Psychotherapy and the Pursuit of Happiness

Ronald W. Dworkin

Freudianism sits alongside Marxism and Darwinism in the pantheon of modern theories held to be so revelatory that they not only gained the adherence of Western intelligentsia but shaped the broader culture. During the first half of the twentieth century, an air of intrigue and mystery hovered around Freud's newly anointed practitioners. Psychotherapists occupied a strange universe, speaking in a language so incomprehensible but seemingly authoritative that it alternately awed and scared the average man on the street.

Psychotherapy is no longer an intellectual movement today as it once was. But in the form of modern professional "caring," it has assumed a new role, which is to provide a peculiar sort of substitute friendship—what we might call "artificial friendship"—for lonely people in a lonely age.

To understand why this occurred and what it means for American culture, we must study the fractious history of the mental health field over the last six decades. It is a complicated story, with a staggering variety of terms, schools, leaders, and techniques, so any overview must necessarily leave out many important details. But from even just a synopsis of the conflicts that gave rise to today's culture of psychotherapy—battles over who would hold the truest title to physician of the mind, tensions between scientists and clinicians, academics and professionals, elites and the public—we can see more clearly how psychotherapy has profoundly shaped the American conception of what happiness is and how we can achieve it.

Disciplines in Conflict

A mental health crisis erupted in the United States after the Second World War, touching not just returning soldiers but people from all walks of life. Alcoholism and juvenile delinquency became rampant. The number of patients admitted to hospitals and outpatient psychiatric

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clinics for mental health problems began to climb rapidly. There were not enough trained mental health personnel—the nation then had only a few thousand clinical psychologists—to deal with the problem. So the federal government responded by passing the National Mental Health Act (NMHA) in 1946, leading to the establishment a few years later of the National Institute of Mental Health and the provision of funding to train more psychotherapists. The new policy represented a genuine attempt to handle the crisis, yet it also brought to the surface important subcurrents and divisions within the mental health community, including skepticism among both academic psychologists and medically trained psychiatrists toward an elevated role for less-trained psychotherapists.

Before proceeding, let us clarify some terminology. It is easy today to conflate psychologists and psychiatrists, psychoanalysis and psychotherapy, and the many other related words used by those who study the mind or seek to treat mental health problems. The vast multiplicity of terms can be daunting and, as we shall see, some definitions and distinctions have grown blurry with time. But if we use the words with care, the contours of our story will be clearer.

Psychotherapy—the therapeutic treatment of individual mental and emotional problems—had fascinated the American people ever since Freud had visited the United States in 1909. Although as late as 1940 no more than four percent of the American population had actually undergone some form of psychotherapy, the public held a generally fixed set of ideas about it, including the belief that *psychoanalysis*—the term used for Freudian psychotherapy, which most people did not distinguish from psychotherapy in general—was a true science.

Psychiatrists are medical doctors; they are trained in biology and anatomy, and like other medical doctors can prescribe drugs. At the start of the twentieth century, most American psychiatrists had worked as superintendents in state mental hospitals and held a biological view of mental illness. Only a third of all psychiatrists offered psychoanalysis in private practice by the 1940s. Nevertheless, the great majority of psychoanalysts at the time were psychiatrists. The medical establishment had made a concerted effort to cleanse America of non-M.D. psychoanalysts, with the result that by 1953, 82 percent of the country's psychoanalysts were psychiatrists. The government's plan to boost rapidly the number of psychotherapists threatened both biology-minded psychiatrists and psychiatrists practicing psychoanalysis. It was unlikely that the number of medically trained psychiatrists could be raised sufficiently to meet the demand for psychotherapists—in the 1950s there were only 10,000 psychiatrists in the United States, with

just 450 new graduates each year—so government support for psychotherapy necessarily meant more non-M.D. therapists.

Psychologists are not medical doctors; they pursue graduate training in psychology, generally obtaining an advanced non-medical degree. In the 1950s, the majority of psychologists were academics working in college labs. Indeed, the public idea of a psychologist was a man in a white coat testing rats in a maze. Treating unhappy people with psychotherapy was as foreign and threatening to these scientists as it was to the biologically oriented psychiatrists.

Academic psychologists had spent decades cultivating the aura of the research scientist while deprecating the role of *clinical psychologists*—that is, those psychologists who actually worked with patients. A minority within psychology, consisting mostly of women and handicapped by a "nursing image," clinical psychologists had spent forty years working under psychiatrists, performing tests on patients, but deferring to psychiatrists on diagnosis and treatment. Many of them were idealists who dreamed of a new social order with psychotherapy at its core, dreams inspired by Freud and his followers. Although academic psychologists didn't begrudge the masses their therapists, they looked down on clinical psychologists, believing that the title of "psychologist" should be reserved for people who had been taught the scientific method in the finest schools. The notion that psychotherapists might be granted parity in the public mind with real professors of psychology was worrisome to these academics.

Indeed, no group of mental health workers stood to benefit more from the federal government's new mental-health policy than the clinical psychologists. Hoping to practice psychotherapy on their own, without restrictions or physician supervision, clinical psychologists saw opportunity in the new push by the government to increase the numbers of psychotherapists.

Inevitably, the NMHA brought psychiatrists and clinical psychologists into conflict. No state laws forbade psychologists from practicing psychotherapy on their own, but the courts tended to interpret medical licensing statutes broadly, so a clinical psychologist practiced psychotherapy at some risk. Yet the increasing demand for mental health clinicians changed the dynamic. Clinical psychologists decided to test the limits of the law, and by the early 1950s, nine percent of clinical psychologists were practicing on their own.

Psychiatrists fought back, arguing that psychologists lacked the training to detect severe mental illness, while academic psychologists, who

resented the popularity of psychoanalysis, attacked the field by arguing that it was unscientific compared to the then-reigning paradigm of behaviorism. Clinical psychologists, however, began working to popularize psychotherapy among the general public. During the 1950s, many major American newspapers began carrying regular columns on psychological lore, typically written by a psychologist. In popular women's magazines like *McCall's* and *Cosmopolitan*, psychologists demystified the therapeutic process. In 1958, a young Joyce Brothers, who held a Ph.D. in psychology from Cornell, hosted the first television show devoted to people's emotional and psychological problems.

The popular rise of psychotherapy was intertwined with the popular rise of psychoanalysis. Freudian ideas had been popular with intellectuals and artists in the 1920s, but it was not until the 1950s, with the crisis in mental health, that they widely penetrated the public consciousness. Although few clinical psychologists of this era practiced Freudian psychoanalysis, they distilled Freud's ideas into buzzwords, which appeared frequently in their conversations, writings, and speeches, thereby tapping into the public consciousness and identifying with people's concerns. Journalists of the time wrote about infatuation and subliminal influences. A social worker visiting a family would look for unhealthy parent-child relationships and refer to the Oedipus complex. A probation officer, even a truant officer, would discuss a juvenile delinquent's family background in the context of aggression and compensation. Freudian concepts saturated popular movies, such as *Marnie* and *The Three Faces of Eve*. Clinical psychologists and the public were in sync.

This democratic exercise further disturbed psychiatrists and academic psychologists, who disliked popular interference into what they saw as purely scientific matters. Yet neither discipline was able to restrain the growth of clinical psychology; the public demand for therapists was simply too great. People increasingly saw clinical psychologists as a reasonable alternative to psychiatrists. By one estimate, fourteen percent of the American population had undergone some form of psychotherapy by 1957, most of it performed by practitioners without a medical degree.

But clinical psychology did not emerge from this shift on entirely stable footing. There was a growing wariness that psychotherapy might be, at best, inert. Most psychotherapy of the 1950s and 1960s just seemed to explain problems, or to give them fancy Freudian names, rather than to solve them. Long therapy sessions often went nowhere. Even important clinical psychologists voiced their doubts. In 1952, psychologist Hans Eysenck published a famous article claiming that patients' conditions

were about as likely to improve whether they received psychotherapy or not, and that most improved on their own.

That clinical psychologists emulated some of the ways of medical doctors may have put a further drag on their image. In 1949, at a major conference in Boulder, Colorado, clinical psychologists had established guidelines that accepted the medical model of mental illness and required future candidates for their profession to earn a Ph.D. But some clients feared that going to a "mind doctor" for an everyday life problem implied they were sick or crazy. Critics and even some anxious patients began to derogatorily refer to therapists as "shrinks" (a slang term shortened from "head-shrinkers"). During the 1960s, the field of psychotherapy began to take on a sinister aura in the minds of some, as social activists accused psychotherapists of "adjusting" patients to conform to the rhythm of a capitalist society with middle-class values.

From the 1950s to the mid-1960s, the relationship between organized psychiatry and clinical psychology assumed the form of a duel. But the real threat to clinical psychologists came from the public's love-hate relationship with psychotherapy. By the 1960s, many Americans were souring on the discipline. To survive, psychotherapy would have to become more relevant to people's everyday lives, and therapists would have to become less disinterested scientist and more interested friend.

The Rise of Short-Term Psychotherapy

The mental health crisis of the 1950s continued into the 1960s. In remarks he recorded on February 5, 1963, President Kennedy emphasized the need to get people out of mental institutions and "back into their communities and homes." Later that year he signed into law the Community Mental Health Act (CMHA), which sought to deinstitutionalize mental health care.

Psychiatrists and psychologists heeded the president's call, adding "community psychiatry" and "community psychology" to their respective lists of hospital departments. All the while, each profession stood guard over its established therapeutic paradigms—psychoanalytic, cognitive, behavioral, and humanistic; these were the springs from which psychiatry and psychology drew their strength.

Yet a shift in the balance of power in mental health suggested that the experts were not as in control as they thought. By 1962, nearly twenty states had recognized the right of clinical psychologists to practice independently. But with the ongoing mental health crisis, government saw

meeting the demand for mental health workers in the new community mental health centers as more important than the turf wars between psychiatry and clinical psychology. Where psychiatrists were available, officials put them in charge; where they were not, they put clinical psychologists in charge; and to meet other staffing needs they tapped the country's growing supply of social workers and counselors working in mental health.

Mental health social workers and counselors had long been delivering psychotherapy informally. Social workers had avoided running afoul of the law by calling their psychotherapy "social casework." Social workers had adopted psychotherapy in the 1920s to help establish themselves as professionals, and to be able to deliver a needed service to the better-paying middle-class. By 1963, as John H. Ehrenreich notes in *The Altruistic Imagination: A History of Social Work and Social Policy in the United States* (1985), five percent of social workers had private practices.

Counselors had taken a similar path. During the first half of the twentieth century, most counselors offered vocational guidance in non-medical settings. Like clinical psychologists and mental health social workers, they quickly discovered the professional value of being associated with psychotherapy, and of being titled. A few years after the Boulder conference established the scientist-practitioner model in clinical psychology, counselors applied the same model to counseling psychology, deciding on the same Ph.D. requirement, although an alternative master's-level program was also added.

Although geared toward the truly sick, community mental health centers quickly became places where Americans suffering from everyday unhappiness went for help, giving millions of Americans their first exposure to psychotherapy. And clinicians soon realized that their clients wanted something very specific: they wanted a professional to solve their problems—not just explain them—and to do so quickly. The professionals working in these centers had their own ideas about how to treat patients, but they found themselves yielding to public pressure and modifying their therapy, with no official paradigm or school of thought to guide them. Time constraints alone were enough to force their hand, as hundreds of daily walk-ins put limits on how long any individual therapist at a center could meet with a patient. Whether they wanted to or not, these professionals began to practice a new technique to solve people's problems: *short-term psychotherapy*, generally defined as therapy lasting twenty sessions or less.

Since Freud's day, psychotherapy had generally been a slow, ongoing process of self-reflection and transformation, often requiring many ses-

sions over years. Experiments with short-term therapy first began during the exigencies of World War II, when government needed to return battled-scarred soldiers to the front as soon as possible. But the real boom in short-term psychotherapy came with the growth of those community mental health centers in the 1960s. It represented an ad hoc response to the public's urgent needs rather than an expert-driven application of abstruse theory—indeed, it grew out of a defiance of the experts.

In the past, psychologists might have followed one of their own—a seductive prophet after whom they would romantically name a new school to add to the literally hundreds of schools of psychotherapy. At the very least, they would pick a flowery name capturing the school's philosophical or perhaps quasi-religious aspects, such as "humanistic" or "existential." The experience in the community mental health centers upset this pattern. The humdrum name of short-term psychotherapy captured the impromptu origin of the discipline. Its first clients were people who failed to keep their follow-up appointments. Experts assumed these people had not gotten along with their therapists; only later did they discover that many of them just thought their problems had been solved after one or two sessions, and saw no reason to come back.

Most psychiatrists and clinical psychologists at the time viewed short-term psychotherapy with contempt. Many still do. Therapists trained in long-term techniques, especially Freudian psychoanalysis, scoff at the idea that anything significant can be accomplished in so few sessions, instead insisting that long-term therapy remains the gold standard. Short-term therapists tend to take a client's self-described problem at face value; they believe using common sense and good humor to fix a client's problem—in the fashion of a friend—is a legitimate goal of therapy. They think significant psychological change can occur in the experience of day-to-day living by simply behaving or thinking differently. Long-term therapists believe no real change can occur on this level.

The dramatic increase in the number of therapists that began in the 1950s only accelerated in the 1960s, with one study reporting an eightfold rise in the number of psychologists involved in mental health between 1950 and 1975. Yet the fact that most of the new therapists practiced some form of short-term psychotherapy attests not to the triumph of these professionals but to the public's increasing control over them. People didn't just want their problems explained; they wanted them solved. And in essence, they got what they wanted.

Short-term psychotherapy represents a democratic invasion of the therapists' interests. What began in community mental health centers

quickly spread across the country. Americans were increasingly replacing their traditional problem-solvers—friends and confidantes—with short-term psychotherapists.

The New Ethos of "Caring"

By the end of the 1970s, the mental health crisis that began in the 1950s had entered a new phase. In the 1950s, observers of the mental health landscape felt that much of what underlay people's negative feelings was their fear of what others thought of them. By the 1970s, the focus on feelings of agitation and nervousness had given way to a view of melancholy, quiet despair, and loneliness. As Vance Packard argued in his 1972 book *A Nation of Strangers*, people's social networks were collapsing. Loneliness was on the rise, compounding the effects of depression. In April 1979, America's most popular psychology magazine, *Psychology Today*, proclaimed the dawn of the new Age of Depression.

At the same time, psychoactive drugs were joining psychotherapy as a growing solution to the nation's ongoing mental health problems. By 1972, an estimated 13 percent of men and 29 percent of women were using some kind of prescription psychotherapeutic drug. One of the decisive factors underlying this aggressive prescription behavior was a rather revolutionary new belief: even without definitive proof, primary-care doctors and the public alike had decided that unhappiness, even in some cases everyday unhappiness, was the result of a chemical imbalance in the brain—which drugs could fix.

Notwithstanding the ever-increasing numbers of therapists and the fact that clinical psychologists were by 1977 permitted to practice psychotherapy on their own in all fifty states, psychiatrists became convinced that psychotherapy was finished: the seemingly miraculous effects of Valium—the top-selling pharmaceutical in the United States through the entire decade of the 1970s—convinced psychiatrists that their future lay in prescribing drugs. They became less concerned about clinical psychologists and social workers practicing therapy on their own; if anything, they enjoyed the prospect of those interlopers chained to the condemned method while they themselves were free to explore psychopharmacology.

Meanwhile, clinical psychologists, who were unable to prescribe drugs, relied exclusively on the talking cure and viewed drug therapy for unhappiness as a threat—with some actively fighting the drug trend. Recognizing that primary-care doctors were giving unhappy patients not just drugs but also ostensibly medical and philosophical justification for

using them, psychotherapists realized they would have to reconnect with people in their own way. This included easing the average person's fear of being "adjusted" by "shrinks." The threat posed by Valium was not simply a problem of professional turf, but a broader struggle over the meaning and nature of human unhappiness. Primary-care doctors offered a vision of mental illness as a problem of neurotransmitters; psychotherapists sought to offer a compelling vision of their own—one that would dispel people's anxieties about psychotherapy while putting the need for therapeutic conversation back into people's lives.

The new vision required an image change for psychotherapy. The detached scientist-therapist had to become a warm and caring friend. Toward this end, clinical psychologists created non-university-based psychology degree programs, the first being the California School of Professional Psychology, which opened its doors in 1969. Though these programs preserved the title of "doctor," science took a back seat to clinical training, with the professional school graduate oriented less toward research and more toward people than his university counterpart. Within three decades these programs were graduating twice as many clinical psychologists as traditional Ph.D. programs.

Much as they had engaged in a broader philosophical struggle with psychiatry during the 1950s, therapists in the 1970s sought to counter the increasingly predominant view within primary care that unhappiness was biochemical in nature, and the best treatment for it pharmaceutical. Clinical psychologists, counselors, and social workers who performed therapy worked together to promote a rival view, changing their image to that of the caring professional. They began to present themselves less as disinterested scientists and more as "caregivers" eager to talk to patients about their everyday problems—unlike doctors, who just wanted to drug them.

Leaving behind Freudian psychology was a key part of this shift. When clinical psychologists used complex Freudian terms to describe everyday problems, they sounded more like scientists attempting to explain people's problems—perhaps in some sense explain them away—and less like caring friends who could help solve them. By drawing on non-Freudian traditions, clinical psychologists built a simpler vocabulary to connect with average people.

Two of the most important words in the new vocabulary were "self-esteem" and "stress." Psychologists and psychiatrists had spoken these words for years, but they were not in general use by the public. The rapid appearance of these words in the public lexicon in the 1970s is as significant

as the earlier rise of Freudian terminology. It is certainly true that these words and the feelings they expressed existed before the 1970s—"self-esteem," for example, entered the English dictionary in the seventeenth century. But for the public to make buzzwords out of these terms meant that the problems they named had stopped being part of the normal back-drop of life and become serious cultural, even political, issues. James L. Nolan, in *The Therapeutic State* (1998), notes that self-esteem would soon become a commonplace subject in regulations issued by the Department of Health and Human Services, the Department of Education, and other federal agencies. By leaving the bounds of psychotherapy and entering the popular realm, these words became part of an emerging worldview. In the new Age of Depression, people came to believe that the good life consisted of high self-esteem and a stress-free existence.

Although clinical psychologists helped to build the new vocabulary, that vocabulary was not consciously contrived. Indeed, the terms "self-esteem" and "stress" touched a chord among Americans almost in spite of professional psychology, not because of it. During the entire decade of the 1970s, when the new vocabulary seemed to be seeping into the nation's water supply, *Psychology Today*—a magazine that often discussed humanistic psychology favorably—published only a single article on "self-esteem." The magazine published a few articles on "stress," but those dealt with the body's response to living at high altitudes or under water, not with the problems of everyday life. The first article on emotional stress (as a cause of sudden death) appeared in 1977.

The popularization of self-esteem, stress, and related ideas was not simply the work of the clinical psychologists who employed the terms professionally. It represented an ideological shift in American society. Whether the words an ideology uses are esoteric or common, the content must express the interests and aspirations of the people to which it is directed. The new "caring" ideology did just this. Many Americans in the 1970s had depressive symptoms or suffered from the psychological toils of everyday life, but for various reasons lacked anyone in whom to confide their troubles. Talk of stress and self-esteem helped convince people that therapists understood their concerns and wanted to help them.

Starting in the 1970s, the public conception of clinical psychologists, counselors, and social workers began to coalesce into a single charac-ter type: the caring professional. Social workers and counselors who worked in mental health began to align themselves more closely with clinical psychologists, thereby laying the groundwork for the emerg-ing caring industry. For example, the term "clinical social worker" came

into common parlance as a way to identify social workers doing work in mental health. The term signified a new consciousness among these professionals that they were somehow different from general social workers, and more like clinical psychologists. A similar trend occurred in counseling. In 1976, mental health counselors broke off from the American Counselors Association to create the American Mental Health Counselors Association.

As clinical social workers and counselors began integrating themselves into the caring industry, organized psychiatry began its long decline. The role of psychiatrists in dispensing psychoactive drugs was increasingly being ceded to primary-care doctors, and they had long since relinquished psychotherapy, the basis of the emerging caring industry. Instead, many psychiatrists were destined for relatively minor roles under the emerging realities of *managed care*, a system in which health care costs are reduced by bringing together panels or networks of health care providers. (Many Americans today are familiar with HMOs, PPOs, and IPAs—different kinds of approaches to managed care.) Under managed care, psychiatrists became little more than medication managers, signing off on a patient's drug prescription after a therapy session with a non-M.D. therapist had failed. Not surprisingly, the number of psychiatrists increased only modestly over the next few decades, in contrast with the explosive growth among clinical psychologists, clinical social workers, and counselors.

Academic psychologists, too, felt sidelined by the rise of the caring ethos. The non-university-based psychology degree programs infuriated them. They spent the next four decades ridiculing clinical psychology, trying to return the discipline to its scientific roots. Indeed, the clinical psychologist today is not entirely different from the caricature painted by the profession's academic critics: earnest, well-intentioned, subjective, and imprecise. Yet academic psychologists err in assuming that clinical psychology is still a branch of psychology, and therefore of science. It is not. Professional psychology and the caring ethos are part of a larger social movement whose purpose is to help unhappy people feel better in a lonely world. While academic psychologists may scoff at so imprecise a notion as "feeling better," clinical psychologists, being more ideologically minded, know that it has a powerful appeal.

Many histories of psychotherapy dwell on the bizarre, sometimes outrageous, therapeutic fads of the 1970s. But focusing on these fads distracts from the broader history of psychotherapy—not because these fads faded quickly, but because doing so obscures the rise of the caring ethos that was occurring at the same time. By 1980, although some Americans were still

screaming their aggressions away, or engaging in orgies to find their true selves—and thereby grabbing the headlines—the less exciting but more enduring fact had been realized: most mental health therapy in the United States had become short-term psychotherapy. Americans were no longer going to "shrinks," but, rather, to caring professionals.

Just who was dispensing this psychotherapy grew increasingly irrelevant, as the basic structure of a short-term therapy session was the same regardless of whether the therapist was a psychologist, a social worker, or a counselor. By 1989, more clinical social workers were performing therapy than were psychiatrists or psychologists. Helping people solve their everyday problems characterized much of this therapy. Increasingly scarce were the metaphysical doctrines, laid down with certitude by solemn psychotherapists with European names. Gone, too, were the sectarian differences, the innumerable delicate distinctions between schools that therapists once drew with an ideological fervor. Now it was: "How are you feeling about your divorce?" or "Is your husband finally sharing in the housework?"

A psychologist's confession confirms the change. When I asked him to explain the difference between psychotherapy and everyday counseling, he replied: "I don't know. I really don't. I am the chairman of a major department of psychology, and even I don't know the difference anymore."

Years of Consolidation

The rise of managed care helped to turn an established trend in American culture—the rise of loneliness, depression, and other mental health ills, along with short-term psychotherapy as the preferred remedy—into a new industry. Managed care grew rapidly in the 1980s and 1990s to contain runaway medical costs. As researchers noted in the journal *Health Affairs*, total enrollment in managed-care mental health programs in the year 2000 was 169 million—higher, in fact, than enrollment in the non-mental-health sector of managed care. The rise of managed care did not really change the degree of access to mental health care; rather, it changed the nature of that care. A 2002 article in *The American Journal of Psychiatry* shows that managed care accelerated the trend toward fewer psychotherapy sessions, with patients receiving six sessions on average, and one third of patients receiving only one or two sessions. It also reduced the time for an individual session. In 1988, the average therapy session lasted 55 minutes; in 2002, under managed care, the average was only 34 minutes.

The trend toward short-term psychotherapy began before the rise of managed care; the real insight of managed care was in recognizing the

trend's cultural significance. Ever attuned to public opinion, managed-care executives realized that the therapist in American life had become a substitute friend for unhappy people. They realized this even before many psychologists did. *Psychology Today* did not run its first piece on short-term psychotherapy until 1981, although short-term psychotherapy had already been dominant for years. Even then, the piece was mildly critical, expressing doubt about the method's future.

Managed care's embrace of short-term psychotherapy was based more on practical contingencies than science. Though providing a caring professional to people with mental health ills seemed intuitively reasonable from a social perspective, from a scientific perspective it was a leap of faith. There was no real proof of the efficacy of short-term therapy by the time the managed-care revolution was underway in the 1980s and 1990s; most of the studies conducted up to that time were flawed. Indeed, as of 2000, as an analysis in the journal *Family Process* notes, only a few studies meeting strict methodological criteria had rigorously scrutinized short-term therapy—despite the fact that it had become and is now the dominant form of therapy. Managed-care executives bet on the method because it saved money and because customers wanted it, not because it was known to be effective. They grasped the shared sentiments of the American people, and the essence of what psychotherapy had become.

Despite initial misgivings—worries that managed-care administrators would push cheap drugs at the expense of therapy—most psychotherapists eventually fell in line, mollified by the administrators' support of short-term psychotherapy. Still, managed care would only pay for psychological services that "did something." Otherwise, the executives argued, what was the point? This is one origin of what became the new mental health emphasis on how people feel: a managed care customer goes to a caring professional feeling bad, and leaves feeling good. Since feelings were much easier to measure in a client than abstract psychological criteria determined by the therapist, starting in the 1980s, improvement in feeling became the standard against which all therapeutic methods were judged. The result was an entirely new literature within psychology called "empirically supported treatments," which enabled therapies to be judged according to whether they made clients feel better.

Since the purpose of long-term psychoanalysis is self-examination as opposed to "feeling better," psychoanalysis scored poorly, and managed care refused to pay for it, calling it "personal enrichment" as opposed to real therapy. Managed care's distaste for psychoanalysis was partly motivated by profit, but managed-care executives also shared the layman's

instinctive aversion to the arcane practices of psychoanalysis that sometimes bordered on superstition. It was only natural that they should see in the innumerable obscure distinctions of psychoanalysis a manifestation of the inherent falsehood of Freudian doctrine. Managed care executives wanted to turn mental health into a commodious institution, a kind of happy home where people might enjoy artificial friendship—and over-intellectual egotists who think dark thoughts in a language that average people cannot understand do not make for a happy home.

Since managed-care executives understood that therapists were now more friends than scientists, they downgraded the importance of scientific expertise when deciding which professionals to hire into their health care panels and networks. They extended billing privileges to clinical social workers and mental health counselors, paying them less than they paid psychologists and psychiatrists. The number of clinical social workers exploded, turning these professionals into the core of managed-care mental health. Indeed, social workers provide the majority of psychotherapy in the United States today. Managed care would go on to add additional layers of non-M.D. therapists in the form of marriage and family therapists and nurse psychotherapists.

Psychotherapy Comes Down to Earth

Psychotherapy has undergone a great transformation since America's mental health crisis began. Gone are the days when therapists were dedicated to the doctrines of Freud and Jung, when the field was suffused with an air of priestly sanctity, heavy with the odors of tradition and authority. In the old days, psychotherapists constructed vast philosophical fabrics out of the writings of visionaries. They dallied with ideas that bordered on philosophy and religion; their emotional natures were totally absorbed in the partisan passions of their analytic cliques; their subtle intellects concerned themselves with the dialectical splitting of dogmatic hairs. The words they used—id, ego, and superego, among many others—seemed like a transcendent manifestation of divine power, an example of humanity being vouchsafed glimpses of eternal truth flowing down through an elaborate and immense cascade of books, with individual therapists stretching back, through their pedigree of technique, to some godhead. A whole universe of understanding was brought about by means of these words. In this universe the therapist was not as his clients, but, instead, a creature apart.

In the past few decades, a new breed of therapist has emerged—sympathetic, friendly, lighthearted, warm, and caring. His therapeutic

style bears everywhere upon it the signs of human imperfection. It is the outcome of efficiency and practicality, of the exigencies of business executives and the ambitions of professionals, of the preferences of society and of the necessities of unhappy people. Gone is the transcendent manifestation, the abracadabra of therapy. Gone are the fervors of piety, the zeal of disciples, and the enthusiasm of intellectuals imagining themselves to have discovered a new theory of human nature.

Once a consecrated priesthood, therapists today walk along the smooth road of ordinary duty. They help people with their everyday problems. They speak in a casual manner and even crack jokes. They are friendly. They smile. They differ neither outwardly nor inwardly from the clients they serve, for whom therapy has become a useful organization, a convenient and respectable appendage to existence, a sometimes necessary form of artificial friendship.