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THE CLINICAL PSYCHOLOGIST AS PSYCHOTHERAPIST IN THE UNITED STATES

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Psychotherapists notoriously agree on few things; however, they will undoubtedly concur in the judgment that impressive change has occurred over the last twenty years in psychotherapeutic practice by clinical psychologists in the United States. Not only have we witnessed tremendous change, but the field continues to be in a state of ferment and flux. Having been part of these developments, I feel I can write about them from first-hand experience if not from historical perspective, which must remain the prerogative of future generations. I remain as fascinated as ever by this exciting area of professional work and am pleased to respond to Dr. Appelbaum's invitation to share my views with colleagues in the Western hemisphere.

Since every writer on so controversial a topic as psychotherapy is influenced by his own biases, predilections, and personal history, it seems appropriate to say a few words about mine. Of necessity, this calls for a brief biographical statement of my professional development.

Born in Germany of Jewish parentage and having lived through the rise of the Nazi movement as a teenager, I came to the United States as a refugee shortly before the outbreak of World War II, sensitized by the atmosphere of hate, persecution, and human degradation that characterized Hitler's Germany. Faced with the necessity of earning a living, I held jobs as a bookkeeper and accountant for the following ten years, during which I was fortunate enough to further my undergraduate and graduate education through attendance of night classes. Despite economic hardships and personal vicissitudes, I remain grateful for the opportunities this country provided the large group of emigrés from Central Europe, many of whom rose to positions of influence and prestige in subsequent years.

My entry into the field of psychology was atypical but rather unremarkable. Partly for practical reasons I abandoned philosophy which had initially intrigued me as a career choice and turned to academic psychology, which offered little in the way of intellectual stimulation or spiritual sustenance. However, I became imbued with the goals of science, the techniques for asking and answering questions through empirical investigation, and an inquiring, critical attitude toward natural phenomena and human experiences. This

faith in the possibility of understandng psychological phenomena regardless of their complexity through systematic study and empirical research was deepened by six years of experience as a research psychologist for the Department of the Air Force and the Department of the Army. While this work had no relation to clinical psychology or psychiatry, which were to become my primary areas of interest, it brought me in contact with a group of first-rate psychologists who were experts in the business of science. From them I learned a great deal about research design, statistics, data analysis—not to mention the framing of hypotheses and the conduct of human research, together with its difficulties and exigencies.

That commitment to research and scientific inquiry has never left me. It was eventually transferred and applied to psychoanalysis and psychotherapy, and constitutes one characteristic of my work as a clinical psychologist as well as psychotherapist. In this respect, to anticipate a later point, I differ markedly from many clinical psychologists who in recent years have aspired to a career in psychothreapy and whose commitment is predominantly that of professional practice. Nonetheless—and this remains one of the significant features of training programs in clinical psychology in this country today—the goal is the dual one of training individuals who are *both* scientists and practitioners, who ideally have as their professional goal the advancement of the science and profession of clinical psychology through research and clinical practice. This training model, called the Boulder model (after a conference on training held in that city in 1949; Raimy, 1950), continues to define the philosophy of most training programs in clinical psychology today although it has come under sharp attack from within the field and its viability has been questioned. Be that as it may, the unique skills of the clinical psychologist in the United States, at least in theory, are those of a scientific investigator who engages in clinical practice in order to advance clinical psychology as a science, not primarily to "deliver services" to meet human and social needs.

Disagreements with this philosophy have given rise to the development of so-called professional schools, several of which have come into existence in this country in recent years. Roughly analogous in certain respects to medical schools, these schools and programs, some of which are part of traditional academic university departments of psychology, stress the training of professionals *qua* professionals, and they essentially eliminate the science component of clinical training, which to many people has become distasteful. Arguing against this position is the undeniable fact that society has a great need for systematic clinical research, which tradtionally has been the psychologist's forte. This role, however, remains largely unfilled unless psychologists continue to embrace it. Conversely,

there are numerous professions that engage in the practice of psychotherapy (e.g., psychiatrists, psychiatric social workers, marital and pastoral counselors), none of whom are either trained in or have a marked commitment to research. Thus, if the creation of additional manpower for service delivery is the goal, that goal can be met more effectively than by training clinical psychologists at the Ph.D. level. In recent years the issue of *levels* of training has received increasing attention, but pursuit of this matter would take us too far afield (see Garfield, 1974, Chapter 1, for a historical account).

These issues were far less salient in the fifties, when I first became attracted to psychotherapy, which then meant substantially psychoanalysis (I have always preferred the generic term, which seems to me far more appropriate and descriptive than the elitist distinction that organized psychoanalysis has endeavored to impose). At that time very few clinical psychologists in the United States were engaged in the practice of psychotherapy, which was almost universally viewed as a medical specialty and as such carefully shielded from intruders. To be sure, the client-centered therapists, led by Carl Rogers, were beginning to evolve theory, practice, and research that was firmly grounded within the field of *psychology*, and this fact itself was part of the powerful appeal of the client-centered school among psychologists. The American Psychological Association, which exercised undisputed control over psychotherapy training through its institutes and graduates, many of whom occupied powerful positions in departments of psychiatry, clinics, and other clinical facilities, had of course long decreed that psychoanalytic training was reserved for graduates of recognized medical schools. In special instances psychologists were accepted for psychoanalytic training, but this was typically not "full" training (i.e., it excluded "control" analyses), and in all cases candidates were required to sign an (unenforceable) oath forcing them to disavow the goal of independent psychoanalytic practice. Most psychologists who were foolhardy enough to apply (including the author) were unceremoniously rejected.

However, there began to emerge several prestigious training institutions in the United States which, partly in keeping with Freud's original position, rejected the medical hegemony over the practice of psychotherapy and welcomed the contributions of social scientists—the term "behavioral scientist" wasa just beginning to gain currency (Eissler, 1965). Thus they displayed a more hospitable attitude toward the aspirations of a growing number of psychologists and cognate groups. The National Institute for Psychoanalysis, founded by Theodore Reik, and the Washington School of Psychiatry, together with its sister institution, the William Alanson White Institute of New York, both inspired by Harry Stack Sullivan,

were in the forefront of this new development. Interestingly, the staff of the latter institutions counted among its members a number of prominent medical psychoanalysts who maintained their affiliation with the "official" psychoanalytic institutes despite threats of excommunication or legal action. As one of a handful of psychologists who entered the Washington School of Psychiatry, I received psychoanalytic training, underwent a personal analysis, and was awarded a diploma which bore the quaint title "Certificate in Applied Psychiatry for Psychologists." It never had great practical significance for me. The number of nonmedical graduates was minuscule, although New York City became the center of various groups of nonmedical therepists, who banded together, set up training institutes, gradually gaining in status and prestige. I, for one, was never able to escape the feeling that I was not *really* a psychoanalyst, had obtained my training in slightly surreptitious fashion, and was a second-class citizen. The fact that over another decade I received intensive supervision from recognized psychoanalysts, participated in courses and seminars, taught, supervised, and underwent another lengthy personal analysis with a full-fledged analyst of the American Psychoanalytic Association did little to erase my sense of inferiority, admittedly in part a personal problem.

In 1957 I was appointed to the position of chief psychologist in a department of psychiatry at a major American university. While the position carried senior academic rank and substantial responsibilities in the areas of professional service, training, research, and administration, it soon became clear to me that psychologists in a medical setting, despite their academic appointments, were subordinate to staff members with an M.D. degree. For example, psychologists were excluded from regular meetings of the departmental faculty (this was changed in more recent years); the practice of psychotherapy was hedged by various restrictive clauses; no psychologist was permitted to treat a patient "on the couch" (that ludicrous fetish of organized psychoanalysis!); they were excluded from private practice, either within or outside the hospital setting; and they were denied various fringe benefits (e.g., insurance and participation in a special retirement plan).

The principal professional activity of clinical psychologists was defined as psychodiagnosis in a broad sense, and in that role pyschologists participated in clinical conferences, making their contribution to decisions concerning diagnosis and treatment, for which the presiding psychiatrist bore ultimate responsibility. Psychologists were expected to confine their contact with patients primarily to an interaction focused around the administration of psychological tests—even "interviewing" was seen as a psychiatric prerogative! —and their growing interest in psychotherapy was generally per-

ceived by psychiatrists as a threatening usurpation of the physician's role. Dissatisfied with the changing scene, the chairman of the Department angrily remarked: "Nobody wants to do any more what they were trained to do; everyone wants to do psychotherapy—the psychologists, the social workers, the nurses, the occupational therapists, and the recreators." He clearly expressed the prevailing philosophy of the medical setting. Despite numerous changes during the last 15-20 years and considerable local variations, the psychologist's role and radius of activity in medical centers have remained severely circumscribed.[1] At this point, I shall conclude my autobiographical remarks by noting that eventually I found the restrictive and oppressive atmosphere of the medical setting greater than I was willing to tolerate and accepted a position in an academic department of psychology at another university. A growing cadre of young clinical psychologists seem to share this view.

Let me attempt to place the foregoing sketch in somewhat broader perspective, focusing on the emerging role of the psychologist as a psychotherapist. Until about 1950, as already noted, clinical psychologists in this country functioned primarily as diagnosticians, typically under psychiatric supervision, or as members of the "orthopsychiatric team," consisting of psychiatrist, psychologist, and social worker (in that hierarchical order). Psychologists interested in the practice of psychotherapy were a small minority; a few members of this group considered themselves "lay" analysts (following the Viennese model; Freud, 1950); and others who wished to practice the art were typically content to do so under psychiatric supervision. Good training was hard to come by and few psychologists were well-trained in psychotherapy. To enhance social acceptability of one's interest in the area, it was politically astute to disguise it in terms of "research" or "research training." As already noted, there were few challenges to the view that all forms of psychotherapy were a medical specialty. Licensing or certification laws for psychologists, which have been passed by most states during the last twenty years, were unheard of, and early attempts to have them enacted were often bitterly opposed by medical and psychiatric groups. Psychotherapy for the most part was synonymous with psychoanalytic psychotherapy or one of its variants. The professional status of the clinical pschologist was generally low although the significant contributions of a number of outstanding clinical psychologists to psychodiagnosis and psychopathology (e.g., David Rapaport, David Shakow, Roy Schafer, Robert Holt) earned them and the profession increasing prestige.

World War II and its aftermath wrought tremendous changes in clinical psychology, altering its course in decisive ways. These developments are too complex to condense into a few paragraphs,

and the reader is referred to full accounts available in the literature (Garfield, 1974; Hoch, Ross, and Winder, 1966). However, I wish to identify briefly a number of factors which in my judgment are significantly associated with the emergence of the clinical psychologist as psychotherapist in the United States, a role that is no longer seriously challenged. The order of listing implies no rank order of importance, nor do I see the factors as independent of each other.

1. The numerical growth of psychologists in the United States, exemplified by the fact that the American Psychological Association, the major scientific and professional organization, now numbers over 40,000 members, has materially raised psychology's influence, prestige, and political power.

2. It has increasingly been realized—even without psychiatry —that psychotherapy is governed by *psychological* principles (including principles of learning), and that the analogy to medical treatment is inappropriate. Similarly, the conditions to which psychotherapy are applied are not diseases in the medical sense but problems of human adaptation, nor is there much comparability between the medical patient and the people undergoing psychotherapy.

3. Disenchanted by the limited role of the psychodiagnostician, fueled in part by psychology's own pervasive criticism of the limited predictive power and utility of the diagnostic function, clinical psychologists in large numbers began to abdicate the traditional role model of the tester, turning to the more challenging and glamorous pursuit of psychotherapy. In recent years psychologists have additionally assumed a wide variety of new roles in American society which radically diverges from the traditional diagnostic one, e.g., design and evaluation of mental health programs, community psychology, the direction of mental health centers, and many others, essentially unrelated either to diagnosis or one-to-one individual psychotherapy.

4. Of considerable importance, of course, has been the inclusion of courses and practica dealing with theories and practice of psychotherapy and behavior modification in the curricula of all universities offering graduate training in clinical psychology. Accordingly, all graduate students in clinical psychology receive substantial training and experience in psychotherapy, which to most of them is the most attractive feature of their graduate education.

5. The gain in professional and political strength has enabled psychologists to seek recognition as health service providers and obtain reimbursement for their services from insurance carriers. In conjunction with current legislative proposals for national health insurance, psychologists are attempting to seek full recognition as a mental health profession, a goal that remains to be fully realized.

6. Coincident with or partially as a function of important social

developments in the United States (such as the civil rights movement, consumer protection, and the struggle against discrimination of minority groups and women), there has been a gradual decline of orthodox psychoanalysis and of treatment modalities based upon the psychoanalytic model. Concomitantly, we have witnessed a growing interest in treatment approaches that are less expensive, more efficient, more suitable for patients previously considered unamenable to traditional therapy (e.g., lower class, uneducated individuals, autistic children, the mentally retarded, individuals suffering from behavior disorders of various kinds). In this matrix of developments, psychologists have played an exceedingly important part in devising, applying, researching, and evaluating new treatment methods, generally grouped under the broad heading of behavior therapy. Thus, rather than concentrating on gaining recognition for the traditional therapist role—although that role continues to be prestigious and sought after—many psychologists have carved out for themselves new therapeutic roles which conceptually and pragmatically have little in common with that of the traditional psychotherapist who importantly relies on the exchange of verbal communications with a patient (or client, as he or she is now frequently known).

7. Psychologists have played a leading role in the so-called human potential movement, sparked initially by group therapy and nontherapy groups (T groups), and subsequently spawning such phenomena as encounter and marathon groups, as well as a broad spectrum of activities and procedures designed to promote "growth" and self-awareness (through openness, body contact, emotional expression, encounter games) as opposed to "treatment."[2] The writings of men like Carl Rogers and Abraham Maslow have exerted a tremendous influence in redefining the role of the therapist as that of group leader or facilitator. Many psychologists have likewise participated in the evolution of humanistic and existential psychotherapy, which has achieved considerable popularity in the United States in recent years.

9. Legislation, vigorously promoted by psychologists beginning in the early 1950s, resulted in legal and social sanction of the psychologist as an *independent* professional. As part of this development, psychologists have evolved their own code of *ethics* (which sets forth high standards for professional practice); they have developed standards of training (the Ph.D. being regarded as the model of competence, augmented by extensive supervised experiences in practica and a full-year's predoctoral internship); and within the boundaries of their competence they assume full responsibility for the conduct of their professional affairs. In particular, certification or licensing laws fully recognize the psychologist's right to practice psychotherapy, with autonomous examining boards determining the

candidate's competence and suitability through written and oral examinations. The creation of a national board (American Board of Professional Psychology) in the late forties has further served to strengthen the standing of highly qualified practitioners.

These brief comments serve to indicate that the practice of psychotherapy by psychologists in this country is a kaleidoscopic set of activities which are exceedingly fluid and difficult to delineate. Disclaiming any attempt to provide a comprehensive overview or a chronicle of developments, I shall proceed to touch only on a few selected facets of the field.

As the preceding sketch has indicated, a clinical psychologist in the United States who wishes to embark on a career in psychotherapy has ample opportunity to obtain the requisite training. Typically this means that a student, having obtained his or her baccalaureate degree (usually with a major in psychology), proceeds to enter an accredited doctoral program in clinical psychology at one of about one hundred universities. The modal program takes approximately five years to complete, culminating in the Ph.D. degree based on a piece of empirical research. The basic training of the Ph.D. clinical psychologist includes (1) a set of courses designed to provide a broad overview of major areas of psychology, such as social, developmental, cognitive, physiological; (2) courses in statistics and research design, which serve as "tools" for the conduct of research; (3) courses and seminars in clinical psychology broadly construed (there are wide variations in these offerings, depending on the department's theoretical leanings and the interests of individual faculty members); and (4) practica and related field experiences under supervision. A full-year's internship in a recognized hospital or clinic is a prerequisite for the doctoral degree in clinical psychology. Those graduates who desire more intensive training in psychotherapy may obtain it either through a postdoctoral fellowship or enrollment in specialized programs. Many students seek some form of personal therapy, but there is usually no formal requirement on the part of the training program.

From the standpoint of the student who wishes to become a skilled psychotherapist, the standard university program has several serious drawbacks: (1) Because of the exceedingly high interest by young people in graduate training in psychology, admission has become fiercely competitive (top students tend to be selected primarily on the basis of *academic* achievement and promise rather than their potential as psychotherapists); (2) many of the academic requirements including research and the writing of a dissertation are seen as irrelevant or tangential to the goal of becoming a practicing psychotherapist; (3) accordingly, graduate training as offered by the typical American university is experienced by the student as a

roundabout way of achieving a practical goal. As early as 1954 the prominent psychoanalyst Lawrence Kubie, identifying similar problems in medical and psychiatric training, proposed an interdisciplinary training program combining basic biological sciences with psychology, sociology, anthropology, together with specialized training in psychotherapy. The plan never gained popularity although in the recent past a training program incorporating salient features of Kubie's proposal is being implemented in the San Francisco area.

The pros and cons of graduate training in clinical psychology have been hotly debated at several major national conferences (e.g., Raimy, 1950; Hoch *et al.*, 1966; Korman, 1974) and a recent conference was specifically focused upon psychotherapy training (Holt, 1971). As director of a university program in clinical psychology for a number of years, I can testify that many students experience the prevailing training model as schismatic, and in their later careers they tend to veer either toward some form of clinical practice (eschewing the research role) or they opt for academic positions which place a premium on scholarly productivity, thus discouraging professional involvement). As a consequence, the ideal of the scientist-practitioner remains largely unrealized, and questions must be raised whether for the *majority* of students it is a viable model. In some sense there appears to be a basic philosophical and temperamental incompatibility between the role of the practicing professional and that of the scientific investigator who seeks to advance knowledge through systematic research. Faced with this dilemma, universities have generally opted for research and scholarship whereas the professional schools which have sprung up in several states of the Union have adopted the position that there must be alternatives to the traditional program. For the reasons indicated earlier, I personally remain strongly committed to the hyphenated model which despite its difficulties impresses me as the most fruitful one in the long run.

Another important issue relates to the role and function of the psychotherapist in contemporary Western society. What precisely does the psychotherapist do? What is the nature of his services? Is he a mental healer, a wise man, guru, facilitator of emotional and personal growth, behavior modifier, educator, mentor, counselor, friend, provider of insight? After Freud had rejected the medical model and created the new professional role of psychoanalyst, it became relatively easy to delineate the prerequisite training. Freud's recommendations, however, did not carry the day, and psychoanalysis in the United States chose to identify itself with the powerful medical establishment. Today, with the advent of a welter of new therapeutic schools, approaches, and activities, the role of the psychotherapist has again become obscured. How can rigorous training

programs be designed for such diversified and diffuse professional activities?

In this connection it should also be mentioned that the American public has become keenly interested in the topic of psychotherapy: A huge literature addressed to the intelligent laymen flourishes; people avidly respond to offers of sensitivity and encounter groups, marathon groups, gestalt workshops, and other "growth experiences," not to mention of course the substantial number of persons who are patients in the more traditional mental health settings, such as clinics, and therapists' offices. The popularization of psychotherapy has been likened to a religious movement (Back, 1972) in which substantial numbers of Americans have become swept up in recent years. In part, the movement represents a fad; but in another important sense it reflects a search for personal meaning, an attempt to cope with existential dilemmas, a yearning for interpersonal intimacy—all of which may be seen as a protest against twentieth-century technocracy and the attendant dehumanization and alienation brought about by an automated and mechanized society. Thus, the modern psychotherapist has become a secularized priest who ministers to a spectrum of human needs that far transcends treatment of the classical neurotic symptoms in the preceding century.

I have found it helpful to distinguish two major groups of psychotherapists: The first is composed of individuals who regard therapy as a *discipline.* As such it is supported by a theory, a body of knowledge, and a set of specifiable techniques that are employed in relatively systematic ways. This view carries with it a serious commitment to study, organized training, evaluation of outcomes through research, and a quest for understanding clinical phenomena and processes by rational and empirical means. This approach unites therapists following the psychoanalytic tradition as well as a growing number of behavior therapists. The second group consists of therapists, leaders, facilitators, etc. who essentially reject the naturalistic approach, including theories, techniques, and systematic research. The primary concern of this group, which includes the adherents of humanistic psychology,[3] existential therapy, and the human potential movement, is with the phenomenology of human experience, personal growth and maturation. The focus of the first group is on the *intellect*; that of the second on *human experience.* In practice, of course, there is considerable overlap, nor does this axis exhaustively define the gamut of practitioners and approaches. Nevertheless it may serve to identify a major trend of the psychotherapy scene in the United States today.

It is readily understandable that university-based training programs for psychologist-psychotherapists generally uphold the philosophy of Group I (although they may offer courses in humanistic

psychology, existential psychology, etc.), whereas adherents of the second group have proclaimed disdain for what they view as the reactionary and constricting attitude of the academy. Accordingly, they have favored the creation of loosely organized institutes which carry on their work through workshops and group experiences of various kinds.

At this juncture it may be apropos to say a few words about the *quality* of training of clinical psychologists as psychotherapists in doctoral programs of American universities. Perhaps the safest and fairest generalization is that it varies within broad limits, depending on a variety of factors, including among others the department's commitment to *clinical* (as opposed to academic and research) training; the interest and competence of faculty members responsible for courses, seminars, and clinical supervision; the quality and diversity of facilities at which field training is conducted (hospitals, clinics, counseling centers, etc.); the competence and availability of clinical supervisors as well as their professional status in the academic department. There can be no question that the caliber of graduate students in clinical psychology—especially their intellectual ability—tends to be extremely high, which is partly a function of the keen competition for admission. Quality control over the structure and contents of the curriculum is enforced by periodic site visits of committees whose evaluations serve as the basis for the program's accreditation by the American Psychological Association. It is generally recognized that the young graduate (who typically receives the Ph.D. degree at age 26-8) has received psychotherapy training and acquired clinical experience at the journeyman level, and that his therapeutic skills must become extended and seasoned through postdoctoral training, supervised experience, and related activities. While many graduates acquire significant experience through on-the-job training (in their first position after graduation), only a small minority undertakes formal postdoctoral training. Accordingly, the typical graduate has acquired reasonably adequate competence in the practice of psychotherapy, but he is by no means an expert. In my judgment, training frequently lacks breadth and comprehensiveness as well as depth. Thus, young Ph.D.'s, particularly if they accept academic positions, soon function as supervisors of inexperienced graduate students, with the result that over successive generations of students a dilution of quality is difficult to prevent. There can be no question that specialized postdoctoral training institutes, particularly those in the psychoanalytic tradition, continue to provide the most systematic, thorough, and painstaking training in psychotherapy, although in going that route the student often unwittingly accepts indoctrination and an insufficiently critical perspective.

The psychotherapist of earlier generations was a relatively narrow specialist: He had acquired command of psychoanalytic theory and therapy; he was competent to conduct essentially one form of therapy with a highly selected group of patients (middle-class neurotics) who were considered suitable for his particular approach; and he could afford the luxury of selecting patients to suit his personal inclinations. If the patient failed to improve, he tended to be classed as "refractory" or "unanalyzable"; rarely would questions be raised about the suitability and appropriateness of the therapist's approach to the patient's particular problems. I believe it is fair to say that the splendid isolation of the psychoanalytic practitioner of earlier decades is rapidly vanishing and that the orthodox analyst has already become doomed to obsolescence.

To the extent that psychotherapy moves in the direction of a discipline, the therapist of the future, in my judgment, will be a comprehensively trained specialist who can identify relatively specific problems for which a patient is seeking help and can tailor a treatment program to meet particular objectives. It is in this area that the influence of research in psychotherapy and behavior modification over the past twenty-five years has had its greatest impact. The new breed of psychotherapist is well exemplified by Dr. Helen S. Kaplan (1974), a psychiatrist and analyst, who specializes in the treatment of sexual dysfunctions, combining analytic teachings with behavioral techniques. Comparing the two approaches, she writes:

> The value of the behavioral approach is inestimable. Not only are the techniques spawned by this approach highly effective in specific clinical situations, but, even more important, the principle of focusing therapeutic intervention on specific and modifiable mechanisms of behavior rather than on general behavior patterns has had far-reaching effects on the field of psychiatry and, in particular, on the development of sexual therapy. However, the same criticism applies to behavior therapy as has been leveled against psychoanalysis. Both have immense value, but neither is complete by itself. Excessive reliance on behavior therapy neglects the deeper problems and the profound roots of sexual problems. Often this approach is effective in modifying specific symptoms; often it is not. I believe that the behavioral approach gains in value when it is seen as a valuable expansion of our therapeutic philosophy and armamentarium within an eclectic framework. It is an addition to rather than a replacement for other dynamically oriented therapeutic approaches (p. 182).

Undoubtedly there will emerge many other role models as therapists respond increasingly to the immense social needs for rehabilitative as well as preventive professional services. Already it has

become evident that as interest in long-term individual therapy with middle-class patients is declining, the field is turning to brief or short-term psychotherapy, marital therapy, family therapy, and therapy focused on target problems, such as alcoholism, drug abuse, sexual dysfunctions, depression, behavior problems in children, to name but a few. Many of these approaches are carried on within a group setting, partly for reasons of economy and practicality but also because the American ethos views the group as the basic social unit (in contrast to Freudian psychoanalysis which extolled the individual and his autonomy).

Pragmatism has long been a basic American philosophy, and it seems fair to note that it is becoming a pervasive force in psychotherapy and behavior modification. The touchstone for any therapeutic approach is: Does it work? Is it efficient? Can results be documented in concrete terms? Is it sufficiently inexpensive to be applicable and available to a wide band of the population, particularly lower class individuals and the poor? Whether he is in the market for an automobile or psychotherapy, the consumer legitimately demands to know what he is buying and whether he is getting his money's worth. While medicine in the United States continues to be venerated and the psychiatrist as a medical practitioner occupies a position of high prestige (although he is also the butt of many jokes), the public is basically not interested in such niceties as whether psychotherapy is a healing art or an educational process. While most people—including highly educated ones—would be hard put to differentiate between a psychiatrist engaged in psychotherapy, a psychoanalyst, and a clinical psychologist functioning in the therapist role, they are perfectly willing to listen to and embrace techniques and approaches irrespective of the professional affiliation or credentials of the originator. Increasingly, too, psychologists tend to be accepted by the public as *bona fide* psychotherapists. By the same token, there is an avid proclivity for fads and fashions in psychotherapy which seem to flourish in this country as nowhere else.

Being on the border of medicine, religion, philosophy, psychology, education, sociology, and anthropology, as well as buffeted by the conflicting forces operating in our pluralistic society, psychotherapy is peculiarly vulnerable. As I have attempted to sketch in this paper, as a profession it is protean and weak in its identity, regardless of whether it is practiced by psychiatrists, psychologists, or other established mental health professionals. Indeed, psychotherapy has become the rallying point for many members of our society who, having become disenchanted with organized religion, seek salvation and answers to the perennial problems of human existence in this manner. At the same time, however, psychotherapy has deep roots in the Western tradition of science, and it is this tradition

which has inspired the evolution of systematic research over the last quarter of a century. A substantial part of this effort is closely linked with the contributions of American psychologists who, trained both as psychotherapists and scientific investigators, have brought to bear increasingly sophisticated research expertise upon the clinical phenomena in the therapist's domain. Whereas the practicing clinician reigned supreme in the 1940s and 1950s, he has become displaced by the researcher whose efforts have been accorded substantially greater prestige by both organized science and society. Concurrently, the Federal Government, chiefly through the National Institute of Mental Health, has played a highly influential role in forwarding the training of clinical psychologists as practitioners as well as researchers.

A question is frequently raised concerning the effect upon professional practice of thousands of studies in psychotherapy and behavior modification, with the implication that the influence has been slight or not nearly as impressive as might appear. The point is of course arguable, the obvious but perhaps overly facile rebuttal being that a quarter of a century is a negligible time span in the history of any science, and *a fortiori* in the case of one that struggles with such seemingly insuperable complexities as psychotherapy. My own judgment is that the literature does reflect substantial contributions from research (e.g., Bergin & Garfield, 1972). Of equal or greater importance, however, has been a palpable shift in attitudes at least on the part of the younger generation of psychotherapists: Whereas in the past the pronouncements of one's mentors were accepted on faith —a questioning attitude being diagnosed as resistance or unresolved transference—the contemporary trend, while perhaps not as strong as my statement suggests, is exemplified by demands for empirical evidence, skepticism toward assertions that appear to be solely grounded in tradition and esoteric theory, and a healthy openmindedness toward innovations, experimentation and departures from orthodoxy. For all these reasons I believe that our best hope for the future lies in the progressive breakdown of orthodoxy, open communication between the various disciplines concerned with the theory and practice of psychotherapy, vigorous pursuit of knowledge wherever it may lead, comprehensive training of young therapists who achieve not only the highest level of skill available today but, even more importantly, remain aware of the awesome gaps in our knowledge, and who learn to ask insightful questions rather than becoming converts to a faith. To have shorn psychotherapy of its mythology may perhaps be recorded by history as the greatest contribution of our time.

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FOOTNOTES

[1]My reference here is to the psychologist's role in the *clinical* arena—not in research. In the latter role psychologists have enjoyed far higher prestige, chiefly because research has been less challenge to the psychiatric profession. However, in the mid-fifties granting agencies typically insisted that research by psychologists in sensitive areas like psychotherapy or psychoanalysis be at least nominally "supervised" by psychiatrists.

[2]Parloff (1970, p. 267, quoted by Garfield, 1974) has called the group "a potent force for great benefit or great mischief."

[3]The term humanistic to me has always had the rich connotations of human dignity and cultural achievements that have come down to us through the centuries from Ancient Greece through the Renaissance. Thus, I have been distressed to see the term co-opted by a movement in which many of its adherents seem to have little understanding or respect for this heritage (Koch, 1971).