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Title:

Psychotherapy

Date:

2019-06-30

Citation:

Buchanan, R. & Haslam, N. (2019). Psychotherapy. Sternberg, RJ (Ed.). Pickren, W (Ed.).
The Cambridge Handbook of the Intellectual History of Psychology, The Cambridge
Handbook of the Intellectual History of Psychology, (1), pp.468-494. Cambridge
University Press.

Persistent Link:

<https://hdl.handle.net/11343/252833>

The Development of Psychotherapy in the Modern Era

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Abstract

Psychotherapy encompasses a broad array of psychological procedures that typically address individual well-being or self-understanding. With diverse roots in hypnosis and persuasion, psychotherapy evolved from marginal treatment option at the turn of the 20th century to central modality in contemporary Western mental health services. Psychoanalysis dominated the theoretical development and public image of psychotherapy in the first half of the 20th century, even though its practice was largely restricted to a psychiatric elite. Input from the emerging field of clinical psychology saw the development of alternative behavioral and cognitive approaches in the 1950s, '60s and '70s. These pragmatic techniques and accessible ideas were combined as cognitive-behavioral therapy and standardized in manualized form. Cognitive-behavioral therapy was more readily adapted to evidence-based paradigms than psychoanalysis, and evaluation research generally confirmed its efficacy. In recent times, the disciplinary basis for psychotherapy training and practice has broadened. While economic factors have prompted psychiatrists to move away from psychotherapy, especially in America, clinical psychologists have been joined by practitioners from other disciplines such as social work and psychiatric nursing. Despite the push for standardization, psychotherapeutic practice has remained eclectic. Psychotherapists continue to expand their professional remit, both upholding and challenging prevailing cultural norms.

Keywords

Psychotherapy, psychoanalysis, behaviour therapy, behavior modification, cognitive-behavioral therapy, standardization, manualized therapy, evidence-based medicine, history.

What is psychotherapy?

Psychotherapy is typically thought of as a loosely structured verbal interaction between a therapist and client, an interaction modelled on the doctor-patient relationship. It is a popular image that owes much to the pervasive cultural influence of Freud and psychoanalysis. However, psychotherapy has always encompassed a more diverse array of techniques, delivery configurations, and goals. As a general label, it can cover almost any psychological procedure addressing individual or group well-being or self-understanding. It employs a range of discursive strategies and instrumental techniques – including interpretation, suggestion, injunction, exposure, and practice.

Specific psychotherapeutic techniques can be roughly grouped according to overarching theoretical models of personhood that vary in terms of complexity and breadth. Some models restrict themselves to relatively narrow accounts of behavior and learning, while others add more elaborate structural accounts of personality and mental processes, and a few extend to totalizing, person-in-society worldviews. To complicate matters further, different theoretical models have conceived of the problems that therapy addresses, and the benefits it can bestow, in markedly different terms. Therapeutic programs thus range from brief sessions targeting discrete problems, to seemingly interminable odysseys of personal discovery. Whereas some merely aim to achieve symptomatic relief and practical payoffs, others set their sights on achieving freedom from troubling emotions and painful experience, and some make more expansive promises of personal fulfillment and self-understanding.

Despite repeated attempts to standardize psychotherapeutic practices, they have continued to evolve in a hydra-headed fashion, making it difficult to think of psychotherapy in singular terms. We ought to speak of *psychotherapies*, rather than psychotherapy *per se*. The everyday language and accessible techniques that psychotherapists necessarily employ also makes it hard to draw professional boundaries around their work and separate it from that of counsellors, life coaches, clerics, and alternative healers (Buchanan, 2003).

Nonetheless, the term “psychotherapist” has come to denote something of an occupational title in most Western democracies, representing highly-trained professionals with an integral role in most health services. This is a far cry from the marginal status psychotherapy had at the turn of the 20th century when it represented an alternative form of treatment for those suffering from “nervous” illnesses. For the wider public, psychotherapy

has taken on the aura of brand name, a widely recognized option for dealing with the age-old questions of existence and the common complications of modern life.

Psychotherapy represents a key technology of contemporary selfhood, one primarily oriented to individual adjustment. However, it also possesses a transformative capacity that extends beyond the individual client. All forms of psychotherapy – even the most pragmatically instrumental – are grounded in a shared cultural framework. But most also attempt to transcend these shared understandings by introducing new ways of interpreting personal experience, challenging received assumptions and norms (Pols, 2018). Because psychotherapeutic attitudes have circulated well beyond the consulting room, they have both reflected *and* reshaped the values of modernity. Psychotherapy has helped usher many shades of *emotionality* into public view. It has made the personal *political* in ways that have reframed hitherto private conduct and has inspired significant re-negotiations of what it means to live the ‘good’ life (Illouz, 2008).

Writing the History of Psychotherapy

The sheer diversity of psychotherapy introduces us to the first of many challenges associated with writing its history. Current compendiums list over one hundred recognized theoretical orientations and practical approaches. Different forms of psychotherapy have developed in interconnected ways within particular disciplines or branched from one to another. Thus, important strands are not captured by conventional histories dealing with one *psyche*-related discipline in isolation (Rosner, 2014).

Then there is the problem of where to start. We could trace continuities in the practice of psychotherapy back to antiquity. This would take us through the ebb and flow of spiritual healing, the pastoral role of church, the writings of Enlightenment scholars, the counselling practices of Classical Greece, and the (often unacknowledged) influence of non-Western philosophies (Ehrenwald, 1991; Pols, 2018). But delving so far back is open-ended and unwieldy. Moving toward the present calls for a decisive starting point. But as Shamdasani (2017) observed, no such point exists. Modern-day proponents of particular approaches have deepened this uncertainty, with some choosing to emphasize their links with the wisdom of

the ancients, while others claim their approach represents a clean break from an “unscientific” past.

One thing we can be clear about is that psychotherapy did not commence with Freud. Nor did he coin the term “psychotherapy” or even the label “the talking cure.” But Freud and his immediate precursors *did* mark the beginning of the modern era, when a set of quasi-scientific techniques labelled “psychotherapy” were first deployed. Tracing these precursors and the origins of the term thus offers a pragmatic and instructive point of departure.

The New Asylums and Functional Nervous Disorders

The term “psychotherapeia” as the “antidote of thought” was first coined by London surgeon Walter Dendy in his 1853 treatise, *Psyche: A discourse on the birth and pilgrimage of thought*. Psychiatrist Daniel Tuke adapted the term as “psycho-therapeutics” two decades later, using it to describe a more rational account of the healing power of the mind, especially the imagination, over the body (Shamdasani, 2017). Not coincidentally, Tuke was the grandson of William Tuke, founder of the York Retreat in northern England in 1796. The retreat was famous for pioneering “moral treatment,” symbolizing a more enlightened approach to the insane that rejected punitive incarceration in favor of humane rehabilitation.

This optimistic new approach led to the construction of numerous mental institutions in Europe and the US early in the 19th century. These new “asylums” were sober, imposing edifices, usually built in bucolic areas surrounding cities and townships. They were intended to be quiet, structured environments, away from the licentious disorder of urban areas. This would make for contemplative respite, a key component of moral therapy. Patients were encouraged to engage in conversation with staff and purposeful activities in the hope that this would return them to their senses. While the context was different, it is not hard to detect continuities with what we would now call occupational therapy. Nonetheless, the high hopes of moral therapy and the asylum movement were soon dashed in the latter half of the 19th century. Discharge rates remained low, while intakes continued to climb. Despite the construction of additional buildings, asylums quickly became grossly overcrowded, mainly

with the poor. Any pretense to treatment was abandoned as most devolved into dumping grounds for long-term custodial care.

The inability to rehabilitate asylum patients was one factor behind the explorations of new kinds of therapy. But it was only a distant driving force; emerging medical specialization and the increasing visibility of a range of puzzling “nervous” disorders were far more precipitous factors. The rise of laboratory research and germ theory in the latter half of the 19th century made for tighter links between disease entities and specific bodily indications. Neurology began to emerge as a distinct medical specialty in both the US and Europe. A materialist parallelism dominated the field: conscious mind was simply seen as the outcome of physical process. It suggested that the causes of mental problems might best be understood in terms of infection or injury. In contrast, the fledgling field of psychiatry – mostly represented by the medical personnel overseeing the remote asylums – remained something of a scientific backwater.

The newly recognized “nervous” (aka “neurotic”) disorders were a vexing problem for neurologists, however. These complaints were labelled “functional” as opposed to “structural” or “organic” because they had no known physical causes. Although their symptomology was regarded as partly psychosomatic, those suffering from functional disorders were not typically thought of as mad. In Europe, much attention focused on the centuries-old category of *hysteria*, a characteristically female affliction that had come to be understood as “ungovernable emotional excess” accompanied by symptoms like fainting and amnesia. Conversely, American physicians were more preoccupied by *psychasthenia*, the new disorder of the overworked male characterized by obsessive worrying and “depleted nervous energy.” Many other labels for similar complaints littered the field, and their incidence appeared to be rising.

While neurologists hardly waived from their materialist assumptions, there was much hand-wringing over how best to deal with these nervous disorders. It opened the way for alternative forms of treatment, especially among practitioners beginning to specialize in the area. Many ‘new age’ cures jostled for attention, marketed with a bewildering variety of neologisms. Most were fundamentally somatic. Manipulations involving diet, water, electricity, and the natural environment provided the basis for regimes such as hydropathy,

electrotherapy, magnetotherapy and climatotherapy, most of which have been assigned to the dustbin of history (Shamdasani, 2005). But among this smorgasbord of treatment programs were a number of mentalistic techniques, most of which challenged the notion of the unity of mind.

The Mysterious Power of Mind

German physician Franz Mesmer's therapeutic explorations in the latter half of the 18th century lent credence to the idea that the mind encompassed hidden forces. While the medical establishment dismissed Mesmer's techniques as quackery, his legacy did help delineate the technique of hypnosis in the first half of the 19th century. In Nancy, France, professor of medicine Hippolyte Bernheim appropriated the term "psychotherapy" to describe his use of hypnosis to dig beyond his patients' conscious awareness and treat them using positive and negative suggestions (e.g., that they would feel better or that their symptoms would disappear). By systematizing the use of hypnosis, Bernheim hoped to make it a respectable medical treatment for nervous disorders – even though the technique was beginning to acquire an embarrassing association with showmen and charlatans.

In Paris, Salpêtrière infirmary neurologist Jean-Martin Charcot was particularly preoccupied with hysteria. Charcot maintained that hypnotic suggestibility was a key diagnostic marker for the disorder, which he considered an inherited pathology of the central nervous system. Charcot used hypnosis to demonstrate hysterical symptomology. But in contrast to Bernheim, he regarded the hypnotized state as pathological and saw little value in it as a treatment technique (Cushman, 1995). Nevertheless, Charcot did open a psychological laboratory in 1893, putting his one-time student, the prodigious Pierre Janet, in charge (Porter, 2002). Janet outlined a more distinctly *psychological* basis for hysteria, which he saw as characterized by the dissociation of memories and sensations buried in the "subconscious." Presciently, Janet suggested that nervous disorders such as hysteria generally had their origins in traumatic events that were often revisited in dreams. The patient had to be led back to self-mastery by the clinician in a process Janet termed "psychological analysis" (Shamdasani, 2017).

As a variety of psychotherapeutic practices began to spread through Europe in the late 1800s, the label “psychotherapy” served as a convenient umbrella term. It had broad appeal because it was not tied to any particular theory or technique, and it avoided reference to hypnosis (Shamdasani, 2005). Swiss physician Paul Dubois adopted the term to launch his more *directive* version of moral treatment in the 1890s, variously dubbed “rational therapy” or “persuasion therapy.” Dubois rejected hypnosis completely and instead argued that what neurotic patients needed was to be insulated from suggestion so that they would only accept the pure counsel of reason. For Dubois, moral re-education and logical instruction would lead to self-mastery, a message that was well-received by the Swiss public (Woolfolk, 2015). Dubois’s version of psychotherapy has often been cast as a forerunner to modern-day cognitive therapy, but at the time it was beginning to be overshadowed by a very different tradition emerging elsewhere in Europe.

On the Couch: The Arrival of Psychoanalysis

In Vienna, an ambitious young neurologist named Sigmund Freud took careful note of Janet’s work and borrowed heavily. Freud had begun collaborating with Josef Breuer in the 1880s, treating the peculiar symptoms of a patient dubbed “Anna O” (real name Bertha Pappenheim). Freud had also worked under Charcot in 1885. Charcot had privately told Freud he suspected hysteria had sexual origins – but Charcot was careful to keep such salacious details out of his public presentations. It was a suggestion that Freud ran with. By the mid-1890s, Freud was building on his hypothesis that his patients’ neuroses were caused by early sexual trauma. However, soon after going public with this scandalous “seduction theory” in 1896, Freud changed his mind. These were not stories of *real* abuse, he now maintained, but the remembered *fantasies* of childhood.

The reasons behind Freud’s fateful reorientation have been fiercely debated. Some suggest it was a failure of nerve triggered by the lukewarm response to his seduction theory. In that light, it looked like a huge betrayal of his patients and all future patients whose stories would be similarly discounted (Masson, 1984). Conversely, Freud’s disciples celebrated it as an enormously important, ‘eureka’ moment. Certainly, Freud had become preoccupied with

fantasy and more sensitized to the impression that he was exploiting the suggestibility of his patients' memories (Porter, 2002; Borch-Jacobsen & Shamdasani, 2012).

Whatever the explanation, there is no doubt Freud's reorientation expanded the scope of his theorizing. Rather than specific trauma, the genesis of neurosis lay in the conflicts of the developing *psyche*. According to Freud, childhood innocence masked an undercurrent of sexual desire that ran through several stages culminating in an Oedipal drama animated by love, jealousy and rivalry for mother and father. Out of this emerged the personality structure of adulthood, encompassing the unconscious (*id*), a conscious self (*ego*), and a moral sense (*superego*). It made for a three-way contest between instincts, rationality, and culture. In Freud's eyes, the present was always overlaid by the past. Any failure to move through the infantile stages without crises or fixations would be revisited in adulthood. Neurotic symptomology was the symbolic expression of poorly resolved childhood conflict. It was a cradle-to-the-grave perspective, albeit one with a distinctly *backward-looking* emphasis. Freedom from neurosis – and greater self-understanding – was only achieved by teasing out our earliest experiences and reconciling the hidden forces they set in motion.

Under his original seduction hypothesis, Freud encouraged his patients to dredge up memories of childhood abuse to achieve cathartic release. Freud now focused on working through Oedipal fixations via free association, with the patient asked to say whatever came to mind, no matter how random or incoherent. This was supplemented by dream analysis and the interpretation of what Freud called "transference." Transference occurred when the feelings the patient experienced in key early relationships were redirected toward the analytic therapist. These transferred feelings had to be treated with care, with Freud cautioning against emotional engagement and overt judgments. Classical versions of psychoanalysis would retain this neutral attitude as a matter of principle right down to a consulting room configuration that stipulated the therapist face away from the couch-bound patient. Moreover, therapeutic neutrality had to be sustained: classical analysis commonly demanded daily sessions extended over several years.

In the early years of the 20th century, a movement began to form in Vienna. Freud was joined by Swiss psychiatrists Carl Jung and Eugen Bleuler, Welsh neurologist Ernest Jones, Hungarian neuropathologist Sándor Ferenczi, as well as Austrians Otto Rank and Hanns

Sachs, and German psychiatrist Karl Abraham. Under the newly-minted appellation of “psychoanalysis” (which Janet claimed Freud stole from him), the movement acquired a distinctly cosmopolitan flavor. But with self-serving acumen, Freud opposed the integration of psychoanalysis within the broader psychotherapy tradition. To this end, the International Psychoanalytic Association (IPA) was founded in 1910 to maintain a sense of independence and cohesion in analytic doctrines.

Onward to America

Developments in Europe would feed into a lively psychotherapeutic scene in the US. Many home-grown self-help regimes had arisen linking mind, body and moral character. Most had a strong evangelical streak. They spread rapidly throughout the country late in the 19th century, especially along the eastern seaboard, their popularity a reaction to the increasingly somatic emphasis of American medicine. For example, Phineas Quimby’s Mind Cure made much of the power of positive emotions and beliefs, setting up mental healing schools throughout the New England area in the 1860s. The charismatic Mary Baker Eddy transformed Quimby’s teachings into Christian Science, an evangelical order that reconceptualized *all* illness as mental delusions. The growing popularity of Christian Science in the 1890s alarmed doctors and clerics. However, this would provide ample opportunities for rival mental healers, including proponents of New Thought who embraced the suggestion techniques of Bernheim (Caplan, 1998).

At the turn of the 20th century, most American physicians still shunned mentalistic approaches, wary of any association with quackery. But a few prominent neurologists, taking note of developments in Europe, began to explore the psychological etiology of “nervous” conditions and trial new treatment techniques. However, the immense popularity of the Emmanuel movement would bring things to a head, making it all but impossible for the medical establishment to disregard mentalistic healing.

The Emmanuel movement was founded in 1906 by Elwood Worcester, lead minister at the Emmanuel church in Boston. While it would quickly dissolve in 1910, its impact was significant. The movement was staffed by a cooperative of physicians, psychiatrists and

clergymen. Free lectures, medical examinations, and spiritual consultations were supplemented by brief, suggestion-based therapy carried out by lay volunteers. Public turnouts were huge and the unease this provoked among medical practitioners and psychologists was palpable (Caplan, 1998). Knowing they could not ignore popular demand, Cornell physician Charles L. Dana urged his colleagues to scrutinize the movement's activities more closely. But Dana also knew that a handful of his colleagues in the Boston area, and even some psychologists, were dabbling in mentalistic techniques. Such techniques, Dana concluded, were safest in medical hands. Likewise, influential German-American psychologist Hugo Münsterberg suggested that medicine and religion were best kept separate, foretelling what was to come. However, what American physicians needed was a coherent and respectable system of techniques they could call their own (Caplan, 1998).

This was the scene leading up to Sigmund Freud's only visit to the America in 1909. Freud came to deliver five lectures at a conference at Clark University outside Boston. At the time, Pierre Janet was the most prestigious international name in psychotherapy, while Münsterberg had just published a notable survey of the field for American audiences. As well as Freud, the Clark conference included acolytes Jung, Jones, Ferenczi and Abraham A. Brill, and a host of other storied figures from related fields. Freud's appearance hardly caused a ripple. Its latter-day iconic status owes more to the historical revisionism of his followers (Shamdasani, 2012). Far more crucial in this context was the fact that Freud's works were being made available for American audiences, courtesy of Brill's translations. While Freud appreciated the open reception he was given in the US, contrasting it with the suspicion he was used to in Europe, he did not hide his distaste for American culture. But this did little to inhibit the uptake of his ideas in the New World in the decades to come.

The Psychoanalytic Movement Spreads and Splinters

During World War One, Freudian concepts would contribute to the increasing recognition of the psychological basis of a range of neurotic disturbances – particularly shell-shock – along with more sympathetic ways of dealing with them. The well-travelled W.H.R. Rivers was a key figure amongst progressive doctors who successfully trialed this new, non-

somatic approach with traumatized soldiers at Maghull and Craiglockhart War Hospitals in Britain.

After the war, Freud would extend the explanatory scope of psychoanalysis to encompass the gamut of human experience, from high culture to everyday life. Humor and slips-of-the-tongue, along with art, music and literature, could all be reinterpreted as the displaced expression of forbidden desires. It was a bleakly atavistic view of human nature, born of the moral hypocrisy, racial persecution and industrialized warfare Freud had witnessed. It was also extraordinarily expansive, making virtually everyone a candidate for psychoanalysis even though it only promised to reduce neurotic misery to ordinary unhappiness (Cushman, 1995).

In the lead up to the war, Jung split acrimoniously with Freud, a man Jung branded a “Godless Jew.” Jung was one of the first in Freud’s orbit to develop their own version of psychoanalytic therapy. He would retain the concept of a deep unconscious. But instead of untrammelled sexual desire, the Jungian unconscious was filled with inherited cultural memories and myths that framed individual development. And in contrast to Freud, Jung argued that the content of dreams was not necessarily sexual, nor disguised in meaning. The goal of Jungian therapy was to reconnect with one’s mythopoetic unconscious, bringing its contents to the surface to achieve a creative and coherent unity in consciousness that overcame the alienation of a rational, secular world. Other psychoanalytic dissents like Alfred Adler and Otto Rank would likewise distance themselves from Freud and his teachings, splintering but spreading related “psychodynamic” forms of psychotherapy.

Psychotherapy Between the Wars

Between the wars, psychotherapy still encompassed an eclectic mix of hypnosis and suggestion, as well as the regimes associated with Janet and the various schools of psychoanalysis. While Bernheim’s kit-bag of techniques had only modest theoretical underpinnings, the analytical practices of Freud and Jung were anchored in vast theoretical structures, representing “some of the most complex hermeneutic systems of the twentieth century” (Shamdasani, 2017, p.372). The literary richness of psychoanalytic theory,

particularly its power to ‘unmask’ and reinterpret almost all forms of cultural expression, proved irresistible to bohemian artists and intellectuals in Europe and America in the 1920s. Psychoanalytic ideas subsequently infiltrated the academy, providing a fertile conceptual language across the humanities. By mid-century, psychoanalysis would permeate popular consciousness like no psychological system had done before, giving the broadly initiated new ways to describe themselves and others.

Before Jung broke with Freud, he suggested a unique form of training for would-be analysts. It would have a profound effect on the way psychoanalysis developed, especially in the US. Freud feared his prized system would be incorporated in general medical practice as merely one additional technique. Wary of unprincipled ‘wild’ analysis, Freud welcomed Jung’s suggestion that only those who had been ‘purified’ – that is, analyzed themselves – should be allowed to practice. It meant each new analyst would be able to trace their genealogy back to Freud. And it would go hand-in-glove with independent psychoanalytic training institutes. The Berlin psychoanalytic institute first established a training syllabus that included supervised practice and seminars to go with personal analyses, a pattern duplicated across the Western world. It separated the training and practice of psychoanalysis from medicine, psychiatry, and psychology, giving it a proprietary advantage over other forms of psychotherapy and reinforcing its image as the most elite and learned of callings.

Psychoanalysis provided a crucial means for American psychiatrists to step out of the asylums and into community-based consultative practice in the 1920s. At this stage, psychoanalytic training in the US was relatively informal and variable. But new training institutes opened in Chicago, Baltimore-Washington, Boston, New York, and San Francisco during the 1930s and 1940s, to go with previously established national and local professional associations. Soon there were more analysts in training than there were in practice (Mosher, 2008).

Freud’s doctrines had taken root in the New World just as American medicine was upgrading its patchy training standards in the wake of the 1912 Flexner report. A ruthless crack down on the medical “diploma mills” was accompanied by the banishment of “non-scientific” heterodoxies like homeopathy and naturopathy (Mosher, 2008). Mindful of the dangers of quackery, Brill had lobbied hard to ensure psychoanalysis remained a medical

practice within psychiatry, despite the disapproval of Freud who felt that analysts should be cultured and broadly-educated. Brill and his fellow American analysts were granted an exception by the governing international body, the IPA, to pursue this narrow guild path. From 1938, American training institutes would *only* accept medical graduates; it would make psychoanalysis a key professional boundary marker in the US mental health marketplace for several decades.

After the Nazi's took control of Germany in 1933, a wave of psychoanalysts, most of them Jews, migrated to the New World. While this robbed the continent of some of its best practitioners, it gave American psychotherapy a decisive boost. Several of these psychoanalytically-trained émigrés – notably Heinz Hartmann, David Rapaport and Erik Erikson – would put an upbeat spin on Freudian concepts after the war. Their brand of *ego* psychology granted far more agency to individuals, with therapeutic approaches stressing the adaptive capacity of the *ego* over the uncontrolled, deterministic instincts of the *id*.

Another pre-war émigré, Karen Horney, would give the androcentric sexuality of Freud a proto-feminist makeover. Girlish “penis envy” was a misnomer, she argued, a misrepresentation of the discovery of – and understandable resentment toward – generic male power. Horney's alternative “masculinity complex” was thus conceived as an overreaction to feeling chronically unsafe and undervalued. During and just after the war, she would help popularize the concept of “self-realization” in the psychoanalytic lexicon.

In contrast, France remained impervious to psychoanalysis until the post-war arrival of *enfant terrible* Jacques Lacan. But even then, French psychiatrists were reluctant to grasp the Freudian nettle. In a reversal of the disciplinary divisions of the US, the inscrutable semiotics of Lacan were mainly embraced by psychologists (Amouroux, 2017). Despite this delayed uptake, the intellectual influence of psychoanalysis would linger longer in the Francophone world in fields ranging from psychology and psychiatry, to politics and social theory (Botbol & Gourbil, 2018).

Other European centers would develop their own analytic traditions. In Britain, the dark, brooding sexuality of psychoanalysis proved an acquired taste. But even prior to the Great War, psychoanalytic ideas had become a notable feature of the various mind healing techniques of asylum psychiatrists and doctors, with David Eder, Bernard Hart, Edward

Mapother, and the self-aggrandizing Ernest Jones prominent proponents (Kuhn, 2017). The success of psychoanalytic therapy during the war provided a crucial boost, and the foundation of the Tavistock Clinic in London immediately afterwards gave British psychoanalysts an important institutional platform. The psychodynamic therapies that subsequently emerged mid-century exhibited a particularly British fixation with the nuclear family and the mother-child relationship (Porter, 2002). These included Melanie Klein's object-relations school and Donald Winnicott's and John Bowlby's developmental systems. London was also the last resting place of Freud in the late 1930s. His loyal daughter Anna would work hard to preserve her father's legacy in the UK, famously taking issue with Klein's reformulations.

Prior to World War Two, American psychologists had played a modest role in the formulation and delivery of psychotherapy. Applied psychological work was a less prestigious alternative to academia and was, at the time, largely the province of women. These pre-war practitioners tended to be restricted to diagnostic and testing roles in adult contexts but had a freer therapeutic hand in educational settings and child guidance. Out of this would come alternative therapies, many developed in opposition to psychoanalysis and medical thinking.

In 1939, Columbia graduate Carl Rogers wrote the first of many books outlining his approach to psychotherapy, *The clinical treatment of the problem child*. Rogers drew from his counselling experience with troubled children in New York and Rochester, and from pioneering social worker Jessie Taft, an Otto Rank disciple. Rogers opted for the precedent-setting term "client" rather than "patient" in a bid to exorcise medical paternalism. Gone too were elaborate structural theories of mind. And rather than strict technique, Rogers put the emphasis on free-form processes. But he coupled this methodological looseness with measurable outcomes – an innovation at the time – using self-report techniques and physiological indices of frustration tolerance. Rogers's "Client-Centered Therapy" required an unconditional empathy to help clients plan a better future and the personal changes needed to achieve it. A warm therapeutic relationship was seen as the key to mobilizing the client's inherent strengths, laying the groundwork for contemporary research on the importance of the "therapeutic alliance."

Rogers's positive take on individual potential – that we can all be entrusted to find our own way – came as a breath of fresh air. It contrasted sharply with the mordant resignation of Freudian therapeutics. Rogerian therapy would become the orientation of choice for many American psychologists and social workers after the war, especially those working in counselling contexts. It was the first of many far more reflective, “humanistic” forms of psychotherapy developed in the US after the war – which included the “self-actualization” theorizing of Abraham Maslow, the existential psychology of Rollo May, and the “Gestalt Therapy” of Fritz Perls. All would shift the goals of psychotherapy in a more meliorative, life-enhancing direction.

World War Two and the Freudian Age

In the aftermath of World War Two, much of Europe lay in ruins, while America emerged as the dominant economic and intellectual world power. As a result, American psychiatrists and psychologists became the global leaders of their respective disciplines. After the war, a young and socially-progressive generation of American psychiatrists took control of their discipline. Long overdue improvements in training were made and new research centers and departments in medical schools gave the discipline a more integrated role within mainstream medicine. Many of these new departments installed leaders sympathetic to psychoanalysis. Private practice took off and earning capacities soared. For the first time, psychiatry became the specialty of choice for the best medical graduates. Talk therapy had become the present and the imagined future of the discipline. But the rapid growth of this intensive, highly paid service was predicated on unstable assumptions: that demand would continue to expand in the absence of alternative treatments, and that generous third-party and indemnity insurance coverage would extend indefinitely.

American psychiatrists' dominance over psychotherapy would soon be challenged by the extraordinary postwar growth of clinical psychology. During the war, many American psychologists turned to clinical work (Capshe, 1999). With the promise of government funds, university psychology departments augmented their graduate programs to include a clinical doctorate (Baker & Benjamin, 2005). These four-year programs would follow the

scientist-practitioner model officially formalized at the 1949 Boulder conference. Boldly, the conference recommended training in some form of psychotherapy.

Does Talk Therapy Actually Work?

Soon after visiting the US to survey these developments, a young and disapproving Hans Eysenck published a paper posing a provocative question: does talk psychotherapy work? The London-based Eysenck reviewed the limited evaluation research that had been done up to 1952 in the US and Europe, some of it by his psychiatric colleagues at the Maudsley hospital. Virtually all this research was based on simple clinical appraisals of improvement, without a “non-treatment” control comparison. Eysenck’s innovation was to construct just such a standard based on the idea that some people will get better by themselves (“spontaneous remission”). But Eysenck loaded the dice against psychotherapy. For example, he bluntly equated remission with discharge or discontinuation of care in contexts where there was a strong incentive to move people on, and he classified deaths, drop-outs and even “slightly improved” ratings as therapeutic failures. Eysenck came up with a spontaneous remission rate of roughly 66%, an exceedingly high baseline that most talk therapies did not surpass. His colleagues at the Maudsley did best of all, achieving a 69% “cured/greatly improved” rate in one study. But psychoanalytic therapy performed particularly poorly, with an average of 44% “cured/greatly improved” suggesting it was harmful (Buchanan, 2010).

Eysenck’s 1952 paper created shockwaves. Personal experience, case study reports, and anecdotal evidence had all reassured psychotherapists that they were helping patients. However, there had been little purpose-designed evaluation research; randomized control trials were still years away. This made it difficult for psychotherapists to mount convincing rebuttals. Ironically, the Berlin psychoanalytic institute had instigated what was probably the first longitudinal evaluation study in 1920, crude by today’s standards, which Eysenck had included in his paper. But psychoanalysts had otherwise tended to shun outcome evaluations. Instead, they privileged an internal processes viewpoint, with the refined clinical observation of the therapist the primary criteria of efficacy. Externally rated measures (e.g., by patients or observers) made little sense in a context where deterioration could be interpreted as a transient “negative therapeutic reaction.” Any attempt to study outcomes could not capture,

and might even compromise, the therapeutic process (Rosner, 2014). In any case, quantitative expertise was not a prominent component of most therapists' skill-set, especially medically-trained psychoanalysts. And analysts had been under little pressure on this score from their medical colleagues, given that clinical medicine was yet to embrace an evidence-based framework.

The postwar influx of psychologists, all hailing from a discipline with a long history of empirical research, would change all that. Eysenck was one such newcomer, an inveterate controversialist at that. While he was immensely skeptical about talk therapy, his colleagues in clinical psychology were committed to it. What they needed were therapies that could be *shown* to work. Armed with sophisticated quantitative tools, they would make the "too difficult, too busy, no need" excuses look quite backward. In tandem with the new therapeutic approaches they developed, psychologists would reframe what clinical efficacy meant. Eysenck's 1952 bombshell represented the beginning of a new evaluation tradition, and much of it would be animated by a keen desire to prove him wrong.

The Advent of Behavior Therapy

Since the 1920s, American psychologists had proposed a range of practical techniques for correcting specific problems. They were generally based on the classical conditioning principles of Pavlov. However, the work of behavioral psychologists such as Mary Cover Jones, Knight Dunlop and Andrew Salter was scattered and systematized, and did not connect with the work of the few psychologists dealing with adults in the US prior to World War Two. Perhaps the best example was the Mowrers' (1938) bell-and-pad method for combatting bedwetting. Moisture on the pad triggered a bell, which would eventually "condition" the infant to wake up before it was too late. While this technique was good for children, it was hardly the basis for a broadly-applicable regime for adults.

The applied US scene would change markedly after the war, with a growing number of clinical practitioners fed by the new teaching and research programs of academia. Even so, the story is one of cross-cutting international influences, with Eysenck again a key player, along with South African Joseph Wolpe.

Wolpe trained as a physician but practiced as a psychiatrist – albeit one with research inclinations. Taking issue with analytic dogma that made conflict the key factor in psychological disturbances, Wolpe re-conceptualized neurotic anxiety as a conditioned response. His research with cats suggested that persistent exposure to an aversive situation was enough to induce such behavior—given that anxiety tended to generalize across other situations or objects resembling the original scenario. And if fears and phobias were learned, they could be *unlearned*. Drawing on Jones’s work on childhood fears, Wolpe trialed various treatment techniques with his patients in the early 1950s. In a pivotal 1954 paper, he outlined a basic strategy of gradual familiarization based on the concept of reciprocal inhibition. While remaining in a state of pleasant relaxation, the patient was confronted by a succession of stimuli that progressively approximated the fear-inducing stimuli. The technique was thought to break the maladaptive stimulus–response connection by introducing an incompatible alternative response (e.g., relaxation) that was said to block anxiety. Thus, the phobia or fear was systematically “de-sensitized.” Wolpe’s original procedure was somewhat laborious, but he was able to claim an unprecedented cure rate of around 90%.

Eysenck realized Wolpe’s “systematic desensitization” could form the basis of an alternative kind of psychotherapy potentially applicable to a huge number of patient problems where anxiety was a central component. With Eysenck’s support, clinical psychologists at the Maudsley began to cautiously use Wolpe’s de-sensitization technique with selected patients from 1955 onwards. The flashpoint came in 1958 when Eysenck presented the results of his colleagues’ work to an eminent group of British psychiatrists, ending with his famously curt maxim: “Get rid of the symptom and you have eliminated the neurosis.” (Eysenck, 1959, p.65). The behavioral approach embodied a stripped-down, pragmatic view of the therapeutic process that emphasized specific outcomes. It was less talk, more a planned course of retraining, and all but banished the concept of mind. It made the patient’s personal history irrelevant and demanded little understanding or empathy from the therapist.

The backlash from British psychiatrists was both intellectual and professional. Analytically-inclined psychiatrists scorned narrowly-targeted symptom alleviation as facile and quaintly Victorian. They likened it to a game of “whack-a-mole”; old symptoms would

be replaced by new ones if deeper level conflicts were left untreated (Scull, 2015). And they hardly welcomed this encroachment on their treatment role. But “behaviour therapy” – as Eysenck dubbed it – was here to stay. It made an immediate impact in Britain and began to spread internationally across Europe and the New World. It would fundamentally shift disciplinary perceptions of what psychotherapy was and how it worked. Broader socioeconomic forces would only reinforce this kind of instrumental, auditable approach.

Some British psychiatrists – such as Isaac Marks and Michael Gelder – saw the promise of this new approach and adapted it to their own ends. But the interdisciplinary turf war over the practice of psychotherapy would continue for years to come at the Maudsley and across Britain, sustained by intra-disciplinary disagreements and organizational strife. By the late 1970s, Maudsley psychologists were finally given full responsibility for their patients. However, the highly regulated National Health System (NHS) did not *fully* embrace clinical psychologists as psychotherapists until 1996. By this time, they were joined by several other groups practicing psychotherapy in Britain – including counselling psychologists, nurses and trained ‘lay’ practitioners (Parry, 2015).

Professional Rivalry in the US: Who Owns Psychotherapy?

Across the Atlantic, the confrontation between psychiatrists and psychologists played out with similar timing but was shaped differently by the globally-unique role that psychoanalysis had in the US. Medical control over the practice of psychoanalysis in the US made medical control over psychotherapy more generally seem like a realistic possibility. Not surprisingly, American psychologists exhibited an intensely ambivalent attitude toward psychoanalysis, half wanting it, half rejecting it. They found it difficult to disregard as an intellectual well-spring, but its insular hermeneutics and difficult-to-test circularities were exactly what many in their discipline vehemently opposed. In response, some American psychologists sifted out the empirically sound components of psychoanalysis in order to reconcile it with learning theory (Dollard & Miller, 1950).

Even though they were barred from becoming certified analysts, large numbers of American psychologists were being trained in some version of psychotherapy – be it

psychodynamic, Rogerian or some eclectic mixture. They were increasingly dealing with adult clients, often in team-based contexts. Moreover, a small but growing number were opting for independent private practice. Even liberal American psychiatrists saw this “unsupervised” lay therapy as a threat. Nonetheless, any attempt to modify medical practice acts to ban lay psychotherapy faced insurmountable hurdles. American psychiatrists would need a workable legal definition of psychotherapy that justified an exclusive medical claim over it, despite its non-somatic basis. But narrow definitions of psychotherapy precluded a broad consensus. Even strictly classical psychoanalysts found it hard to agree. Conversely, broad definitions would make it difficult to demarcate from other forms of counselling and pastoral care.

Spurred on by the threat of more protective medical legislation, American psychologists began enacting legislation of their own in each state to protect their right to practice. In many states this would explicitly guarantee psychologists’ right to dispense psychotherapy. Their ongoing campaign produced a tense standoff between the respective national bodies in the late-1950s, neither psychologists nor psychiatrists willing to concede ground. But in the ensuing years, psychiatrists quietly backed off, unwilling to force a potentially disastrous court test. In the absence of a consensus over definitions, psychotherapy would have to be shared. By the late 1960s, American psychologists began to convince private health insurers and government agencies to increase coverage of their psychotherapeutic services and achieved legal recognition in all states by 1977 (Buchanan, 2003).

Psychoanalysis had begun to lose its luster by that time. The medical stranglehold over psychoanalysis in the US was finally broken in 1988 in the wake of a monumental anti-trust suit launched by four psychologists. The institutes were subsequently forced to admit psychologists as trainees (Mosher, 2008). Credentials and training, rather than approach or discipline of origin, came to define the right to practice of psychotherapy in this competitive and privatized market – as it generally would across the Western world. In lieu of formal definitions, psychotherapy became what a fully qualified psychotherapist did.

From the Behavioural to the Cognitive

Led by Eysenck's Maudsley clinicians, behavioral therapy spread internationally in the early 1960s. Eysenck had unsuccessfully tried to get Wolpe to join him in London. Instead, Wolpe settled in the US and was followed by his charismatic protégé, Arnold Lazarus, who extended Wolpe's techniques to new populations and problems. Eysenck edited two versions of an influential compendium, *Behaviour therapy and the neuroses*, in 1960 and 1964. The latter volume included contributions from American psychologists who had begun using Skinner's operant conditioning principles to modify mental hospital patients' behavior using spendable tokens to reward desirable conduct, broadening the movement advantageously. Psychologists could now proudly proclaim that the theoretical purism of the laboratory had yielded practical results that reframed psychotherapy as a research-based practice.

The partisan hubris that characterized the early promotion of behavior therapy began to dissipate by the late 1960s, however. Learning theory was racked by disagreement, with competing classical versions pitted against radical operant formulations. De-sensitization was explainable in terms of several different models of learning theory, even if it was still judged to work in a therapeutic sense. And while the general stimulus-response framework of behaviorism banished all forms of mentalism, it made for huge explanatory gaps. For example, why did phobic behaviour often arise without an initial intense trauma, and why did such behaviour often escalate without apparent reinforcement? The cumbersome procedures and limited generalizability of specific behavioral treatments were more pressing clinical concerns. The many and varied challenges of life made it difficult to rehearse adaptive responses for all situations seen to cue maladaptive behaviors like phobias. Behaviour therapists were forced to admit that only a fraction of mental health problems could be treated with their methods (Yates, 1970).

Albert Bandura's *Principles of behavior modification* (1969) highlighted the pervasive influence observational modelling had on learning. Bandura's protégé, Michael Mahoney (1974), reinforced the importance of language and thought in psychotherapy, linking behavioral approaches with the new cognitivism beginning to dominate the academy. These developments would generate more efficient, broadly applicable treatment techniques, such as visual rehearsal and participant modelling, and legitimate two similar therapeutic approaches that had independently arisen from clinical practice (Hollon & DiGiuseppe, 2011).

Albert Ellis was a member of the vanguard generation of postwar clinical psychologists. While he was born in Pittsburgh, he became the quintessential New Yorker. Ellis trained in clinical psychology at Columbia Teachers College during and just after the war. After finishing his Ph.D. in the late 1940s, he went into full-time private practice, where he remained for the rest of his career. Ellis had been well-versed in psychoanalytic theory, applying it in early work in sexology and marriage counselling. But he was frustrated with the detached passivity that classical analysis demanded, not least the way therapist and client were required to be positioned. Moreover, he felt the arcane conceptual schemes of psychoanalysis did not connect with his clients' problems in tangible ways, most of which seemed to be the product of social taboos rather than serious disturbances. Unimpressed with alternatives like Rogers's approach, Ellis began experimenting with his own "straight-thinking" methods.

Ellis sought a theoretical framework that operationalized Freudian concepts in a quasi-behavioral language, allowing for a far more interventionist approach. The real basis for sexual "hang-ups" and self-defeating behaviour of his clients was their underlying irrational belief systems that produced pathological "self-indoctrination." And while these beliefs might stem from childhood experiences, they could be made both legible and tractable (Stark, 2017). Ellis's main aim was to close the gap between what one wants and what one has, outlining four main areas of irrationality that could be targeted for change: impossible demands, disastrous consequences, lack of trust, and poor self-worth.

In a pre-online era, Ellis was the ultimate media performer. In the late 1950s, he began to promote his approach on radio and television with a missionary zeal. By the early 1960s, he had authored 13 books. Many were geared to popular audiences, including *Sex without guilt* and the influential self-help book (co-authored by Robert Harper) *A guide for rational living*. Ellis systematized his approach for his fellow professionals with *Reason and emotion in psychotherapy* (1962), which included a key innovation: worksheets to counter irrational beliefs. Ellis's take-home assignments extended therapy beyond sessions. They were a way of helping clients help themselves, prefiguring a broader disciplinary push to "give psychology away." Ellis liked to shock audiences at workshops and seminars with his irreverent profanity. But to see him work with clients and winkle out barely noticeable absurdities in

their thinking was inspiring, a key factor in the personal following he developed for what he called “Rational-Emotive Therapy” (RET).

While his intellectual path would later merge with Ellis, Aaron Beck hailed from a very different background. Ellis was something of a self-made outsider; his entrepreneurial savvy saw him found his own private institute. In contrast, Beck was a privileged insider, spending almost his entire working life at the University of Pennsylvania. Specializing in psychiatry, Beck was inculcated in analytic ego psychology early in his career. But like Ellis, he would become increasingly frustrated with Freudian orthodoxy. Beck put far more faith in empirical research than his analytic colleagues did. His career-shaping epiphany stemmed from an attempt to confirm the dynamic theory of depression, which suggested it was the result of inwardly directed anger. To his surprise, it seemed sadness and passivity were reduced by success but intensified by failure, the opposite of what would be expected if depression was driven by unconscious masochism. It prompted Beck to question the concept of unconscious drives altogether.

Beck took a long sabbatical from the infighting in his department in the mid-1960s but maintained his part-time practice. During this “splendid isolation,” he re-molded analytic thinking to match his clinical data and began to reach out to his psychological colleagues for inspiration and advice (Rosner, 2012, 2014). Beck’s landmark 1967 monograph summarized his findings. Depression was caused by a certain class of its symptoms: the systematic tendency to perceive oneself, the world, and the future – the “cognitive triad” - in an overly negative manner. The basics of treatment involved teaching people to critically scrutinize these negative cognitive schemes to head off their damaging effects.

Both Ellis and Beck extended treatment beyond the consulting room – now a standard part of most psychotherapies – but they did so in different ways. Ellis urged his clients to monitor and progressively act on their new beliefs, while Beck had his clients test the accuracy of their beliefs. Both systems feature a simplified ontology of mind and an optimistic, *forward-looking* faith in our capacity for reinvention. By exploiting our capacity for meta-cognitive reflection, pathogenic thought processes could be brought to the surface and *consciously* ironed out. With a little effort, they could be redirected to reduce or eliminate the troubling

emotions they gave rise to. This hardly required the client to explore how such patterns developed or find any deeper meaning in their suffering.

Beck worked hard to bridge the intellectual space between psychiatry and psychology. By adapting his thinking to that of Ellis, he broadened the application of his approach beyond depression. Beck was soon joined by a range of psychologists with integrative inclinations – including Mahoney, Marvin Goldfried and Don Meichenbaum. Collectively they began to construct the hybrid approach now known as cognitive-behavioral therapy (CBT). Proponents of behavioral therapy had needed new ideas and allies. Significant sections of the American behaviour modification community had tired of the ideological rivalry dividing psychotherapeutics and welcomed Beck and his colleagues into the fold.

As well as being narrow and unwieldy, behavioral techniques had developed something of a public relations problem. Detractors had lambasted them as authoritarian and inhuman, with aversion therapy particularly reviled. The new cognitivism extended behaviour therapy's reach, making the therapeutic process more streamlined, portable, collaborative, and efficacious. More importantly, this new fusion projected a far softer image by packaging cognitive and behavioral techniques in a *volitional* ethos. CBT combined an accessible set of tools with an empowering promise: that we can re-narrate our lives in more productive ways. CBT was attuned to broader cultural values stressing individual autonomy and personal responsibility. But what also distinguished it from competing therapeutic approaches in the US was the way in which it could be synchronized with emerging interdisciplinary trends, especially an evidence-based framework for health services.

The cognitive revolution swept through British psychotherapeutics, with some localized twists. Prior to the arrival of Beck and Ellis, George Kelly's personal construct theory achieved a curiously strong resonance with British clinical psychologists in the 1970s (Parry, 2015). In the 1980s, Anthony Ryle combined Kelly's constructivist ideas with a cognitive translation of object-relations theory to develop a popular short-course approach he called "Cognitive Analytic Therapy" (CAT).

Redefining What Works

Along with Eysenck's wake-up call, insurance companies, government agencies and the new psychotropic drugs put psychotherapists on notice to prove their value. Evaluation research mushroomed, but in a somewhat diverse, disjointed fashion. Methodologies tended to split according to therapeutic approaches. Committed to external outcome measures of symptomatic amelioration, behavioral therapists began to amass evidence for the specific effectiveness of their techniques. Nevertheless, the first well-controlled studies on systematic desensitization did not appear until the mid-1960s (Paul, 1966). Rival talk therapies did their own research using preferred (or convenient) samples, methodological designs, and ratings. Much of this early research was difficult to interpret, low in quality by contemporary standards, and not particularly encouraging in its findings. Eysenck (1966) and his behavioral colleagues remained skeptical. Part of the reason for this was that psychotherapy researchers faced a unique set of practical and ethical difficulties.

Eysenck had foregrounded the baseline comparison issue that made the interpretation of single treatment group designs problematic. They might be the easiest form of research to do, but their value was limited. However, constructing adequate control groups introduced several challenges. Simply using a comparable number of patients on a clinic's waiting list hardly made for fair comparisons. These wait-list patients may differ in systematic ways from treated patients. Wait lists also invoked the dilemma of withholding treatment. Researchers had to find ethical ways to generate randomly assigned, equivalent groups. They also had to confront the suggestion that therapeutic effectiveness may be a *placebo effect* – the result of the inherent care and attention of the clinical context rather than the product of the putatively active ingredients of therapy. To evaluate placebo effects, researchers could assign control subjects to non-specific routine psychological care, or they could take the placebo issue out of the picture by comparing various types of psychotherapy against each other.

By the beginning of the 1970s, researchers had begun to at least partially solve these problems. Two relatively comprehensive *quantitative* reviews cogently argued for the outcome-measured effectiveness of talk therapies based on a range of control group studies (Bergin & Garfield, 1971; Meltzoff & Kornreich). But the most significant breakthrough enabling a more coherent overall assessment of psychotherapeutic efficacy came a few years

later with the advent of meta-analysis, a statistical technique that became standard in psychology, psychiatry, education, and medicine for aggregating across disparate studies.

The idea behind meta-analysis was an old one, but the technique was first formalized by the brilliant American statistician Gene Glass. Smith and Glass's 1977 meta-analytic review was a landmark in the field. They integrated the results of 375 studies, most of which compared psychotherapy to no treatment, and concluded that the typical therapy client was better off than 75% of untreated individuals. Shocking to some, no discernible differences in effectiveness were found between behavioral therapies and the major talk therapies (e.g., Rogerian, psychodynamic, RET and humanistic). The study popularized the "dodo bird verdict," a term first coined by Saul Rosenzweig in 1936. The term was a reference to *Alice in wonderland* in which the dodo bird declares at the end of a race: "*Everybody* has won, and *all* must have prizes." Rosenzweig had suggested all psychotherapies might be equally successful, given all competent therapists would share common features or factors. Proponents of behavior therapy were not swayed by Smith and Glass's results. Eysenck (1978) labelled the method "mega-silliness." He and Rachman and Wilson (1980) suggested meta-analytic results were inflated by averaging and the inclusion of poor studies. But further statistical refinements and re-analyses dispelled these concerns (Landman & Dawes, 1982), and Smith and Glass' effectiveness estimates have stood up reasonably well.

The dodo bird verdict reassured all those with an investment in some form of psychotherapy – except perhaps those who spurned such evaluations altogether. While it tended to license an integrative eclecticism in clinical practice, it left many technical questions unresolved. For example, just because differences between therapies could not be observed did not mean they did not exist for some (or even all) types of complaints. And while various psychotherapies could be shown to work, there was still much to be learned about *how* they worked, not to mention how best to assess this.

The Demise of Psychoanalysis and the Rise of Evidence-Supported Psychotherapy

Psychoanalysts were on the losing end of the fight to make psychotherapy empirically auditable. Those ensconced in university and medical schools found it hard to play the

research grant game and they ignored sleeping diagnostic issues. They found themselves outflanked by the descriptive positivism of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), the product of a renegade group of US psychiatrists led by Robert Spitzer. The seemingly theory-neutral, checklist categories of DSM-III banished the psychodynamic terminology of previous editions, casting the label “neurosis” on the scrapheap. And while DSM-III said almost nothing about etiology, it conveyed an implicit commitment to a biogenetic model. Its appearance in 1980 signaled a changing of the guards within American psychiatry. One by one the psychoanalytically-inclined psychiatrists in key clinical and academic institutions were replaced by a new biogenetic breed that could bring in the research dollars.

At a broader social level, the psychoanalysts suffered in the aftermath of the anti-psychiatry movement of the late 1960s and 1970s that saw them excoriated as paternalistic moral guardians. Philosophers like Karl Popper (1963) and scientists such as Peter Medawar (1975) dismissed psychoanalysis as a pseudo-science, while feminists attacked its patriarchal assumptions. The “memory wars” of the 1990s brought the issue of real versus imagined child sexual abuse to the forefront and made the criticism far more personal. Scholars lined up to attack Freud as an egotistical, ethically-challenged scoundrel who changed his mind, invented evidence and rewrote history to suit his purposes (Crews, 1995; Esterson, 1993).

The vacuum created by the slow demise of psychoanalysis was amply filled by the CBT juggernaut. Ellis and Beck both championed defined outcomes. However, with the support of influential figures such as Gerald Klerman and Morris Parloff, Beck led the way in manualizing CBT with the *Cognitive therapy of depression* (Beck, Rush, Shaw & Emery, 1979), later doing the same with anxiety, personality, and substance use disorders. These manualized and targeted versions of CBT could be aligned with the diagnostic categories of the DSM and integrated within the Randomized Controlled Trial (RCT) methodologies that were rapidly becoming the evaluative ‘gold standard.’ Duly standardized, psychotherapy could be readily included in comparative pharmacological trials. Critics complained that this reduced the status of psychotherapy to that of a drug. But these concessions to a biogenetic model made sure that psychotherapy retained a central place within the rapidly evolving evidence-based framework for medical research and practice (Rosner, 2018).

Manualized therapy also made for more efficient, codified training courses. The road to fully qualified CBT practice was far shorter than for psychoanalytic forms of therapy, for example. It was easier to learn and did not require the same level of supervision, nor a personal training analysis. The cost-effectiveness of CBT enabled its mass roll-out – a crucial factor in the context of public systems like the NHS in the UK, where locally-adapted versions began to be delivered by a range of professionals from the 1970s onwards (Marks, 2012). By the 1990s, various behavioral associations would begin to acknowledge and integrate a diversity of therapeutic approaches under the CBT banner. The British Association of Behavioural Psychotherapies inserted “Cognitive” into their name in 1992, but the American-based Association for (the Advancement of) Behavioral Therapies did not do so until 2004.

Recent Research Developments

Standardization of psychotherapy within an evidence-based framework represented the end of an era. The contemporary emphasis on guidelines mandating empirically supported practice placed constraints on previous forms of innovation. We are less likely to see new therapies derived from the trial and error of clinical practice promoted by their charismatic originators. But despite the dominance of CBT and the emphasis on integration, the field has moved in several creative directions, allowing for a polyvalence in practice. For example, the development of generalized “transdiagnostic” approaches for anxiety disorders has taken place alongside the growth of specific techniques for anxiety-related problems such as eating disorders (Marks, 2012). Older forms of therapy have likewise been made new again, reworked and combined to suit contemporary concerns. For example, “Schema Therapy” draws on humanistic, psychoanalytic and constructivist thinking to treat chronic issues such as personality disorders (Young, Klosko & Weishaar, 2003). Conversely, “third wave” variants of CBT stress commitment and “in-the-moment” mindfulness. With more than a little input from non-Western spiritual traditions, these newer forms of therapy focus on the client’s relationship with their emotions rather than their content (Hayes & Hofmann, 2017). Instead of arguing clients out of their irrationalities or exploring and testing their cognitive wrinkles as a prelude to ironing them out, “third wave” CBT aims to cultivate an attitude of acceptance.

The last two decades have also seen an explosion of highly-specific evaluation research. Critics complain that too many individual studies are done by researchers with commitments to a particular form of therapy or funding sources that invoke conflicts of interest (Coyne & Kok, 2014). While meta-analysis might cancel out some of these biases, the panacea Glass offered in the 1970s has bred its own problems. There are now more meta-analyses of psychotherapy studies than there were individual studies when Smith and Glass did their initial meta-analysis in 1977. To some degree, each new meta-analysis puts a selective spin on the collective wisdom of the literature.

The dodo bird verdict is far from extinct. Various psychotherapies exhibit differential effects, but “common factors” explanations are still very much in play. The efficacy question has been broken into components that has given the internal processes perspective of psychoanalysis renewed relevance. Placebo effects have been divided into extra-therapeutic factors and expectancy effects. This leaves the effects of specific therapy techniques versus common factors such as the therapist’s empathy, warmth and relationship with the client. Typically, the effects of these common “processes” factors have been shown to be more crucial to treatment outcomes than those of specialized techniques (Lambert & Barley, 2001; Wampold, 2015). This research has still left open questions about how therapeutic change occurs, not to mention how permanent such changes are. However, recent research suggests that relapse rates for those treated with CBT are lower than for those given medication (de Maat, Dekker, Schoevers & De Jonghe, 2006). To complicate matters further, some studies have suggested that the overall benefits of psychotherapy, CBT in particular, may have declined over the years (Johnsen & Friberg, 2015; Ljótsson, Hedman, Mattsson & Andersson, 2017). More attention has also been given to the logical possibility that psychotherapeutic changes may not always be for the better (Lilienfeld, 2007). Such negative effects are estimated at 5 to 15 percent (Barlow, 2010; Chow, Wagner, Lüdtke, Trautwein & Roberts, 2017). Ascertaining the circumstances and factors implicated in these negative effects can help safeguard against them and tell us more about why beneficial effects *do* occur.

Economic Influences

Psychotherapy remains an integral part of the health systems across the Western world, mainly as an outpatient or community-based practice. It only ever made a modest impact on inpatient populations, largely because it has had limited success with the severely disturbed. The asylums disappeared for other reasons. They were generally rebadged as “mental hospitals” in the first half of the 20th century and were increasingly seen as shameful. Changes in management policies and new psychotropic drugs began to empty them out in the 1950s, a trend greatly accelerated by the idealism and economic expediency of the de-institutionalization movement of the 1980s and 1990s.

Sociopolitical and financial pressures continue to reshape the way psychotherapy is delivered. In the US, the rise of intermediary health management organizations in the 1990s meant that psychotherapists had to increasingly justify their services in cost/benefit terms, leading to shorter, outcome-oriented treatment courses. Decreasing insurance reimbursement levels also made for dwindling income streams. At the turn of the 21st century, this trend reached a tipping point for American psychiatrists. By 2005, they had all but abandoned talk therapy in favor of high through-put pharmacological treatment. Psychotherapy in the US was left to psychologists and, increasingly, rival paramedical groups like psychiatric nurses and social workers. From 1998 to 2007, the proportion of Americans receiving psychotherapy declined while the considerably higher proportion taking psychiatric medication rose (Olfson & Marcus, 2010). Although these trends are somewhat specific to the American context, they also reflect a global shift in public attitudes toward biogenetic conceptions of mental health (Schomerus *et al.*, 2012). Even so, in 2010 it was estimated that 50% of Americans had received psychological services at some time in their life (DeLeon, Patrick, Kenkel & Garcia-Shelton, 2011).

In most other Western countries, psychotherapists are still expanding their role. In schools and universities, “duty of care” has been broadened to include student well-being, accompanied by a suite of psychotherapeutic services to address perceived problems. Psychotherapeutic services have also been promoted in the public and private employment sectors, increasingly justified on economic grounds. In Britain, for example, the NHS has worked hard to increase access to psychotherapy, largely based on mooted improvements in productivity (Marks, 2012). In Australia, a broadening of government rebates in 2006 made

the services of clinical psychologists more attractive, leading to significant growth in private practice psychotherapy. In the European Union, there has been a strong push to standardize credentialing and training, and to recognize psychotherapy as a distinct professional discipline.

Psychotherapy in Society

Psychotherapy has achieved a primary role in developed societies dominated by the social units of individual and nuclear family. For better or worse, it has largely supplanted the pastoral role of the church and the support networks of extended family and local community – appropriating and formalizing aspects of these older social relationships as an expert professional service (Cushman, 1995).

There is more than a tinge of ambivalence in its public image, however. Cued by Michel Foucault, social theorists have long positioned *psyche* professionals as *disciplinarians* as much as healers, noting the inherent asymmetries in power of the therapeutic relationship. By this rubric, psychotherapy becomes an instrument of social control, a quasi-medicalized means of dealing with those who don't fit prevailing social norms. But the "social control" thesis only had significant traction for some psychotherapeutic practices – such as the coercive treatment of homosexuals, 'difficult' women, and rebellious adolescents – that are now largely a thing of the past. Moreover, this critique was always best directed at the general authority bestowed on *psyche* professionals, rather than therapeutic practices *per se*.

Nonetheless, contemporary commentators have suggested that overt forms of coercion have been replaced by the more subtle neoliberal imperatives: an obligatory self-surveillance oriented to achieving the modern version of happiness and our 'best' lives (Davies, 2016). They argue that in offering a means to these ends, psychotherapy intensifies this inward gaze, defining problems in terms of individual adjustment rather than unjust or pathogenic social circumstances. Certainly, psychotherapists can and do fall prey to larger managerial forces that exploit the narrowness of their professional remit, making the "servants of power" tag hard to completely shake off. But this should not obscure the social transformations psychotherapists *have* helped achieve as a function of the *liberatory* potential

of their work. One way or another, psychotherapy has brought various forms of abuse, bullying and oppression out from the shadows, offering victims a sanctioned idiom to articulate their suffering and redress their fate (Wright, 2011). In tandem with feminism and the articulation of children and minority rights, it has situated emotions and their consequences in the center of public life, putting discredited attitudes and reprehensible behaviour in the dock to face some form of reckoning.

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