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WHAT DO PSYCHOTHERAPISTS REALLY DO IN PRACTICE? AN INTERNET STUDY OF OVER 2,000 PRACTITIONERS

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Abstract

Over 2,200 North American psychotherapists completed a Web-based survey concerning their clinical work, including theoretical orientation, client characteristics, and use of specific psychotherapy techniques. Psychotherapeutic integration was common, with the majority of respondents identifying with more than one theoretical orientation or as having an eclectic orientation. The modal patient was a White female adult suffering from a mood or anxiety disorder and interpersonal problems. Individual psychotherapy was the preferred treatment modality. The most frequently endorsed techniques were relationship-oriented such as conveying warmth, acceptance, understanding, and empathy. The least frequently endorsed techniques were biofeedback, neurofeedback, body and energy therapies, and hypnotherapy. Efforts to disseminate empirically based therapies require understanding and accommodating clinicians' tendencies to integrate techniques.

Keywords

psychotherapy; professional practice; evidence-supported treatment

There is limited information about what constitutes the routine conduct of psychotherapy in community settings. To aid in the dissemination of empirical evidence to frontline clinicians, researchers need to understand the patients being seen, their problems, and currently used treatments (Hohmann & Shear, 2002; Kazdin, Siegel, & Bass, 1990). Such information could also allow for monitoring changes and trends in the delivery of mental health services.

Some data concerning what practitioners actually do in therapy comes from a survey of psychologists over two decades ago (Wogan & Norcross, 1985). Over 300 psychologists

working with adults were asked about use of 99 techniques. Relational interventions were widely employed, whereas some highly specialized techniques such as flooding were rarely used. A more recent investigation examined the practice patterns of members of the United Kingdom Council of Psychotherapy (Tantam, 2006). Although analytically informed conceptualizations guided most treatments, only 39% actually used psychoanalytic techniques.

This article describes theoretical orientations, caseloads of and techniques used by a large and diverse sample of U.S. and Canadian mental health professionals. The composition of the mental health workforce has changed radically over the past several decades and may be unique in North America. One trend is proliferation in the number of core disciplines (psychology, psychiatry, social work, psychiatric nursing, and marriage and family therapy) and additional categories of providers such as addiction and pastoral counselors (Robiner, 2006). There has also been an increase in clinicians who are female and those representing racial and ethnic diversity, a decline of psychoanalysis, and an increase in client self-change and cognitive-behavioral interventions (Norcross, Hedges, & Prochaska, 2002; Norcross, Karpiak, & Santoro, 2005). In addition, there is more access to psychotherapy by socioeconomically disadvantaged individuals, a rise in psychotherapy for mood disorders (Olfson, Marcus, Druss, & Pinkus, 2002), and more positive attitudes toward mental health treatment (Mojtabai, 2007).

Method

The Columbia University-New York State Psychiatric Institute Institutional Review Board (IRB) approved this study. The Editor of a popular psychotherapy magazine, the *Psychotherapy Networker*, sent email invitations twice to subscribers with known email addresses (~40%; $N = 22,000$), directing them to a secure Website where they could read a study description, offer consent, and complete the survey. Between September 2006 and April 2007, 2,739 participants registered and at least partially completed the survey.

Response metrics such as view, participation, and completion rates are recommended for reporting of Web-based surveys (Eysenbach, 2004). To guarantee participant confidentiality, the IRB did not allow tracking devices. Thus, lack of information about the number of unique visitors to the Website prevented calculation of exact view and participation rates. An estimate of participation rate is the number of Website survey registrations divided by the number of subscribers who were sent emails (13%), which is conservative because it is unlikely that every subscriber who was sent an email visited the Website. The completion rate among individuals who consented to participate was 72%.

Because of differences in formal training, licensure, and practice circumstances as well as primary focus on practicing psychotherapists, those living outside of the U.S. and Canada (92; 3%) and students (40; 2%) were excluded from further analyses, leaving 2,607. Because scope of practice and patient profiles are different for M.D.s versus others, 14 (<1%) psychiatrists and 4 (<1%) other physicians were excluded. Of the remaining 2,589 participants, 433 (17%) were excluded because they had <25% missing responses. In the remaining sample of 2,156 participants reported on here, the modal clinician was White ($n = 1981$, 92%), female ($n = 1644$, 77%), 59.30 ($SD = 9.89$) years old, with an average of 15.26 ($SD = 9.86$) years of clinical experience. The largest group were social workers (36%; $n = 775$), next were professional counselors (23%; $n = 488$), followed by psychologists (17%; $n = 374$), marriage and family therapists (17%; $n = 360$), and others ($n = 158$, 7%) including certified drug/alcohol and pastoral counselors. Half were in independent practice ($n = 1129$, 53%), and the rest worked in outpatient mental health clinics ($n = 450$, 21%) or other institutional settings. Most practiced in the Eastern region of the U.S. ($n = 1056$, 50%),

followed by Pacific area ($n = 451$, 21%), Central zone ($n = 390$, 19%), Mountain region ($n = 140$, 7%), and Canada ($n = 70$, 3%).

In brief, the construction of the survey was a systematic, sequential, and iterative process, which started with interviews of seven psychotherapists, representatives from several disciplines, regarding their clinical practices and influences on practice. Additional items were added from a variety of professional sources (e.g., Websites and publications). Several national clinical researchers reviewed the initial document and six clinicians completed the survey to provide feedback on clarity, redundancies, and response burden. The survey addressed numerous areas, including influences on uptake and sustained use of psychotherapies (Cook, Schnurr, Biyanova, & Coyne, 2009), influential figures, books and authors on practice (Cook, Biyanova, & Coyne, 2009a), and perceived barriers to adoption of treatments (Cook, Biyanova, & Coyne, 2009b). None of the information presented here is duplicated in earlier papers.

The primary focus of this paper is to report information on theoretical orientation, caseloads, and psychotherapy techniques. Theoretical orientation was assessed by the following question, "How would you describe your current theoretical orientation? Please fill in percentages to total 100%." Additionally, information was gathered regarding client characteristics such as sex, age, and types of presenting problems. Practice over the past 30 days was also assessed, including number of clients, number of sessions, mean session length, number of new clients, and whether therapy was individual, group, or family and couples. Participants were asked to indicate using 5-point ordinal scale (none/very few, some, half, most, and almost all/all) what proportion of their clients in the preceding month received each of 60 psychotherapy techniques.

Results

Forty-eight percent of clinicians worked mostly with female clients, 13% saw primarily men, and 40% had about equal distribution of genders in their caseloads. Most clinicians (91%) reported treating predominantly White clients, with few working mostly with Black (4%) or Hispanic clients (5%). Sixty-nine percent worked mostly with adults, 14% with children and adolescents, and the rest had a mixed clientele. Mood and anxiety disorders were most prevalent in the caseloads of 40% of the clinicians and 21% reported that majority of their clients had social problems such as family discord or lack of social support. Only 8% of clinicians devoted most of their time to posttraumatic stress disorder clients; less than 8% reported that majority of their clients had issues such as homelessness, unemployment, inadequate housing; 6% worked mostly with substance use problems; 5% primarily with serious behavioral problems such as aggression; 4% addressed mostly health behavior problems; 4% specialized in personality disorders; 3% in serious comorbid medical conditions; 2% in serious psychopathology and less than 1% devoted most of their time to clients with eating disorders. Forty-one percent saw primarily clients with income below \$19,000; 27% worked mostly with those whose income ranged from \$20,000 to \$49,999, 26% with clients in the \$50,000-\$99,000 income category; and only 7% saw those whose income exceeded \$100,000. Individual psychotherapy was the preferred treatment modality in 84% of clinicians; 9% saw mostly families and couples; and the rest specialized in group therapy. In a typical week, most therapists saw 19.28 ($SD = 10.95$) clients, with 2.5 ($SD = 4.35$) new clients each week. Most clients (67%) were seen weekly; 16% monthly; 8% two or more times a week; and 7% less than once a month. Most clients (70%) had 50–60 min sessions; 14% had 45 min sessions; for 10% sessions lasted more than 1 hr; and 6% were seen for less than 30 min.

Participants were asked to assign a percentage value to each theoretical model, comprising their total theoretical orientation (equal to 100%). Then, the percentages for each model were summated across participants and divided by the number of participants in the sample. Cognitive-Behavior Therapy (CBT) was the most popular approach, that is, it constituted a larger percentage of the practitioners' models when all the endorsed percentages were combined. CBT was followed by the family systems, psychodynamic/analytic, and acceptance/mindfulness based (in that order). When the participants were summed to include everyone who mentioned using a given approach in their practice, CBT was still the leading orientation ($n = 1,940$; 79%); family systems was the second (1,212; 49%), mindfulness was the third (1,013; 41%), psychodynamic/analytic was the fourth (885; 36%), and Rogerian/client-centered/humanistic the fifth (758; 31%). Only 59 participants (2%) identified themselves completely with one orientation. The rest either endorsed "eclectic" approach or specified the exact percentages each orientation informs their practice.

Table 1 enumerates use of specific therapeutic practices. These practices are arranged in descending order, from techniques used by most clinicians with all or almost all clients to the least used techniques. The top 10 practices were endorsed by more than half of participants: trying to convey warmth and respect with all or almost all of their clients, followed by communicating that client is accepted and prized, communicating understanding of client's experience, empathizing with the client, promoting clear, direct expression of client's feelings, making reflective or clarifying comments, focusing on cultivating therapeutic relationship, encouraging client to develop healthy recreational activities, encouraging emotional processing of distressing experiences, and raising awareness of how client relates to others. The following 10 practices were endorsed by less than five percent as used most or all of the time and included biofeedback, neurofeedback, body therapies, hypnotherapy, paradoxical techniques, Eye Movement Desensitization and Reprocessing (EMDR), psychological testing, energy therapies, dream analysis, and use of empty chair or roleplaying techniques.

Discussion

This study documents use of a wide range of mental health practices by a broad scope of psychotherapists from various disciplines and settings across North America. The trend of synthesis or merging of theoretical influences continues. Similar to the findings from a survey of psychologists conducted over 25 years ago (Smith, 1982), the majority of participants in this sample identified themselves with more than one theoretical orientation or as having an eclectic orientation. Clearly, any attempts to disseminate evidenced-based practices to community psychotherapists should understand and accommodate tendencies to integrate techniques. In addition there is a strong trend in the continued strength and impact of CBT as it is the most frequently endorsed theoretical orientation. This is consistent with a national survey of marriage and family therapists in which the most frequently endorsed primary treatment modality was CBT (Northey, 2002), and a review of clinical psychologists reported orientations from 1960 to 2003 (Norcross, Karpiak, & Santoro, 2005).

Consistent with results from a representative sample of psychologists conducted over 25 years ago, individual therapy was the most popular modality (Prochaska & Norcross, 1983). Relationship-oriented common-factor techniques were the most frequently utilized. These techniques are at the core of Rogers' (1957) client-centered approach and focus on building and sustaining a good therapeutic alliance. A meta-analysis of 79 psychotherapy studies indicates empirical support for a number of these techniques (Martin, Garske, & Davis, 2000). Their reported common usage may suggest that this is what clinicians believe are the most important mechanisms that facilitate patient improvement in psychotherapy.

Techniques that likely fall under the rubric of CBT (e.g., assign homework or behavioral tasks outside of session; challenge clients' thoughts or use other cognitive restructuring techniques; follow a treatment manual; and assign readings or self-help books) also appear quite popular in use. Since development over 40 years ago, CBT has proven effective for a variety of psychiatric conditions as well psychosocial issues (Beck, 2005; Butler, Chapman, & Forman, 2006). In addition, CBT appears to be gaining influence and popularity with clinicians in terms of self-rated influential figures, authors, and books (Cook et al., 2009a). Its use may also be due, in part, to insurance panels requiring providers to offer CBT.

Psychodynamic techniques (e.g., relate current problems to childhood and family experiences; help clients explore unconscious processes) were also used often. Indeed, almost one in three therapists used them with most or all of their clients, and a similar number used them with some of their clients. This is consistent with results of a prior study that found over one third of clinicians used psychodynamic treatment with anxiety disordered patients in their practice (Goisman, Warshaw, & Keller, 1999). Using the Delphi methodology, a panel of psychotherapy experts predicted that the use of classical analytic techniques, such as free association and dream interpretation, would decrease over time (Norcross et al., 2002). Whether the popularity and use of dynamic therapy reduces over the coming years, however, remains to be seen.

The least frequently endorsed techniques (e.g., hypnotherapy) seem to require specialization or certification beyond what is provided in standard graduate education. Thus, their lack of use may not reflect their lack of popularity per se, but rather their additional requirements for training.

While there are numbers of well-known professional organizations such as the American Psychological Association, the National Association of Social Workers, and the American Association of Marriage and Family Therapy, there appears to be no joint organization currently serving the interests of a broad array of psychotherapists in their entirety. Similar to the United Kingdom's Council for Psychotherapy, it might be a good idea to have a registry of all psychotherapists in North America. This would allow periodic assessments of the mental health practitioner field as well as act as conduits for dissemination. In addition, a national registry or entity could assist in the coordination, deployment, tracking, and control of the training for this work-force (Robiner, 2006).

The main strength of this study is also its primary limitation. It was conducted with a large group of therapists in diverse clinical settings across North America via a Web-based survey and exact generalizability is unknown for a number of reasons including lack of data on nationally representative samples of psychotherapists, and detailed information on Psychotherapy Networker subscribers with which to estimate representativeness of this sample. However, similar to a study with an international sample of over 4,000 psychotherapists (Orlinsky, Botermans, & Ronnestad, 2001; Orlinsky et al., 2005), this sample's composition is likely to be more representative of the mental health workforce as a whole than those in the majority of clinician surveys, in which samples are drawn from single professional discipline or restricted geographical locations (e.g., Becker, Zayfert, & Anderson, 2004; Freiheit, Vye, Swan, & Cady, 2004; Rosen et al., 2004). Compared to Orlinsky et al.'s (2001) psychotherapists, this sample had a higher proportion of female therapists (77 vs. 53%), and therapists were about 17 years older (59 vs. 42). The majority of our participants were White (92%), but ethnic composition could not be compared to Orlinsky et al.'s (2001) sample, as this information was not provided in published reports. Psychologists were the largest professional group in the Orlinsky sample (57 vs. 17%, respectively); while social workers were the predominant profession in this study (36 vs. 6% in Orlinsky's et al. study).

Another limitation of this study is that self-reported practices may not necessarily indicate what clinicians actually do (Hoyt, 2002). This may particularly be true of relationship-oriented common-factor techniques. Objective measures of psychotherapy utilization might include video samples of random therapy sessions or other verification such as patients' perception of use or automated record-keeping. In addition, information on use of techniques does not indicate effectiveness (Prochaska & Norcross, 1983). In addition, there is some overlap in the therapeutic technique categories (e.g., follow a treatment manual and EMDR) making it difficult to definitively determine use of particular techniques. Because of small numbers as well as likely practice differences, another limitation is the noninclusion of psychiatrists. Previous research, however, has found that there are differences between psychologists and psychiatrists in terms of patient caseload and practice profile (Pingitore, Scheffler, Sentell, & West, 2002), psychotherapy techniques (Kazdin, Siegel, & Bass, 1990) as well as goals of treatment (Strupp, 1973).

Because most practitioners were experienced professionals, our sample underrepresents younger, less educated, or less credentialed peer counselors and paraprofessionals who provide a considerable proportion of counseling services, particularly to disadvantaged populations. Such persons are difficult to recruit for a representative sample or even count, but may be the most accessible sources of therapy available to members of low income and minority populations. In addition, most clinicians in this study were masters-level clinicians. Although there are currently no data on the proportion of masters- and doctoral-level clinicians in the mental health field as a whole to which study findings could compare, the data may reflect a trend in the field of the continuing increase in the number of master's-level therapists (Norcross et al., 2002).

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Table 1

Frequency of Usage of Therapy Practices

Therapeutic Technique	None/Some		Half		Most/All	
	N	%	N	%	N	%
Convey warmth, caring and respect	39	2	21	1	2094	97
Communicate that client is accepted and prized	91	4	44	2	2009	93
Communicate understanding of client's experience	120	6	81	4	1948	90
Empathize with client's situation, feelings, struggles	117	5	104	5	1927	89
Promote clear, direct expression of client's feelings	117	5	104	5	1927	89
Make reflective or clarifying comments	110	5	125	6	1913	89
Focus on cultivating therapeutic relationship/alliance	182	8	109	5	1856	86
Encourage client to develop healthy recreational activities	532	25	330	15	1284	60
Encourage emotional processing of distressing experiences	589	27	298	14	1254	58
Raise awareness of how client relates to others	485	23	417	19	1249	58
Encourage venting of feelings	680	32	249	12	1217	57
Encourage simple self-care behaviors	738	34	274	13	1123	52
Provide education about symptoms	697	32	349	16	1103	51
Emphasize here and now experiences rather than past experiences	703	33	444	21	998	46
Relate current problems to childhood and family experiences	784	36	390	18	968	45
Challenge thoughts or use other cognitive restructuring techniques	692	32	495	23	965	45
Assign homework or behavioral tasks outside of session	885	41	389	18	876	41
Explore metaphors and images used by clients	1040	48	237	11	849	39
Deliberately model desired behaviors for client in session	1054	49	302	14	789	37
Help identify and prepare for triggers or situations that risk relapse	1006	47	403	19	741	34
Encourage to make new friends and create social support networks	1064	49	412	19	669	31
Use stories and examples as a therapy technique	1089	51	406	19	661	31
Use direct confrontation about adverse behavioral consequences	1284	60	343	16	517	24
Measure symptoms/functioning in a systematic way	1419	66	226	11	491	23
Provide basic life skills training (e.g., anger management)	1221	57	435	20	490	23
Help client change environment to support recovery	1429	66	275	13	447	21
Help clients explore unconscious processes	1399	65	290	14	441	21

Therapeutic Technique	None/Some		Half		Most/All	
	N	%	N	%	N	%
Provide case management	1536	71	169	8	393	18
Coordinate care with other providers	1491	69	251	12	375	17
Teach independent living or social skills	1529	71	220	10	372	17
Recommend changes in diet and exercise	1438	67	335	16	357	17
Meet with family members or significant people in clients' lives	1527	71	274	13	349	16
Teach clients to accept symptoms as part of everyday reality	1544	72	279	13	321	15
Assign readings or self-help books	1529	71	316	15	306	14
Empower clients to break free from traditional gender molds	1649	76	215	10	281	13
Teach mindfulness-based skills (e.g., meditation)	1683	78	184	9	275	13
Use relaxation training and/or tapes	1616	75	261	12	275	13
Engage patients in a long-term psychodynamic treatment model	1730	80	155	7	244	11
Promote client's relationship with God or higher power	1719	80	185	9	239	11
Identify ethnic or cultural themes in personal issues	1706	79	206	10	237	11
Act as a liaison to community services	1799	83	148	7	199	9
Provide crisis evaluation, stabilization or triage	1845	86	136	6	152	7
Recommend acupuncture, massage, meditation or yoga	1783	83	188	9	174	8
Encourage clients' attendance at self-help or 12-step groups	1837	85	141	7	159	7
Promote clients' engagement in their religious community	1868	87	132	6	144	7
Promote abstinence from anxiety-increasing foods and beverages	1875	87	135	6	138	6
Provide dance, art or music therapy, creative writing, psychodrama	1911	89	100	5	134	6
Utilize in vivo or imaginal exposure	1867	87	153	7	115	5
Follow a treatment manual	1937	90	85	4	110	5
Refer, prescribe or administer medication	1889	88	153	7	98	5
Use empty chair or role-playing techniques	1936	90	114	5	94	4
Analyze or discuss dreams	2005	93	90	4	48	2
Make use of energy therapies (e.g., Thought Field Therapy)	2036	94	44	2	48	2
Administer or refer for psychological testing	2059	96	46	2	43	2
Use Eye Movement Desensitization and Reprocessing	1958	91	50	2	33	2
Use paradoxical techniques such as restraining change	2043	95	62	3	28	1

Therapeutic Technique	None/Some		Half		Most/All	
	N	%	N	%	N	%
Provide hypnotherapy	2072	96	42	2	24	1
Use body therapy techniques (e.g., Feldenkrais)	2084	97	26	1	24	1
Utilize and provide neurofeedback	2117	98	11	<1	8	<1
Use biofeedback	2106	98	17	<1	6	<1