Psychotherapists have traditionally embraced core values and beliefs that differ significantly from many values and beliefs that pervade contemporary, commercially oriented Western cultures. With their clients, therapists often question or challenge the culture’s materialism, consumerism, appeals to vanity and greed, disdain of dependency and vulnerability, and abetment of narcissistic entitlement. Currently, however, psychotherapy is being reshaped by descriptive psychiatric diagnosis, pressures from powerful corporate interests, and antagonism from influential academic psychologists and is threatened with becoming the servant of the surrounding culture rather than its participant/observer and critic. The author notes symptoms of this trend and offers ideas about reversing it.

As it has developed over the past century, the profession of psychotherapy—until recently composed mainly of practitioners influenced by psychodynamic, humanistic, and existential thinking—has been characterized by cardinal beliefs, attitudes, and values (Jensen & Bergin, 1988; Stern, 1996) that are strikingly at odds with many beliefs, attitudes, and values that suffuse contemporary, technologically advanced, market-driven Western cultures. Although none of us can stand fully outside our own culture, within the larger social context, psychotherapy subcultures have flourished as a kind of alternative sensibility to the radically individualistic, consumeristic, technocratic mass culture we inhabit.

Numerous seminal writers have tried to articulate therapeutic values, including, among others, self-understanding (e.g., Blum, 1981), authenticity (Bugental, 1989; Meissner, 1983), empathy and compassion (e.g., Kohut, 1977; Rogers, 1951), egalitarianism (Sullivan, 1947), adaptation to unchangeable realities (Freud, 1937/1971; Stark, 1994; Yalom, 1980), growth in agency and personal responsibility (May, 1958; Schafer, 1976), acceptance of normal dependency (Aron, 1996; Ghent, 1990; Kernberg, 1970), and respect for others as subject rather than object (Agassi, 1999; Benjamin, 1997). It could be argued that with every individual with whom they engage in a deeply therapeutic way, therapists quietly challenge many of the more facile and potentially destructive assumptions of the larger society (cf. Aponte, 1996; Augsburger, 1986; Brace, 1992; Christopher, 1996; Grant, 1985; B. Hansen, 2004; Harari, 1989; Meares, 1999; Messer & Woolfolk, 1998; Rieff, 1966; Robinson, 1997; Wachtel, 1997).

Thompson (2004) contended that because of the centrality of an ethic of honesty in the original Freudian project, psychoanalysis is inherently subversive. In insisting that we try to tell the truth about sexuality, aggression, dependency, narcissism, and other features of human nature that post-Victorians found less than seemly, Freud (1937/1971) exposed some hypocrisies and conceits of his era and culture. Whatever his own blind spots, he set a tone for the attempt to get beyond individual and cultural illusions into territories that are unsettling and humbling and that undermine the pieties and complacencies of both scientific and popular habits of mind. Ultimately, he related the project of trying to be honest to the relief of psychological suffering, associating truth with freedom in an ancient equation (Rieff, 1959). Brown (1994) has made a similar argument about the subversiveness of feminist therapies, and writers from other perspectives have made comparable observations (e.g., Cushman,
Similarly, one can regard the culture of the profession of psychotherapy, the culture of practitioners, as inherently subversive. Its unconventional project has been carried forward more or less explicitly by most practitioners of psychodynamic, existential, and humanistic orientations and implicitly by many clinicians trained in family systems and cognitive and behavioral ways of working. Practicing therapists are all confronting the same phenomenon, the troubled human animal, and striving to find ways to relieve emotional misery, often in defiance of the pressures and demands of the surrounding culture. Some of the current stresses on practitioners may be interpreted as indicating that the dominant cultural voices have identified this project as subversive. Or perhaps those voices are now simply so ubiquitous that their indifference to traditional therapeutic values undermines those values by starvation and attrition, as psychotherapy is redefined according to norms that most practitioners regard as defensive, dehumanizing, alienating, inauthentic, reductionistic, and even perverse.

This essay began as a speech to a like-minded audience. In rewriting it for publication, I might not have succeeded in expurgating a tone of indignation about the current status of a profession I cherish. I suspect that part of what makes someone an effective therapist is a passionate belief in his or her way of working (cf. Helm, 2004). Because I find it hard to leave such an attitude in the consulting room, I ask more skeptical readers to make allowances for my identifications and to consider that it is more honest for me to be frankly biased than to make putatively neutral observations. I have organized the following argument in a case presentation format, with the “disorder” construed as a societal problem.

The Presenting Problem

From my perspective, the main manifestation of a threat to traditional therapeutic values is the pervasive message that psychotherapists should not be trying to understand and mend the broken heart, or heal the tortured soul, or promote the acceptance of painful realities. Instead, we should be trying to medicate, manage, reeducate, control, and correct the irrational behavior of people whose suffering is inconvenient to the larger culture. Few therapists oppose the judicious use of medication, management, education, and even control, but most of my colleagues have become alarmed at the erosion of what have for decades been the more fundamental aspects of our mission as psychotherapists: to understand; to help; to speak the truth; to make a meaningful connection with our clients that fosters their sense of agency, their capacity for enjoyment and mastery, and their ability to tolerate grief and limitation, whether or not their behavior is unconventional and inconvenient according to ordinary cultural norms.

The original popularity of psychoanalytic ideas among American intellectuals and professionals in medicine, psychology, social work, education, and religion was a bit of a fluke. Psychoanalysis was an anomalous visitor to the United States. Americans have long been noted for optimism, practicality, rationalism, materialism, privatism, and (despite the individualistic language we inherited from Locke) stifling conformity (Bellah, Tipton, & Sullivan, 1985; de Tocqueville, 1835,1840/2000; Riesman, 1950/1968). The psychoanalytic movement was hardly notable for a comparable sensibility. Notwithstanding his friendships with American intellectuals such as Stanley Hall and James Jackson Putnam, Freud viewed the United States with barely disguised scorn; privately, he was known to refer to the nation as “Dollarland.”

But Americans, whose Puritan origins were rooted in a utopian project and who have had recurrent romances with utopian movements (Fogarty, 1972), crave the latest thing. When psychoanalysis was the latest thing, many embraced it with uncritical enthusiasm—claiming too much for it, treating competing ideas contemptuously, and making inevitable the disillusionment that followed. Now that psychoanalysis is no longer new, now that its quirkier ideas have been debunked and its better ones have been absorbed into the vast body of cultural assumptions that we think of as common sense rather than psychoanalytic revelation, Freud’s cherished movement has been relegated by many to the dustbin of ancient and failed ideologies. Whether or not psychoanalysis ever regains widespread respect as a scholarly theoretical discipline, to me there is a larger question: whether the general psychotherapeutic sensibility that psychoanalysis set in motion will be similarly devalued. If it is, the life work of most of us in the therapy professions, whether or not we identify with
the psychoanalytic tradition, will be seriously compromised.

Context of the Problem

The influx of a European, mainly Jewish, philosophically sophisticated sensibility into the United States in the intellectual diaspora accompanying World War II lent a tone to scholarly discourse that differs significantly from more conventional American attitudes (see Ash, Solnner, Mauch, & Lazar, 2002). The infusion of this tone into American intellectual life, not only in the psychotherapy-related fields but also in the sciences, arts, humanities, and social sciences, created a rich and fertile tension. The more European sensibility, as it applies to the therapeutic endeavor, embraces curiosity and awe about unconscious processes, assumes complexity, emphasizes identification and empathy, respects affect, values subjectivity, appreciates attachment, and embodies faith in a complex interpersonal process that cannot be broken up into its component parts without doing violence to the whole (McWilliams, 2004). Now, as the generation of Holocaust-displaced thinkers is dying out and the influence of those intellectual heavyweights on American discourse wanes, the pragmatic, rationalistic, conventional, logical–positivist, scientific sensibility that has historically been mainstream in American universities seems to be reasserting its dominance in ways that many therapists find disturbing.

Symptoms

Cultural historians may ultimately conclude that Freud’s most enduring impact on North American culture was to increase our success at selling cars. Advertisers and image makers have mined psychoanalysis with breathtaking effectiveness. Our sexuality, aggression, attachment, emotional insecurity, envy, and narcissistic vulnerability have all been ingeniously exploited in the service of commercial interests. Now that pharmaceutical companies are permitted to appeal directly to TV viewers, we are regularly told that their products will cure most of the more uncomfortable symptoms of being human. Let me summarize some conclusions one can draw from the current popular media and the tone of contemporary political commentary, emphasizing those messages that therapists have traditionally regarded with considerable skepticism:

1. If you’re rich enough, you’ll be happy.
2. If you’re famous enough, you’ll be happy.
3. If you’re beautiful enough, you’ll be happy (if not, there’s always cosmetic surgery).
4. If you get enough sex, you’ll be happy.
5. If you can retire and play golf all day, you’ll be happy.
6. You can do anything you set your mind to do. (A staple of American child rearing yet a blatantly psychotic belief!)
7. All problems are solvable by practical ingenuity.
8. Everything that goes wrong is somebody’s fault.
9. If something goes wrong, find out who is to blame and sue them. If you get enough monetary reparation, you’ll be happy.
10. The “American dream” is all about making money.
11. The cure for a bad relationship is separation.
12. The cure for an unsatisfying job is quitting.
13. The cure for workplace problems is downsizing—that is, firing people, irrespective of their former contributions, loyalty, or personal situations.
14. People are naturally mobile and can relocate easily in response to corporate needs.
15. Youth is preferable to age, and children are resilient. We can displace them, disrupt them, subordinate their interests to our convenience, and they’ll recover just fine.
16. Freedom inheres in having more choices rather than in the capacity to decide what is a choice worth having.
17. Image is more important than substance.

Reviewing these messages, one can find sympathy for people from culturally conservative groups both inside and outside America who are dismayed by such ideas, though the most compelling rebuttal to these omnipresent secular themes may be not religious or moralistic but empirical; namely, the lack of evidence that living by these precepts increases well-being (cf. Lane, 2000). Most clinicians can attest that there is massive evidence for the converse, for the considerable satisfactions that ensue when people acknowledge limitation, respect their interdependence, grieve over inevitable disappointments, and tame their sense of entitlement.

With TV and video games doing so much child rearing these days, the impact of commercial pandering should not be underestimated. In earlier eras, many similar ideas suffused American popular ideology, but the rootedness of most citizens in smaller, stabler extended families and communities, along with their exposure to contradictory messages from civic and religious groups, diluted the power of such themes and fostered a more balanced view of the value of wealth, beauty, fame, sexual gratification, infinite possibility, and boundless entitlement (Bronfenbrenner, 1979; Glendon, 1991; Lasch, 1995; Putnam, Felstein, & Cohen, 2001). In some minority subcultures, especially those with a central spiritual life, such counteractives still exist, but, overall, very few cultural forces are currently calling these assumptions into question.

Until fairly recently, therapists could undermine the more pernicious effects of popular ideas such as these, one patient at a time, and restore a sense of perspective to people for whom the dominant culture’s attempted solutions to the problem of human suffering left their own suffering unformulated, untouched, and unmitigated. At this point, the power of mental health professionals to counteract the effects of the destructive messages that pervade the so-called developed societies may be declining. Assumptions that used to characterize the culture of psychotherapists, distinguishing it from the culture of the larger society, are starting to disappear.

Consider, for example, our once bedrock belief in the value of the examined life. In a recent perusal of therapy texts, I found that it had been over 50 years since anyone had made a comprehensive, systematic argument for the advisability of therapy for the therapist (Fromm-Reichmann, 1950). Yet for most of those years, the psychotherapeutic equivalent of the adage, “Physician, heal thyself!” was a mainstay of clinical lore, passed on by therapists, supervisors, teachers, and colleagues to those pursuing their development as a therapeutic instrument. Although most explicit in analytic institutes, the notion that therapists should undergo therapy themselves was not restricted to the analytically oriented. Humanistic therapists entered experiential treatments; family therapists explored their family of origin; Gestalt therapists attended intensive Gestalt workshops. Most of us trained before the 1990s assumed that the wisdom in the norm of self-examination was so self-evident that we would never have to belabor the point.

Yet, in recent years, advocacy of therapy for the therapist seems to have been disappearing from the professional scene. In graduate programs and medical schools, students are taught to carry out assessments; to master manualized interventions for discrete, reified disorders; to prescribe medication; to observe the letter (though arguably not always the spirit) of the ethics codes of their professions; and to adopt careful risk-management strategies. But they are not necessarily urged to explore their own psychologies, to find their own vulnerabilities, and to learn how it feels to try to talk about their most private and shameful shortcomings with an intently interested stranger. The erosion of the conviction that one needs to experience therapy to provide it to others is only one symptom of what has been happening to psychotherapy in recent years. Here are three events that raised my own consciousness about what is starting to look like the handwriting on the psychotherapeutic wall:

1. A few years ago, while consulting with psychiatrists in the inpatient unit of a well-regarded, university-affiliated medical center, I conducted two interviews with severely disturbed patients in front of some medical residents. Afterward, I overheard one young doctor comment to another, “That’s a great line that she uses! I’m gonna use that line myself!” Curious, I asked the resident which “line” of mine he was appropriating. His response was, “It was your question, ‘Can you say more about that?’” He had been trained to ask questions like,
“Has it been more than 2 weeks or less than 2 weeks?” and to check off the relevant criterion in the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 1994).

2. Around the same time, a social worker I supervise got a detailed directive from an insurer, explaining that to stay on its panel of approved providers, she should be calculating each client’s “improvement per dollar.” The company helpfully supplied a formula for doing so.

3. Last fall, one of my students reported that on his internship at a state mental hospital, he heard another intern—an intelligent and rigorously prepared prospective psychologist—say to a colleague, “You know that guy in Room 17? I think he has a delusion.” “Yeah, I’ve noticed that,” his friend replied. “And you know what?” the first intern continued, “I couldn’t talk him out of it!” “Yeah,” his friend agreed, warming to the topic. “I had the same experience!”

These and similar stories I hear from colleagues suggest that the moral and assumptive center of psychotherapy has been stunningly altered in a few short years. The commercial culture from which therapists traditionally have been taken a critical distance seems to have devoured us, redefining the complex project of psychotherapy in terms of the most simple-minded notions of how one person influences another and subordinating the therapist’s humanity to the interests of social control and short-term cost saving. It is worth wondering why, in an era when psychology has gone far beyond a narrow behaviorism into cognitive, affective, and relational science, the venerable concept of mental and emotional health has been replaced by the term behavioral health, implying that the clinician’s job is essentially to make people behave appropriately. The implicit metaphor for the therapist seems to have changed from healer to technician.

Lest my remarks be misunderstood as an attack on short-term and cognitive–behavioral approaches, let me emphasize that I am not challenging the value, where appropriate, of brief therapies and empirically derived techniques for targeting specific problems. Rather, I am concerned with the overall atmosphere in which all therapists now find themselves practicing. My experienced cognitive–behaviorally oriented colleagues (e.g., Lazarus, 1996) feel similar consternation at how psychotherapy is being divested of its humane essence and reduced to a potpourri of technical strategies, aimed at isolated symptoms, in the absence of a concern for the larger human context.

Suspected Etiology

Although this sea change—from therapy as antidote to contemporary mass culture to therapy as enforcer of its requirements—has been shaped by countless tides, I focus on four central and interconnecting influences. First, some responsibility for the current state of affairs lies with the shift in our diagnostic conventions from dimensional, contextual, internally defined, and inferential models of assessment to discrete, acontextual, externally defined, and descriptive paradigms. The effort to redesign the DSM of the American Psychiatric Association so that it would be more useful to researchers—the guiding principle of the seismic shift from the second edition of the DSM (American Psychiatric Association, 1968) to the third edition (American Psychiatric Association, 1980) and subsequent editions—has had wide-ranging effects on clinical practice. There is a vast critical literature on the limitations of the DSM (e.g., Barron, 1998), but my main point here is to suggest that this shift in diagnostic sensibility was the start of a slippery slope of devaluation of therapists’ humanity and a consequent decline in their power to protect and nourish the humanity of their patients. It clearly feels that way to most clinicians I have met, whose cynicism about the DSM and its uses has created a “least stigmatizing but still reimbursable” rule of diagnosis. In other words, therapists put their clients’ dignity and fiscal welfare ahead of their scientific values, which would require accurate use of DSM criteria.

Second, and probably most pervasive in its effects, is the success of the “Jackson Hole group” of think tankers in the 1970s in arguing that health care should be funded according to what is essentially a venture-capitalist model. The accident that the American economy did well during much of Reagan’s presidency seems to have contributed to a belief in the magic of privatization (Kuttner, 1999). In the United States, all kinds of enterprises that were once public, or at least publicly regulated, have since been pri-
vatized: Communications, transportation, utilities, penitentiaries—even some public schools—are being run by private contractors, and, in the name of the overvalued concept of “choice” (Schwartz, 2003), some elected officials are arguing for expanding opportunities to send children to private institutions rather than putting resources into improving public education. It is not uncommon in American politics to equate public ownership or responsibility with socialism or communism and to equate those systems with tyrannical dictatorship. Conversely, market-driven capitalism is conflated with democracy and held out as the moral alternative to ideological menace.

Ceding responsibility for health care to private insurance companies, on the assumption that competition between corporations would reduce costs, seems in retrospect to have been a remarkably naive idea, one that most practitioners believe has had profoundly destructive effects on both treatment and prevention of mental illness (Chipman, 1995; Kirschner, 2001). Insurance companies marketed their policies to employers with assurances that these plans included “comprehensive mental health care.” Within months after closing such deals, they began redefining comprehensive mental health care as brief treatment for discrete disorders and pharmacological management of so-called “biologically based” conditions. Thus, in a single stroke, they dramatically reduced mental health services and contributed to an attitude of denial about the complex etiologies of many conditions with a biological component.

Almost half of those seeking therapy have a personality disorder that meets DSM criteria; many more have clinically significant personality pathology (Westen, 1997; Westen & Arkowitz, 1998). But American insurance companies, having persuaded employers that they could save big money without sacrificing needed care, quickly realized that personalities are not transformed by brief, inexpensive interventions and unilaterally opted to deny reimbursement for Axis II conditions. In keeping with the profit-driven mission of these corporations, “psychotherapists” morphed into “providers” and even “vendors,” and vendors who served the “consumers” of psychotherapy for longer than a few sessions were unceremoniously dropped from the lists of therapists whose services insurance companies would cover.

Therapists are all too familiar with the consequences. Some waste has doubtless been eliminated, but at a terrible cost. Quality mental health care, especially for minorities and poorer patients, is disappearing (La Roche & Turner, 2002; Virnig et al., 2004). Sensitive, adequate psychotherapy for the seriously mentally ill is virtually nonexistent (Whitaker, 2003). Hospitals struggle to provide even minimal care. Individuals with longstanding substance use disorders are “detoxed and rehabbed” within a week. Suicidal people are kept in treatment facilities only until they agree not to kill themselves, whereupon they are discharged, often without follow-up psychotherapy. If they take their life successfully once liberated from the insults of this experience with the mental health system, at least the hospital is not liable; the patient has been “treated,” and the case is no longer on its rolls.

In supervision and consultation meetings where practitioners once brainstormed to determine the best possible treatment for a given client, they now spend their time comparing notes on how to approach the relevant insurance company so that the client has some chance to get any treatment at all. Rather than immersing themselves in the work for which they underwent a long and demanding training, they devote inordinate time to haggling with bureaucrats and writing vapid reports full of the insurance industry’s favorite buzz words. What used to be a rich professional lore about various intervention programs and treatment strategies has turned into a shared expertise about the idiosyncracies of different insurance plans. The stress of all this on the identity and self-esteem of therapists has been severe (Donald, 2001; J. Hansen, 1997).

In the United States, the fact that medical benefits are conferred by one’s employer means that no one who develops medical insurance plans has a long-term perspective: People change jobs frequently enough that insurance companies have no motivation beyond saving costs in the short term. Benefit managers, who are evaluated on an annual basis, have no incentive to pay for long-term savings. The fact that psychotherapy demonstrably reduces overall medical expenses (Dossmann, Kuttner, Heinzel, & Wurmser, 1997; Gabbard, Lazar, Hornberger, & Spiegel, 1997; Lazar, 1997) and probably reduces expenses for incarceration, drug abuse, posttraumatic enactments, and other costly accompaniments of psychopathology, while increasing productivity and life satisfactions that go well beyond simple symp-
tom reduction, does not figure into a private insurance company’s calculations. A close friend of mine was hired as the CEO of a managed care company insuring poorer families. She began her tenure there by telling the staff, “We need to keep in mind that while we want to make money, we also want to do right by the people we insure.” She overheard an employee whisper, “She won’t last long.” He was right.

There may even be dispositional reasons why people in the insurance industry devalue psychotherapy. The temperament that inclines one toward corporate life may be significantly different from the temperament that seeks a therapeutic vocation. I recently asked a relative who heads a major insurance corporation how psychotherapy is regarded in his field. He was happy to educate me, in memorable phrases such as “a load of crap,” “a needless crutch,” and “a course in self-indulgence for whiners.” Therapists and their patients should not have expected, and cannot expect for the future, a lot of sympathetic understanding and support from that direction.

Third, we need to scrutinize the role of the pharmaceutical industry, whose profitability depends on framing problems in living as reified “disorders” that can be treated chemically. It is in the financial interest of both insurance companies and pharmaceutical corporations to define mental and emotional suffering in terms of physical processes that can be targeted, chemically altered, and “managed.” Despite the effectiveness of medication for many conditions, troubling questions remain. Have we really had an epidemic of attention-deficit/hyperactivity disorder over the past 2 decades? Does that mean we should be medicating vast numbers of children? What has changed biologically that this generation has so many diagnosable disorders treatable only with drugs? Do 4-year-olds really display the symptoms of biologically based bipolar disorders for which they will need a lifetime of medication? Does the drastic increase in adolescent suicide in recent decades mean that something ominous has happened to the gene pool? Pharmaceutical companies fund much of the research on questions such as these, and we know which studies they publicize. Psychologists should think critically about a state of affairs in which so much basic research is sponsored by investigators with a huge financial stake in a particular outcome.

The context for the recent movement to establish “empirically supported” or “evidence-based” treatments in our field includes the fact that research psychologists have understandably wanted to test the pharmaceutical industry’s claims that chemical treatments are superior to psychotherapeutic treatments. In demonstrating that psychological treatments can relieve depression as fast as medication can, researchers have concentrated on studying brief therapies. With remarkable swiftness, their work was expropriated by insurers to argue that if one must have psychotherapy, there are empirically supported, short-term ways to bring about changes that experienced practitioners, not to mention several decades of outcome research, have determined to require both time and trust (Weinberger, 2004).

Fourth, the longstanding, worsening estrangement between academic researchers and full-time clinicians in psychology has reduced the chances that academics will feel identified with and empathic about the realities of clinical life. Given pressures to get research grants, often privately funded ones, that support the kinds of publications that secure tenure and promotion, even those faculty members who wish to have a small practice may be well advised not to do so (A. Demorest, personal communication, March 27, 2002). An indirect result of such pressures is that undergraduates aspiring to be therapists are increasingly being taught by psychologists with comparatively scant clinical experience and little time to read primary sources in depth. Many of my current graduate students complain that they were never assigned anything by Freud, Rogers, Erikson, Skinner, or Bandura, to say nothing of Winnicott, Kohut, Perls, Ellis, and Gendlin.

The contempt of some academic psychologists for their psychotherapist colleagues, along with their distortion of what we believe and do with our clients, is hard to miss. A subtle disdain for practitioners suffuses some writing on evidence in psychotherapy. Some researchers have a troubling tendency to take the moral high ground and accuse their therapeutically oriented peers of credulity to the point of malfeasance (e.g., Dawes, 1996; Lilienfeld, Lynn, & Lohr, 2004). There is a vocal and powerful contingent in the American Psychological Association (APA) currently arguing that if a person comes to a therapist with a condition for which an “evidence-based treatment” exists and is treated in accordance with any other approach, the therapist should be held in violation of the APA ethics code and subjected to sanctions. In recent months, spokespeople for this...
group have caught the ear of the popular media (e.g., Goode, 2004), through which they have been implying that conventional therapists are undisciplined, lazy, exploitive, and antiscientific.

There has always been ample misunderstanding between academic psychologists and clinicians. Even in my own practitioner-oriented graduate program, one encounters versions of the myth that the independent practitioner hangs out a shingle, rakes in the money, fosters an unnecessary dependency that keeps the cash cows coming back, and is accountable to no one. Some of my university colleagues persist in assuming that private practitioners treat mainly the "worried well." (Ironically, one could argue that it is psychologists touting evidence-based treatment who now treat the worried well, as they exclude complexly disturbed individuals from their research protocols; Westen & Morrison, 2001). Conversely, therapists envy professors' freedom from responsibility for the welfare of unhappy, destructive, and suicidal people. They may minimize the unique stresses suffered by academics and the legitimacy of their concern that psychotherapists document their claims. It is understandable that researchers are critical when therapists ignore the empirical literature on therapy, and it is equally understandable that therapists regard academics as having little sense of the realities of practice.

As the cognitive revolution in psychology has illuminated unconscious cognitive and affective processes that therapists have described in theories and metaphors for years (e.g., Magai & Haviland-Jones, 2002; Westen, 1998), many practitioners have hoped for a rapprochement between academic and therapist sensibilities. But the recent co-optation of the prejudices of many academic psychologists by the wealthy and politically powerful insurance and pharmaceutical corporations, in the service of their own agendas and with widely perceived damage to patient care, has painfully exacerbated the scientist-practitioner divide.

For many decades, therapists seemed to be winning the public-relations war against denigrators of their efforts to take seriously the complex subjective experience of people who suffer mentally and emotionally. At least we won some important battles. Cultural attitudes toward mental illness have clearly changed. In contemporary European-influenced countries, patients are unchained and unlobotomized. Bipolar illness and schizophrenia are seen as treatable conditions rather than moral depravities. The addicted, once simply condemned, are urged to get help. But just as the stigma that has clung to the status of mental patient for centuries was beginning to disappear, a new, multidetermined, and economically overwhelming juggernaut has threatened humane mental health care.

Of late, therapists are losing the public-relations war, and we are not without culpability in this loss. By not delivering on ambitious and empirically unsupported promises, by talking to each other more than to the educated public, by isolating ourselves outside the disputatious classrooms of the universities and refusing to engage in relevant academic controversies, by viewing outcome research with indifference, by talking about therapy in impenetrable jargon and implying that ordinary folk cannot be expected to grasp such concepts, many practitioners have contributed to their own marginalization. If therapists are to counteract the dehumanizing effects of the antitherapeutic messages that pervade contemporary life, they need to address these failings and start fighting proactively on behalf of their values.

If I am any example, fighting is the last thing therapists want to do. We prefer to find common ground, to see the other guy's point of view. Most of us would rather spend our time learning how to become better clinicians and passing on that wisdom than spend it trying to persuade people of opposing sensibilities that what we do is valuable. But a lot is at stake in our profession right now. Clinicians are in danger of being redefined in terms of categories that make sense to the powers that be in the larger culture and of losing a valuable role as critics of the deleterious assumptions of that culture.

Treatment Plan

The remainder of this essay contains ideas about how clinicians can act on behalf of our profession and the values that have traditionally infused it. First, we need to join forces with psychotherapists of other disciplines and competing orientations to articulate a vision of mental health care that is more humane and less technocratic. It is certainly possible for psychologists to appreciate their own training without talking down to colleagues in social work, education, pastoral counseling, psychiatry, and psychiatric
nursing. We cannot afford interdisciplinary squabbles when the survival of our work as a fundamentally humane enterprise is at risk. The beleaguered minority of psychiatrists who persist in doing therapy, rather than the much more lucrative business of serial medication consultations, is a valuable ally. In this political environment, APA’s decision to seek prescription privileges for psychologists—however sensible on its own merits—has been politically disastrous, in that it has escalated hostility between psychologists and psychiatrists at a time when such turf wars are tantamount to fighting over deck chairs on the Titanic. Similarly, we need to appreciate that practitioners of even starkly contrasting orientations within the psychotherapy community are trying to grapple with the same human phenomena and that there is wider agreement among diverse clinicians than we might expect about how long it takes to help someone with significant psychopathology. We need to unite against influences that diminish what any of us can do for our fellow human beings.

Second, we need to challenge current claims that traditional and longer-term therapies are not evidence based. There is more evidence for the effectiveness of analytic and experiential therapies than for any other approaches, given that all the research on therapy outcome conducted before the cognitive–behavioral movement picked up steam was done on dynamic and humanistic treatments, and researchers consistently found evidence of their effectiveness (Doidge, 1997; Seligman, 1995; Smith, Glass, & Miller, 1980; Strupp, 1996; Wallerstein, 2001). There is emerging empirical evidence that long-term and intensive therapies are more effective—and probably ultimately more cost effective—than the brief interventions favored by managed care companies (e.g., Blomberg, Lazar, & Sandell, 2001; Target & Fonagy, 1994). And there is a robust empirical basis for traditional psychotherapies in the research literatures on attachment, emotion, perception, memory, defense mechanisms, infant and child development, interpersonal relations, brain function, and personality. Researchers may reasonably chide therapists for not staying current with data on specific, empirically tested, symptom-targeted treatments, but their enthusiasm for the techniques they investigate should not obscure the fact that therapists’ more generic, holistic, traditional approaches are also grounded in evidence (Goodheart, 2004).

The most consistent finding in the outcome literature is that the quality of the relationship between therapist and patient has more impact on outcome than any other variable (see Norcross, 2002). Messer and Wampold (2002) have concluded that instead of choosing a therapist on the basis of expertise in empirically supported treatments, prospective clients should check out clinicians’ reputations within a community of practitioners and select a well-regarded therapist whose theoretical orientation resonates with their own outlook. In addition, there is research showing that both pretreatment qualities of clients and stable characteristics of the therapist as a person contribute significantly to psychotherapy outcome (e.g., Shahar, Blatt, Zuroff, Krupnick, & Sotsky, 2004). Such findings support clinicians’ longstanding concern with the implications of personality differences for treatment as well as their faith in the relationship to carry the therapeutic power.

Scrutiny of the vast data set from the National Institute of Mental Health study on the treatment of depression (Blatt & Zuroff, 2004) has also cast doubt on the assumption—a handy assumption from the perspective of drug companies and insurance cost cutters—that symptom reduction is the best indicator of change in psychotherapy. Therapists have been saying for decades that loss of symptoms does not necessarily equate with cure. So have friends and relatives of the untreated “dry drunk” whose sobriety has not reduced the dysphoria that initially attracted him or her to addictive substances. Even if we accept the medical model that has so dominated our professional metaphors, we may note that no physician would equate the relief of the symptoms of an illness with its eradication.

Third, we need to press for more research, but it should be research that avoids the artificialities of requiring participants to have single, delimited disorders with no comorbidity. Such clients are virtually unknown to therapists (Hufford, 2000). It must be research that includes follow-up studies, that appreciates the complexity of the treatment process, and that controls for the “allegiance effects”—effects of the theoretical identification of the researcher—that currently account for 85% of outcome (Luborsky et al., 1999). It should be designed to study clinical phenomena as closely as possible to how they occur in more natural settings.

It is time to reduce our homage to research that
generalizes findings from culturally modal participants to those of markedly discrepant age, race, socioeconomic status, educational level, physical condition, and ethnicity (Bernal & Scharro´-del-Río, 2001). It is even time to raise questions about randomized controlled trials (RCTs), the ostensible gold standard of psychotherapy research. We now know that different types of patients respond to participation in RCTs in different ways. For example, those with elevated perfectionistic strivings are relatively unresponsive to treatments over which they feel little control and during which their progress is frequently evaluated. Although RCTs have good internal validity, their external or ecological validity is questionable. Blatt and Zuroff (2004) noted, though random assignment to treatment groups can control for a number of potential experimental artifacts, it may also induce other experimental artifacts as a consequence of the meaning to the patients of participating in a design in which they feel controlled, observed, and evaluated beyond what would occur in a more natural treatment relationship. . . . Further, if one of the goals of treatment, in addition to the reduction of symptoms, is to enable individuals to assume responsibility for their lives—to develop a sense of agency—this sense of agency may be compromised by a therapeutic experience in which the patients are essentially passive in the selection of the type of treatment they receive and in the decision when to terminate the treatment process. (pp. 43–44, italics added)

At the same time, the mental set that defines science so narrowly that only artificially operationalized concepts can be studied needs to be exposed as a caricature of science. Naturalistic observation has a long and distinguished position in the history of science, despite the bias against it held by many academic psychologists. In the current climate, a Darwin or Lister or Pasteur would never be funded. Psychologists should insist that pharmaceutical companies publish negative findings of the research they underwrite rather than only the studies that support their fondest claims for their favorite medicines—otherwise, money will trump truth every time. We need to question the routine medicating of younger and younger patients, when the data are not yet in on long-term effects of early drug treatment, and to insist that professional evaluators of children’s problems be given enough time with each child and family to make a discerning judgment about the recommendation of psychotherapy medication or both.

Finally, therapists need to be politically proactive, to take their concerns to ordinary people and enlist their enlightened self-interest on the side of investing in the survival of a humane, sophisticated psychotherapy. Although practitioners have far less money and a much less effective organizational base than the corporate interests that have been undermining psychotherapy, they have the advantage of trying to tell the truth. Even people who hate paying taxes are not likely to believe that there is a pill for everything or that the pain of a lifetime can be eliminated with a few sessions of manualized cognitive–behavior therapy. Like most of us, they prefer to see doctors who take time to listen, who go beyond the manual, who treat a person, not just a diseased organ.

Prognosis (Guarded)

Self-observation and self-report have limitations, but when all is said and done, clients know when therapy has been useful (Seligman, 1995), and they spread the word. On the simple ground that they help people, I expect that the traditional psychotherapies, and the values they honor, will survive. But they may do so only outside the health care mainstream. In response to insurance-driven limits on treatment, some professionals have already redefined what they do as “coaching,” an activity that can be marketed to those who can pay out of pocket. Other therapists simply reduce their fees for less wealthy patients who need more comprehensive, personalized treatment than their health plan offers (though there is a limit to how generous clinicians can be without becoming self-defeating). We all find ways to adapt, to keep doing what we value, whatever the social context. Whether therapeutic values can enter public discourse and influence how mental health questions are viewed nationally, however, remains to be seen.

In my more optimistic moments, I see some signs of a turnaround. Public opinion seems to be moving toward holding drug companies more accountable. Books are forthcoming in which practitioners and researchers try to talk with each other (Goodheart, Kazdin, & Sternberg, in press; Norcross, Beutler, & Levant, in press). Stanley Greenspan (Greenspan & Shanker, 2004) is spearheading an international effort to develop a classification system that goes beyond the DSM, one that will reflect rigorous research in psychopathology and therapy outcome, take seriously the subjective experience of the patient, and de-
fine the goals of therapy as including improved affect regulation; attainment of realistic self-esteem; growth in the sense of agency; integration of complex representations of self and other; ability to empathize; increased capacity for love, work, and play; and other traditional therapeutic aims. He plans to interest the media and the American Congress in this document.

If we in the United States can reverse the trend toward making psychotherapy just another technology of control, such a movement may have a ripple effect worldwide, one that can begin to counteract the existing ripple effects of the damaging forces I have enumerated. I am hoping that the values that brought most clinicians to the difficult but rewarding work of psychotherapy can be reclaimed despite the power of the substantial interests now threatening them. By taking on the hypocrisies and conceits of our own era and culture, perhaps we can do a better job of preserving our humanity in the therapeutic role and, in the process, inoculate our clients against the worst aspects of living in this confusing and fragile world.

References


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