad range of problems considered psychopathological, but for any one individual, the identification of a disorder is often dependent on his or her own reports of symptoms. In contrast to physical diseases, which are usually accompanied by measurable physiological changes, mental disorders must usually be identified by a patient's or another person's report of a problem. Notwithstanding the many exceptions to this distinction between physical and mental illness, the difficulties of diagnosis of mental illness are widely recognized. An additional problem in diagnosis is that the severity of a mental/psychological problem is based on the context in which it occurs. A problem that may be diagnosed as a severe disorder in one situation (e. g., at work) may be considered a minor disturbance in another context (e.g., at home).

Widely varying phenomena have been considered mental disorders. Most therapists and researchers seem to contend that any problem which causes a patient discomfort and dysfunction is a mental health problem requiring treatment. For present purposes, the most important aspect of the problem would seem to be the level

of dysfunction. Any person who is unable to carry out his or her normal responsibilities is a potential candidate for therapy. Level of dysfunction, however, is a difficult distinction to make. An individual may appear to be functioning well, but may be extremely troubled. One would want to alleviate such dysfunction and prevent more serious dysfunction.

Below, the disorders treated by psychotherapy have been grouped within three general categories: neuroses, psychoses, and conduct disorders. While the most current diagnostic manual (63) lists mental disorders somewhat differently, for the purpose of describing the range of mental disorders, this organization seems more appropriate.

Psychoses are severe disorders characterized by grossly illogical thought patterns and distorted perceptions of reality. The psychotic individual may have prolonged periods of melancholy or elation and may exhibit extreme isolation or withdrawn behavior. The symptoms of a schizophrenic disorder, the most prevalent type of psychosis, include bizarre delusions, auditory hallucinations, and incoherence. Schizophrenia is accompanied by a deterioration in level of functioning in areas such as work, social relations, and self-care.

Neuroses, the most common disorders, are problems marked by feelings of anxiety, fear,

depression, guilt, and other unpleasant emotions. Anxiety, for example, is related to physical symptoms such as trembling, sweating, and heart pounding. It may result in the individual's feeling continually worried and being overly attentive. The individual may feel impatient and irritable, and may have insomnia. While associated with discomfort, such anxiety may not impair social or occupational functioning more than mildly. In contrast, agoraphobia (an irrational fear of crossing or being in open spaces) causes individuals to avoid certain situations, and thus may interfere seriously with social and occupational functioning. Neurotic conflicts may also be the basis of other problems, such as divorce and child abuse.

Conduct disorders are characterized by a lack of normal feelings and conscience that results in behaviors which violate basic social rules. Conduct disorders are reflected by problems such as uncontrolled impulses (e.g., outbursts of aggressiveness, failure to resist impulses to steal or to set fires) and drug and alcohol abuse. Conduct disorders among children and adolescents include such symptoms as physical violence against persons or property (e.g., vandalism, rape, mugging), chronic violations of rules (e.g., truancy from school, alcohol or drug abuse), and persistent lying and stealing.

In addition to the above disorders, there are a variety of conditions which reflect interactions between different types of problems. Most prominent here are psychosomatic disorders, where physical symptoms are thought to have a psychological base (e.g., 188). Some have suggested (e.g., 152) that over 50 percent of the patients seen in general medical practice have psy-

chologically based problems. Conditions such as asthma, colitis, anorexia nervosa, as well as physical problems such as obesity and headaches due to stress, have been considered suitable problems for psychotherapeutic treatment.

The severity of any psychopathological disorder depends, in part, on the individual's reaction. For example, whereas depression in some individuals may be associated with poor appetite, insomnia, and loss of energy, in others it may be associated with an attempted suicide. Individuals also differ in the degree of subjective distress they experience and the urgency with which they desire and need help. Whereas for some individuals, mild depression is so bothersome that they cannot function, others who appear very depressed carry out normal lives. Whereas some individuals who seem only mildly troubled feel in great need of therapeutic help, others who have suffered major trauma are resistant to seeking help.

The diagnosis of a disorder, as well as its seriousness, is thus inevitably part of a subjective decisionmaking process on the part of the therapist. The therapist is usually responsible for the diagnostic decision and is influenced both by the patient's report of the problem and by objective evidence (e.g., data on the patient's inability to communicate with others). As described in the next section, particular therapists may view these problems differently, some focusing on behavioral disorders, others on dysfunctional thoughts and emotions. These different emphases sometimes make it difficult to compare effectiveness across psychotherapies and psychotherapists.

## PRACTITIONERS

As indicated above, the delivery of psychotherapy differs not only in terms of theoretical assumptions and types of disorders treated, but also in terms of the personnel who offer therapy. Therapists have an important influence on the nature of psychotherapeutic treatment. Differences in therapists' theoretical orientation, or preferred technique, as well as differences in

their training, contribute to the difficulty of describing and assessing psychotherapy.

Professional therapists differ in a number of ways, both related and unrelated to their training and disciplinary orientation. Thus, therapists may differ with regard to their underlying assumptions concerning psychotherapy. They

may adopt a psychodynamic, humanistic/phenomenological, or behavioral perspective, or an eclectic set of beliefs based on several major orientations. Therapists also differ in the modalities and techniques they employ to provide treatment. For example, practitioners may perform therapy mainly with individuals, groups, or families; as well, they may focus more on early events in the patient's life or on recent events, or lead a patient to insights concerning behavior or feelings. These differences in approach are not clearly associated with the therapist's professional training and identification.

The nature of the relationship that a therapist establishes with a patient may be a particularly important factor in the nature of changes caused by psychotherapy. The patient reacts to the therapist in a general way, not necessarily to specific characteristics. Thus, therapists and researchers have been very concerned with the therapist as a human being (see 274). Professional therapists obviously differ in terms of their personal characteristics. Some of these characteristics, such as sensitivity, empathy, activeness, and involvement, are seen by some theorists (e.g., 86) as essential to successful therapeutic outcomes. Therapists also differ with regard to age, sex, cultural background, ethnic factors, level of professional experience, psychological sophistication, social and cultural values, and cognitive styles. Any of these characteristics may have a significant effect on the way in which psychotherapy is delivered. These characteristics may interact with the practitioner's theoretical perspective to produce a unique therapeutic treatment.

For the purposes of this report, it seems important to distinguish professional from nonprofessional helpers. While it is sometimes difficult to make distinctions between what professionals and nonprofessionals actually do in treatment settings, the professional usually has a very different orientation and different responsibilities from those of the nonprofessional. Obviously, persons with mental distress can be helped by a variety of other individuals, including family and friends. These other individuals may assist the patient in understanding his or her problems and in making behavioral adjust-

ments. The unique contribution of professionally trained therapists is important to specify.

The primary professionals who deliver psychotherapy are psychiatrists, clinical psychologists, and psychiatric social workers (see 118). In 1977, there were approximately 28,000 psychiatrists professionally active in the United States. Of this number, approximately 24,500 spend at least half of their time in patient care; the others are primarily administrators, teachers, or researchers (5). Psychiatrists are medical school graduates who have had a 1-year internship and a 2- to 3-year residency in psychiatry at an approved hospital or clinic. In addition, they must have practiced their specialty for 2 years and be tested in order to qualify for certification by the American Board of Psychiatry and Neurology.

One problematic aspect (103) to understanding the delivery of psychotherapy is that many nonpsychiatric physicians also provide psychotherapy services. Thus, according to the National Institute of Mental Health (see 225), over half of the patients seen for psychiatric problems are treated by primary care physicians. It is important to emphasize, however, that while many nonpsychiatric physicians are involved in mental illness diagnosis and treatment, their involvement may be very limited (see 60).

In terms of psychologists, according to a 1976 membership survey by the American Psychological Association, there were approximately 23,000 psychologists engaged in mental health activities. These psychologists worked in individual or group practice settings, mental health centers, general or psychiatric hospitals, and outpatient clinics. A 1977 survey (183) found similar results, although it uncovered a slightly higher number (approximately 26,000) of clinical psychologists (because nonmembers of the Association were located).

Generally, clinical psychologists hold a doctoral degree (either a Ph. D. or a Psy. D.), although some (less than 10 percent) hold only a master's degree. An integral part of the training of clinical psychologists is a 1-year internship in a clinic or hospital setting approved by the



American Psychological Association; in addition, clinical psychologists typically have several years supervised experience, and Ph.D.s receive training in research (which culminates in a dissertation). A psychologist who has had at least 5 years of postdoctoral experience may apply for advanced certification from the American Board of Professional Psychology.

A large number of psychotherapists are clinical social workers. In 1978, 10,922 social workers were included in the Register of Clinical Social Workers (see 2); in addition, many other social workers who are members of the National Association of Social Workers practice psychotherapy. Psychiatric social workers have had 2 to 3 years of postgraduate training in a school of social work which typically includes an internship. Psychiatric social workers with a masters degree in social work and 2 years of experience may take a test for certification by the Academy for Certification of Social Workers.

Although the largest number of identifiable psychotherapists are either psychiatrists, psychologists, or psychiatric social workers, various other professionals are trained in psychotherapy and administer it to patients. These other professionals include psychiatric nurses,

pastoral counselors, educational psychologists, and occupational therapists, as well as a number of individuals from other disciplines. Nurses, in particular, play an important role in the provision of psychotherapy. According to a 1972 survey (see 2), almost 38,000 registered nurses reported working in a "psychiatric/mental health area;" about 4,000 of them had master's degrees. These nurses and other professionals have had unique disciplinary training, but they have also completed internships with (or under the supervision of) psychiatrists and psychologists, and they often provide treatment in combination with other professional therapists. To assess the effects of psychotherapy, the role of these professionals needs to be recognized.

In addition, the work of paraprofessionals (i.e., psychiatric aides and trained volunteers) should be noted. The Alcohol, Drug Abuse, and Mental Health Administration (2) has estimated that over 150,000 paraprofessionals work in direct contact with mental patients. Many psychotherapy settings rely on the services of personnel who, though not formally trained as therapists, have a great deal of contact with patients. Such paraprofessionals may play a role in identifying patient problems and maintaining therapy begun by the professional therapist (4,65).

## DELIVERY SETTINGS

Variations in psychotherapy are also seen in the diversity of settings in which therapy takes place. These settings may have an important impact on the nature of psychotherapy. In some cases, the setting influences the type of therapy available to the patient. Settings may include traditional inpatient mental hospitals, community mental health centers (CMHCs), private offices, residential treatment centers, and other locations such as schools, offices, and military facilities.

Prior to the establishment of CMHCs in 1963, most psychotherapy was provided in mental hospitals; certainly, these settings provided much of the societally supported mental health treatment. Although there is some controversy

as to the relationship between the development of CMHCs and deinstitutionalization of mental hospital patients, there has been a sharp decline in the number of hospital beds for mental patients. In 1962, psychiatric hospitals had a total of 717,000 beds with 91.0-percent occupancy (194); in 1978, there were only 219,517 beds with 80.7-percent occupancy (121). Although large numbers of the severely disturbed are still hospitalized, their stays are generally much shorter than was previously the case. The nature of treatment has also changed. Patients today have more frequent access to specific treatments (i. e., treatment other than being "housed" in the hospital), including group therapy, individual therapy, and psychoactive drugs (i. e., substances that alter mental states). In addition,

patients are usually exposed to a number of different therapists (e.g., a psychiatrist who supervises their use of drugs, a psychologist who does individual counseling, and a psychiatric nurse or social worker who leads group therapy).

CMHCs and other outpatient services represent the fastest growing segment of the mental health delivery system. Since their inception in 1963, CMHCs have been made available to almost 50 percent of the U.S. population. In 1975, according to the National Institute of Mental Health (197), patient visits to CMHCs totaled 1,961,000. As do outpatient mental hospitals, CMHCs use a variety of mental health professionals, and a patient is likely to have exposure to several modes of treatment. CMHCs tend to emphasize short-term treatment, even though they often deal with chronic patients.

A large segment of mental health treatment takes place in private offices. Once available only to the well-to-do, private practice has flourished recently as public and private insurance coverage for mental health disorders

has become more widespread. It is estimated that there are now 15,562 physicians, 4,700 psychologists, and 2,189 social workers engaged more than half-time in the private practice of psychotherapy (2).

Several other settings for psychotherapy are worth noting. Outpatient mental health services are growing in acceptance as part of medical primary care. Health maintenance organizations, hospital-based outpatient clinics, and even some small physician groups are including mental health professionals on their staffs (e. g., 26). In general, such services are used to supplement medical treatments and/or to reduce reliance on physical health care. Much psychotherapy also goes on in nonpsychiatric residential treatment centers. For example, under some circumstances, homes for children with behavioral and learning problems and prisons can be considered treatment centers. In addition, many organizations such as schools, industries, and the military provide in-house resources to deliver psychotherapy for members with mental health problems.

## SCOPE OF THIS REPORT

As should be clear at this point, psychotherapy refers to a broad range of treatments used to ameliorate a number of different kinds of conditions, by different therapists, and in a variety of settings. The present report, whose goal is to describe the scientific basis for assessing psychotherapy, attempts to delimit its discussion in two ways.

First, the report attempts to describe those aspects of psychotherapy that have the most important implications for financing and reim-

bursement policy. This is reflected in an emphasis on severe dysfunctions (which are, potentially, the most costly) and an effort to distinguish the applicability of psychotherapy to particular problems. Second, the report attempts to describe the current range of practice and research on psychotherapy by referring to the four categories of variables described above. Thus, the theoretical assumptions of therapy, and the characteristics of patients, therapists, and delivery settings serve as categories that need to be considered in psychotherapy assessments.