chapter 1

Crisis

In the United States and, increasingly, in the economically developed areas of the world, psychotherapy, psychology, and the mental health professions are ubiquitous. We find therapeutic interventions administered not only in consulting rooms but also at meetings of 12-step programs, at stress management workshops, in anti-bullying programs in schools, during yoga classes, in various kinds of team building and organizational development training, and in numerous life-enhancement interventions administered via the Internet. There is also the therapy provided by life coaches, self-improvement gurus, writers of self-help books, and media shrinks. And, of course, there is the omnipresent lay therapy, that informal guidance offered by so many to so many with the aim of helping friends and loved ones cope more effectively with the difficulties of life. Over the course of the 20th century, the concepts underlying the ministrations of psychotherapists were so influential in shaping our understanding of what it is to be human that they trickled down into our everyday vocabulary and were incorporated into our conventional wisdom and common sense (Wollheim, 1993). Psychotherapy both reflects cultural norms and concurrently shapes those norms, through direct contact with patients and students and indirectly, through its influence on art, literature, the media, educational practices, and various social institutions too numerous to name.

Despite the immense cultural impact of psychotherapy and the ubiquity of the "psychological perspective" within our world, the future of psychotherapy within the professions that practice it—clinical psychology, social work, psychiatry, and counseling—is very much in flux. There is

great uncertainty with respect to what role psychotherapy will play in the emerging healthcare economy. After an early meteoric rise, psychotherapy has undergone a change in trajectory and, in particular, has been adversely affected by changes in the way psychopathology is conceptualized and treated. This book provides an analysis of these various changes: what is currently happening to psychotherapy, why it is happening, and what the wider collateral effects are. Some speculation about the future is also included. To examine these developments I step back a bit from the object of inquiry and take a broad, interdisciplinary view, one that is not only scientific but that is also sociocultural, historical, and philosophical. I start with some history.

THE RISE OF PSYCHOTHERAPY

For much of the 20th century psychotherapy was so unquestionably on the rise that it seemed to be an irresistible social institution (Moloney, 2013). Although precursors and analogues of the "talking cure" can be seen in various practices as diverse as the counseling of the Epicurean philosophers and the suggestion methods of Anton Mesmer, it was not until the late 19th century that the professionalization of psychotherapy began. What burst forth in fin-de-siècle Vienna was not initially a smash hit in Europe, except among the intelligentsia. It was to be in the New World, in the United States, that psychotherapy would be incubated and then flourish. By the beginning of the 20th century, Americans already were receptive to the prospect of a technology of the mind. Already in use were various "mind cures" that we today recognize as rudimentary forms of cognitive-behavioral therapy and autosuggestion.[1] The stresses of urbanization and industrialization had hit the American psyche hard (Lutz, 1991), and it was popular at the time to view the urban parts of the country as experiencing an epidemic of "nerves" and "neurasthenia." Many physical treatments were advanced, including electrotherapy, hydrotherapy, and the "rest cure," but one commonly employed therapy was talk therapy. "Mental therapeutics" did not receive universal acceptance,[2]

[1]There were both religiously based and secular "mind cures." These included the New Thought, the Emmanuel Movement, and various ministrations of physicians influenced, as was Freud, by Charcot, Bernheim, and Janet.

[2]That iconic figure in American thought, William James (1898/1987), defended the embryonic psychotherapy of his day by stating, "What the real interest of medicine requires is that mental therapeutics should not be stamped out, but studied, and its laws ascertained" (p. 58).

but as historian Eric Caplan (1998) points out, "on the eve of Freud's historic visit to the United States in September, 1909, mental therapeutics was already integrally woven into the fabric of American medicine and culture" (p. 9).

The 1909 visit of Sigmund Freud and Carl Jung to America for a series of talks given at Clark University marked a watershed in the history of psychotherapy. In 1910, the *Index to Periodical Literature* contained not a single reference to Freud or psychoanalysis. But by 1920 psychoanalytic ideas were ubiquitous in America. In the land of individualism, freedom, and prosperity, psychoanalysis struck many cultural chords. One of these was a seemingly endless American appetite for self-improvement; another was the genie of sex coming out of the bottle. In the denouement of the Victorian era, it became socially acceptable to possess libido and to read about it, talk about it, and see it in films, some of which, though they contained no audible dialogue, veritably smoldered with eroticism. In 1925, Hollywood mogul Sam Goldwyn offered Freud $100,000, an immense sum at the time, to consult on scripts for cinematic love stories. Freud turned down the offer, as he had an earlier, smaller one from a Chicago newspaper to psychoanalyze the infamous murderers Leopold and Loeb. These overtures, whether they were shrewd business moves or mere publicity stunts, indicated that Freud and his ideas were generally considered to be authoritative. By the 1920s, psychoanalytic ideas were widespread in the print media across the cultural spectrum, ranging from scholarly journals to the *New York Times* to the lowest lowbrow tabloids.

All that was lacking for a social transformation was a critical mass of psychoanalysts. And almost as if the fates had willed it, the country was soon crawling with them, when multitudes of leading psychoanalytic thinkers sought safe haven in the States as they fled Europe prior to World War II.[3] These therapists trained others, some of whom were innovators, and the field of psychotherapy grew and diversified as a motley array of new and decidedly un-Freudian forms of psychotherapy emerged. Being in therapy became fashionable among members of the moneyed and educated elites. As American culture spread around the world, psychotherapy became one of our principal exports. Psychotherapy has become a commonplace and influential practice in many other nations. At least one other

[3]Alfred Adler, Karen Horney, Wilhelm Reich, Erik Erikson, Otto Fenichel, Eric Fromm, and Theodore Reik were notable among the psychoanalytic A-list immigrants. One might argue with including Adler, but he clearly never totally repudiated Freud and was instrumental in promulgating psychodynamic ideas and treatment.

country, Argentina, has more psychotherapy patients per capita than does the United States. The place of psychosocial intervention as an important and legitimate aspect of healthcare has been established in most of the world.

In the first third of the 20th century, the consulting of a professional for mental health issues was a rarity, partly because there were not that many mental health professionals around to consult (Engel, 2008). In 1940 no more than 4% of the U.S. population had undergone some form of therapy (Dworkin, 2012). By the early 1960s, 14% had at some time in their lives formally consulted a professional for a psychological problem, and by 1976 the figure was up to 26% (Veroff, Kulka, & Douvan, 1981). By 1990 it was estimated that at least 33% of Americans had been the recipients of mental health services (VandenBos, Cummings, & DeLeon, 1992). More recent estimates are that closer to 50% of the U.S. population has received some form of mental health treatment (DeLeon, Kenkel, Garcia-Shelton, & VandenBos, 2010).

Accompanying this rapid growth in utilization was a similarly rapid expansion of training. For example, in the mid-1940s, just over 30 universities were accredited by the American Psychological Association for training in clinical psychology. By 1956, 45 universities had been so accredited; in 1962, 60 universities; and in 1979, 110 universities. In 2012, there were 375 accredited doctoral programs in clinical psychology (as per the website of the American Psychological Association). The number of psychotherapists from all disciplines in the United States more than doubled, from 72,000 to 159,000, between 1975 and 1985 (VandenBos et al., 1992). The American mental health workforce is tracked biennially by the U.S. Substance Abuse and Mental Health Services Administrations (SAMHSA). The most recent published data indicate that there are 92,227 practicing psychologists in the United States. Add to that number about a quarter of a million clinical social workers. Psychiatrists have increased in numbers, from about 4,500 in 1945 to 42,120 currently. There are, in addition, another assorted 190,000 mental health professionals, a figure achieved by aggregating counselors in educational settings, psychiatric nurse practitioners, marriage and family counselors, and various other licensed counselors (SAMHSA, 2012).

Virtually all the fundamental elements of every form of therapy we currently recognize were developed or fully emerged between 1940 and 1975. This period was psychotherapy's most recent great age of invention. Nothing much in the way of genuine innovation has since appeared on

the scene.[4] The ranks of mental health professionals, however, have continued to swell. Jerome Frank (1973) once observed that the demand for psychotherapy seemed to increase as a function of its availability. Martin Gross (1978) dubbed America the "Psychological Society." Others have lampooned the United States as a place so obsessed by psychology and self-improvement that the market for psychotherapy was and would continue to be elastic enough to absorb any conceivable number of therapists (Zilbergeld, 1983). The notion of America's expanding and inexhaustible market for psychotherapy appeared plausible to many as recently as the 1980s.

But that was then; this is now.

PSYCHOTHERAPY IN DECLINE

The practice of psychotherapy no longer appears to be growing. Not only has the growth of psychotherapy subsided, but for the first time in its history, it may also be experiencing a decrease in popularity.

The decline in the practice of psychotherapy among psychiatrists has been especially marked, written about, and lamented (Tasman, 2000). Psychodynamic psychotherapy was once the primary intervention employed by psychiatrists when treating outpatients. Drugs were always part of the psychiatric armamentarium, but with the advent of the current biomedical psychiatry regime, the balance began to shift dramatically. Sessions with patients became shorter and more oriented toward drug treatment. Less psychotherapy was provided (Olfson, Marcus, & Pincus, 1999). One study focused quite specifically on the practice of psychotherapy among psychiatrists (Mojtabai & Olfson, 2008). It indicated that the decrease in the use of psychotherapy by psychiatrists continues. The percentage of psychiatrists who administered psychotherapy to all of their patients fell from 19.1% in 1996–1997 to 10.8% in 2004–2005. From 1996 through 2005, the percentage of office visits involving psychotherapy fell from 44.4% in 1996–1997 to 28.9% in 2005–2006. Visits provided under managed care tended not to include psychotherapy at all.

[4]One can, of course, quibble with such a bold assertion. But I do not consider eye-movement desensitization and reprocessing or dialectical behavior therapy to be qualitatively distinct innovations, as were client-centered therapy and family systems approaches. This conclusion also applies to acceptance and commitment therapy. Each of these approaches, no matter how effective, involves a rearrangement of components that were already developed and widely practiced within the field.

Many explanations for these data can be adduced. The most straightforward of these is that psychiatrists do what they have been trained to do and actually have great confidence in the drugs they administer to their patients. In addition, medication management is substantially more remunerative than psychotherapy. A common private practice business model consists of psychiatrists handling the medications and hiring one or more psychologists or social workers to provide psychotherapy for patients, generating additional passive income for the psychiatrist. Then, of course, an important influence has been those ever-industrious drug companies with their attractive salespeople, gratuities, consulting payments, free continuing education credits, "vanity" authorships,[5] conferences in attractive locales, free meals, and free tickets to plays and ball games. The pharmaceutical industry has dialed back the slush somewhat in recent years, in part as a result of efforts by the American Medical Association (Rothman et al., 2009) and the American Psychiatric Association (Carey, 2009) to curb the rather blatant conflicts of interest that turned all but the strongest stomachs. But the pharmaceutical industry has made and continues make a powerful impact on psychiatric education and prescribing practices. It has spent billions on various tactics: lobbying politicians, appointing psychiatrists to lucrative memberships on corporate boards, providing free ghostwriters to psychiatrists, hiring psychiatrists for various consultation functions, and advertising in professional journals. It is money effectively spent that successfully influences legislation and treatment guidelines and indirectly subsidizes various psychiatric organizations. Direct-to-consumer advertising of prescription drugs on television was illegal in the United States before the mid-1980s.[6] People now walk into psychiatrists' offices with clear agendas for augmenting their antidepressants or getting some chemical in their brains that will enable them to focus their attention. The psychotherapy industry, on the other hand, does not have much in the way of lobbyists or even an effective public relations campaign.

Portrayals of psychotherapists in the media are a mixed bag of some wise and decent people one would respect and trust along with various pathological types and lowlifes. In the psychiatric world of today there is no equivalent of the sage of Zurich (Carl Jung), whom various sophisticated Americans regarded as the apotheosis of wisdom and who was sought out

[5]This is the practice of giving an authorship to an individual who has done no real work on a paper. It is usually given to an "opinion leader" who is placed on a paper with multiple authors.

[6]As of this writing only the United States and New Zealand allow direct-to-consumer advertisement of prescription drugs on television (Shaw, 2008).

for treatment by them not only as a man of clinical brilliance but as a man of great sagacity. Today we have no figures of Jung's stature, no one who possesses the highest level of psychiatric expertise combined with international recognition as one who has acquired uncommon wisdom through lifelong efforts to comprehend the entirety of the human condition.

But whatever the causes for the waning of psychotherapy within psychiatry may be, when psychotherapy ceases to be the favored intervention of the highest status mental health profession, it portends many bad things for therapy. And, indeed, it is not only within psychiatry that we observe the diminution of psychotherapy. Two pivotal studies, utilizing excellent research methodology and employing very large, nationally representative samples from Medical Expenditure Panel Surveys conducted by the Agency for Healthcare Research and Quality (AHRQ), have provided us with a clear and detailed picture of outpatient psychotherapy utilization in the United States since 1987.

The first of these studies to be reported (Olfson, Marcus, Druss, & Pincus, 2002) examined data on the overall utilization of psychotherapy per capita per year averaged across all types of healthcare providers in the years 1987 and 1997. A slight nonsignificant increase in the overall rate of psychotherapy use was observed (3.2 per 100 persons in 1987 vs. 3.6 per 100 in 1997). But the psychotherapy landscape was changing. Long-term psychotherapy, as defined by a course of treatment of 20 visits or more, declined by 50% during this decade. Between 1987 and 1997, the percentage of patients who were taking psychotropic medication concurrently while receiving psychotherapy doubled, rising from one-third to two-thirds of all therapy patients. Although the use of psychotherapy remained relatively constant, the overall use of mental health care services increased rapidly and dramatically, especially the use of psychotropic drugs. For example, during the interval between 1987 and 2001, total annual expenditures for prescription drugs used by providers to treat mental health conditions increased more than tenfold, from $1.3 billion (in 2001 dollars) in 1987 to $14.3 billion in 2001 (Stagnitti & Pancholi, 2004). By 2008, estimated psychoactive medication costs were about $25 billion (SAMHSA, 2012, p. 56). Many of these drugs were prescribed by primary care physicians.

The second study (Olfson & Marcus, 2010) looked at utilization in the subsequent decade (1998–2007) and confirmed the trend revealed in the first: Psychotherapy was no longer growing in popularity. But most striking and relevant to our inquiry was the finding that psychotherapy was steadily losing its place as the primary method of treating psychological disorders. The percentage of all sampled U.S. residents in outpatient

psychotherapy was 3.37% in 1998 and 3.18% in 2007. Of patients receiving mental health care, those being treated solely with psychotherapy declined from 15.9% in 1998 to 10.5% in 2007, as did those treated with a combination of drugs and psychotherapy (40.0% in 1998; 32.1% in 2007). Patients treated with psychotropic drugs and no psychotherapy increased from 40.0% to 57.4%. Annual visits per psychotherapy patient declined from 9.7 to 7.9. Psychotherapy also became less lucrative for providers, as fees declined from $122.80 per session to $94.59 per session. Overall expenditures on psychotherapy declined from $10.94 billion to $7.17 billion.[7] The authors concluded the following:

> During the decade from 1998 to 2007, the percentage of the general population who used psychotherapy remained stable. Over the same period, however, psychotherapy assumed a less prominent role in outpatient mental health care as a large and increasing proportion of mental health outpatients received psychotropic medication without psychotherapy. (Olfson & Marcus, 2010, p. 1456)

The authors' conclusion, though correct as far as it goes, may be somewhat understated. The absolute percentage of Americans in psychotherapy remained stable (though actually declining slightly) after rising for many years prior to the mid-1980s, but the stability was only in relation to the population at large, not to the segment of the population seeking mental health care. These data were collected during a time when the percentage of Americans seeking mental health services was increasing rapidly. So although the pie was getting larger, psychotherapists were getting a smaller slice and finding that it contained substantially fewer monetary calories.

All available research seems to paint the same picture. Another piece of evidence came from Wang et al. (2006) and their examination of data from the two National Comorbidity Surveys, conducted in 1990–1992 and 2001–2003, respectively. These authors discovered that treatment with psychotherapy alone without concurrent medication, though it had been the most frequently employed treatment modality in the first study, had declined substantially in the decade between the studies. Treatment with psychotropic drugs administered by primary care physicians, however, had increased dramatically during that decade.

The *Consumer Reports* survey of individuals who had sought treatment for depression or anxiety indicated that 78% received psychotropic

[7] All expenditure figures in this book have been adjusted for effects of inflation.

medication ("Mental Health: Does Therapy Help?", 2009). Although precise figures are hard to locate because of the accounting practices of the pharmaceutical industry, it would appear that drug companies in 2010–2012 spent approximately $30 billion per year on marketing drugs, including promotion to physicians and direct-to-consumer advertising, roughly twice what is spent on research and development (Kornfield, Donohue, Berndt, & Alexander, 2013; Shaw, 2008). This heavy emphasis on marketing has been very effective, both in establishing the primacy of drug treatment for psychopathology and in producing immense profits for the industry.

The profession of psychotherapy clearly has entered a transitional phase. Over the past few decades it has been waning, both with respect to public utilization and practitioner income. Why has this happened? Some of psychotherapy's decline stems from being dragged down with healthcare in general, suffering from the austerities of managed care and the privations of Medicare and Medicaid (and now, possibly, the Affordable Care Act). We can also credit the successful "medicalization" campaigns of the pharmaceutical industry and the medical profession to define problems of living as disorders of malfunctioning brains, disorders that are conceived as something analogous in every way to somatic medical ailments. Excessive emphasis on tertiary care through drug treatment puts the focus upon the "bio" portion of the biopsychosocial approach to problems of living. Not only are cultural, social, and psychological dimensions and causes of human suffering deemphasized, but also it is tacitly suggested that it is scientifically sufficient and clinically most effective to conceptualize psychopathology as arising from malfunctioning individual human brains rather than from the effects of pathogenic social learning or from the stresses of problematic marriages, families, vocations, and various other social factors.

For most nonmedical practitioners, providing a diagnosis of a "mental disorder" often has been largely an administrative necessity. Without a specific diagnosis on a bill, insurance carriers and Medicare/Medicaid will not pay for (or reimburse for) a session with a psychotherapist. Seeking and achieving legitimate status in the healthcare economy, for most psychologists and social workers, did not include acceptance of the "disease model" of human suffering. Indeed, psychologists and social workers were often inclined to see their patients' problems in nonmedical terms and to view treatment from a very broad and complex psychosocial (person-in-environment) perspective, even while they understood that "organic" or "biological" factors might be crucial to account for in achieving a favorable

outcome with some patients. And in this regard they were correct and closer to the truth of the matter than those who sought to reduce the practices of the mental health professions to medical technologies.

Although the healthcare data reported above show psychotherapy to have declined in prominence, there are indications that the trends that have diminished psychotherapy's role in healthcare have failed to serve the public interest and have likely run their course. Intellectuals, laypeople, and even the U.S. Congress have begun to figure it out. The paradigm that has been dominant since the advent of the third *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association (DSM-III; American Psychiatric Association, 1980) and perpetuated in successor DSMs (American Psychiatric Association, 1987, 1994, 2013) already has begun to crumble. Current National Institute of Mental Health (NIMH) director Thomas Insel, speaking for a growing number of critics, has asserted that the last five decades of psychopharmacology in psychiatry have seen no "reductions in morbidity or mortality for people with serious mental illness, including relatively common disorders such as depression, bipolar disorder, and schizophrenia" (Insel, 2012, p. 1). Many pharmaceutical companies have deemphasized or abandoned entirely the effort to develop new drugs for psychiatric disorders, citing the lack of an adequate scientific basis for the endeavor (Hyman, 2012). The NIMH has announced that federally funded research on mental illness will no longer be structured entirely by the diagnostic categories of the DSMs because of their inadequate scientific validity (Insel, 2013). In the United Kingdom, the National Health Service has prohibited the use of antidepressant medication in mild and moderate depression and mandated the expansion of psychosocial interventions. What all this means for psychotherapy is not entirely clear, but the aforementioned developments open the possibility that we may see in the mental health professions the restoration of a more complex and comprehensive view of humanity, a true multidimensional approach to human suffering and its treatment in which there would be a central role for the theory and practice of psychotherapy.

THE AIMS OF THIS BOOK

This book is, in essence, an exploration, analysis, and affirmation of the value of psychotherapy. I examine the recent history and ancient roots of the mental health professions, not only to demonstrate the perennial insights contained in the field but also to identify those past mistakes that

we should hope not to repeat. One of those mistakes was to marginalize a very effective form of treatment, psychotherapy, and to assume that it could be replaced by a putatively more expedient clinical technology. As I discuss, the biomedical revolution in psychiatry was predicated upon an overestimation of the short-term and long-term benefits of psychotropic medication. Another mistake was to assume that we could, in our ministrations to patients, dispense with the broader, deeper, richer conception of human existence that is contained in the various schools of individual, marital, and family therapy.

My Perspective

I have for more than 40 years observed and participated in all phases of psychotherapy as an academic researcher and theorist, a practitioner, a patient, a trainer of psychotherapists, and one who has attempted to grasp the broad social functions of psychotherapy and those cultural factors that shape it. I have also attempted to understand the intellectual underpinnings of psychotherapy through examining those disciplines that can occasionally assist in our comprehension of it. A multidisciplinary analysis can not only help us better understand what is happening to the field of psychotherapy but can also give us some insight into some of the broader changes that have been occurring in society at large.

Psychotherapy is an estimable and emotionally rewarding profession. The life of the psychotherapist is in some respects a demanding one, but one that provides, in ways that few other lives do, the satisfactions of helping others to emerge from darkness and suffering. I continue to respect and affirm the endeavor of psychotherapy to which I have devoted my adult life, but I am unhappy with many of the directions it has taken in recent years. It is not merely the decline in popularity that troubles me but also the movement to transform psychotherapy into a psychotechnology and the attendant view of the human condition that underlies this effort.

The Present Situation

The meeting of life's ubiquitous and inevitable challenges has preoccupied human beings throughout our existence. Some problems are easy, and some are difficult. Some are relatively straightforward, such as the acquisition of food, water, and shelter. Other problems are less palpable and occupy that domain that has been policed, over the centuries, by shamans, clerics, philosophers, physicians, gurus, and various other folk who

have claimed answers to the questions and solutions to the problems. In this domain we find emotional distress, social deviance, medically unexplained physical symptoms, conduct that is injurious to oneself or others, and what most Buddhists view as the inevitable result of the encounter between human consciousness and a world that does not readily accord with human desires: *dukkha*, which is variously translated as suffering, stress, or dissatisfaction—take your pick.

Psychotherapy as a remedy for human suffering arose in the late 19th century and burgeoned as those fields that encompass therapy, psychology, psychiatry, and social work, became larger and more influential parts of the social fabric. The mental health professions today are well established and have taken their place alongside organized religion and the criminal justice system as societal instruments that "process" many of those who deviate from what sociologists (e.g., Parsons, 1977) have termed the *normative order*, those varied complexes of social values and standards for conduct that regulate behavior, cognition, and emotion in every society. Deviant, offensive behavior in children or adults these days leads to one of two places: the courtroom or the consulting room (perhaps located within a hospital). Unhappy or disruptive people are not placed in the stocks; they are placed on medication and/or hooked up with a therapist. Rowdy, disagreeable, or inattentive children are descended upon by a team of psychometricians, behavior modifiers, and pharmacologists. In this fashion the remediation of human suffering has become "civilized" and putatively humane.

The scope of this book is intentionally broad. There are, however, some specific, focal claims that I emphasize and, I hope, adequately defend:

- No important fundamentally new developments or techniques or schools of therapy have arisen since the 1970s. I make my case in Chapter 2.
- Psychotherapy has been largely medicalized. Its targets increasingly are conceived as malfunctions of individual minds or brains. The attempt to turn psychotherapy into a psychotechnology modeled on medicine has limited the cultural scope and conceptual depth underlying our endeavor, minimizing those qualities that once caused it to be regarded as one of the most venerable products of our civilization. How this happened is described in Chapter 3.
- With the rise of psychotechnological, manualized treatments, the quality of psychotherapy is, in some respects, declining, as discussed in Chapter 4.

- The biological focus that has accompanied the medicalization of psychotherapy is intellectually premature given the primitive state of our psychiatric science.

- There are serious deficiencies in the logic and the evidence base that supports efficacy claims for both psychiatric drug treatment and the specific "empirically supported" psychosocial treatments targeted at putatively discrete disorders described in the diagnostic manuals. As detailed in Chapter 4, the clinical science model we have appropriated from pharmaceutical efficacy trials has been a failure in psychiatry, advancing neither scientific understanding nor the effectiveness of treatment. It will likely fail in psychology also, if used as the primary tool to establish an evidence-based psychotherapy.

- Despite claims to the contrary, there is evidence that psychotherapeutic talent, ability, or skill does exist and that it matters for effective treatment. I consider the different perspectives and evidence on psychotherapy expertise in Chapter 5.

- We need to develop a new intellectual framework for our research and to conduct a reexamination of the various conceptual levels at which causal mechanisms are conceived. In Chapter 6 I explore alternatives to the current, narrow biomedical framework. These emphasize the human side of therapy and an ecological, contextual understanding of human beings.

- We must come to accept the interrelatedness of the science of psychotherapy and the inevitable ethical component that is present within it and the breadth of perspective that is required to practice it well. In Chapter 7 I offer some cautionary tales of harmful therapies that were not recognized as such until later developments proved them to be injurious and broadly ill-advised.

- We must also understand how to best conceptualize psychotherapy as a practice that encompasses fact and value, art and science, the individual and the social context, and that somewhat ineffable quality that has been called *practical wisdom*. In Chapter 8 I review emerging opportunities for a psychotherapy resurgence and explore the directions it might take.

There will be other topics addressed. The idea here is for us to step back a few paces from psychotherapy and look at the big picture. The view can be enlightening.

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