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The Futility of Psychotherapy

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While psychotherapy is helpful to individual clients, the slim cadre of therapists and the vast number of disturbed people precludes any hope that more than a relative few will receive help. Nowhere is the futility of psychotherapy as obvious as among the poor and powerless whose suffering, crowding, and despair will yield only to social and political solutions. In the United States the expansion of the number of psychiatric diagnoses and the demographic changes in populations will only make larger the gap in numbers between therapists and clients. Psychotherapy is an expensive oddity to the poor, but their taxes will help the affluent obtain prepaid care. Psychotherapy does reveal some of the social and economic factors, like bad parenting, homelessness and unemployment, that cause emotional disturbances. But one-to-one treatment, medical or psychological, does not, and cannot, affect incidence. The rightward movement of American psychiatry, supported by political conservatives and by activist parent-citizens groups, espouses an organic explanatory model for all mental disorders and for a wide range of human problems. Only effective primary prevention leading to social change will reduce future incidence.

Back at the beginning of the "Age of the Psychotherapist," Raimy (1950, p. 3) defined therapy as: an "unidentified technique applied to unspecified problems with unpredictable outcomes." And, he added, "for which long and rigorous training is required!" In the intervening decades a veritable flood of training programs, workshops, demonstrations, articles and books has modified only modestly this description. Now Strupp (1986) says: "Psychotherapy has become a billion-dollar industry . . . lacking clear boundaries, with hazy quality control and relatively vague ethical standards . . . the training of professional therapists remains fairly heterogenous, unsystematic, and in many cases, insufficiently thorough" (p. 121).

The most compelling arguments against psychotherapy do not start by questioning its effectiveness. The early, and frequently quoted, criticisms of therapy

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by Eysenck (1952, 1964) have been adequately refuted (Meehl, 1965; VandenBos, 1986). A major review of the efficacy of therapy was done by Saxe (1980) who found overall positive outcomes. Rather, a more critical problem, after accepting the evidence that psychotherapy is often effective in reducing anxiety and developing more effective and mature social relationships, is the unbridgeable gap between the enormous number of people with serious emotional problems and the small number of therapists available. The prospect is slim for developing a sufficiently large cadre of therapists to increase significantly the present barely perceptible impact on demand (see Kiesler and Sibulkin, 1987). Further, as the history of public health methods (that emphasize social change) has clearly established, no mass disease or disorder afflicting humankind has ever been eliminated by attempts at treating affected individuals. Changing the incidence of emotional disorders will require large scale political and social changes affecting the rates of injustice, powerlessness, and exploitation, none of which is affected by individual psychotherapy. These bed-rock facts make futile a reliance on therapy to affect directly the incidence of both physical and mental disorders. Yet individual treatment remains the focus of medicine, psychiatry, clinical psychology, and social work.

The American focus on psychotherapy was made "official" in the final report (*Action for Mental Health*) to the United States Congress of the Joint Commission on Mental Illness and Health (1960). The Commission proposed that hundreds of new Community Mental Health Centers be built, offering services focusing on individual treatment. Grudging acceptance in the report of psychotherapeutic practice by psychologists and social workers in the Centers was occasioned by the chronic shortage of psychiatrists. But it was psychotherapy that was to be the "backbone of treatment" (see Glasscote, Sanders, Forstenzer, and Foley, 1964). Fifteen years later Henderson (1975) was still arguing that ". . . help is therapy not prevention. Early therapy by all means, thorough therapy if at all possible, but above all *therapy*" (p. 243).

How Many Disturbed People?

A recent major epidemiological investigation funded by the National Institute for Mental Health (NIMH) illustrates the startling dimensions of the problems commonly defined as mental disorders (see Regier, Myers, Kramer, Robins, Blazer, Hough, Eaton, and Locke, 1984). On the basis of this study nineteen percent of the adult population of the United States is believed to have a diagnosable mental/emotional condition. The NIMH study is a major contribution of psychiatric epidemiology, but many of the problems remain that have always faced epidemiologists trying to count past the present mental conditions. Computer-generated DSM-III (American Psychiatric Association, 1980) diagnoses were made on the basis of what people could remember

or were willing to reveal to interviewers about their use of alcohol and drugs, and about their fears, delusions, anxieties, depressions, and anger. Women – probably because they were more likely to be home when the interviewers visited, or were more willing to be interviewed – were overrepresented in the sample. Institutionalized people were not included, nor were the homeless. Other sources of error included the fact that older interviewees remembered fewer emotional crises than did younger persons; if someone could not complete an interview, the interviewer asked someone else about the person; no attempt was made to differentiate among the various kinds of organic mental disorders; there was a significant number of refusals.

The study did not explore the presence of many of the conditions contained in the DSM-III. For example, "psychosexual dysfunctions" that are said to affect nearly a quarter of the adult population were not investigated, probably because it was decided that people would be reluctant to discuss their sex problems with interviewers they were seeing only once. To push the adult prevalence figure to its ultimate absurdity, we could add in the well-established clinical observation that, on the average, three other people are strongly distressed by each person with a serious emotional problem. Pull all these numbers together and we might end up with more mental disorders, serious and otherwise, than there are people in the United States (see Albee, 1985).

The Expansion of Disorders and Diagnoses

Kramer (1983) has raised some important and alarming questions about what he calls "the rising pandemic of mental disorders" throughout the world. He points out that the United States faces, in the decades immediately ahead, a steadily increasing prevalence rate of both serious mental disorders like "schizophrenia" and diseases involving hypertension and cerebrovascular accidents. The growth in frequency of these conditions will result from the large increase in the numbers of persons in those age groups that are at highest risk for their occurrence, as well as the steadily increasing duration of chronic conditions resulting from the development of medical techniques for prolonging the lives of affected individuals. Further, more people, throughout the world, are living into middle and old age, and at the same time high birth rates continue to produce crowded cities, undernourishment, and despair, so physical and mental problems of both adults and children proliferate. And now we learn that the AIDS virus is attracted to brain tissue and often leads to dementia, with further demands for neuropsychiatric and neuropsychological interventions, in short supply or unavailable in much of the world.

A related problem involves the continuing expansion of the number of conditions identified as "psychiatric disorders." About every decade or so, the American Psychiatric Association (1952, 1968, 1980, 1987) publishes a *Diagnostic*

and Statistical Manual of Mental Disorders (DSM). The first DSM, published in 1952, listed 60 types and subtypes of mental illness. Sixteen years later, DSM II more than doubled the number of disorders. The number of disorders grew to more than 200 with DSM III in 1980. The current guide, DSM III-R (1987), includes tobacco dependence, developmental disorders and sexual dysfunctions, school learning problems, and adolescent rebellion disorders. DSM IV (in preparation) will add more disorders. Clearly the more of the ordinary human problems in living that are labeled "mental illnesses," the more people will be found who suffer from at least one of them – and, a cynic might add, the more conditions that therapists can treat and for which they can collect health-insurance payments.

From DSM II to DSM III, several conditions ceased to exist as officially recognized mental disorders. Traditional neuroses no longer exist; their numerous manifestations have been dropped or included in other DSM-III classifications. As the neuroses were primarily a Freudian, psychodynamic construction, rooted in alleged problems resulting from bad parenting, the biological psychiatrists, now in control of the field, threw them out. The decision in 1973 by the American Psychiatric Association to remove "homosexuality" from its list of mental disorders lowered overnight by many millions the total number of Americans considered mentally ill. However, the *International Classification of Diseases* (ICD-9, 1989) of the World Health Organization still includes homosexual behavior as a disease. The decision by the National Association for Retarded Citizens to make a 70 IQ rather than an 80 IQ the cutoff point for defining mental retardation reduced by millions the number of retarded Americans.

Clearly, most "mental disorders" are different from real organic illnesses. In mental disorders there is ordinarily no physical marker that can be identified by objective tests and only the most vague beginning or ending is discernable. Most mental disorders are based solely on a judgment about behavior. Wootton (1959) pointed out that the diagnosis of "mental illness" nearly always requires a social judgment:

> . . . anti-social behavior is the precipitating factor that leads to mental treatment. But at the same time the fact of the illness is itself inferred from this behavior; indeed it is almost true to say that the illness is the behavior for which it is also the excuse. But any disease, the morbidity of which is established only by the social failure that it involves, must rank as fundamentally different from those with which the symptoms are independent of social norms. (p. 225)

While most "mental illnesses" are really learned patterns of disturbed behavior for which psychotherapy is more helpful than organic treatment, it is only necessary to look carefully at the prevalence data – nearly one in five American adults exhibits disturbed behavior – to see the futility of relying on individual intervention by individual therapists.

How Many Therapists Are There?

The public is regularly misinformed about the availablity of therapy. Each week Ann Landers, and other popular advisors, suggest counseling and therapy as the solution to individual problems described in letters from readers. Even as scientifically sophisticated a writer as Jane Brody (1981) can be misinformed, and therby misinform her readers, about the availability of help. In a *New York Times* article she stated that 34 million Americans are in psychotherapy. She was wrong. Probably no more than 1½ million are actually in therapy (see Albee, 1985) at any given time. To treat 34 million clients would require a 20-fold increase in the currently existing number of therapists. No foreseeable increase of this magnitude is in prospect.

How many therapists actually are available for the vast sea of troubled people? Kiesler and Sibulkin (1987, p. 812) have calculated the total number of (full-time equivalent) therapists in the United States to be about 45,000. This may be a conservative estimate but even if we add to this figure the unlicensed and unregulated personal counselors, yoga instructors, teachers of meditation, pastoral counselors, and school guidance personnel, we have only doubled or tripled the total number of licensed and unlicensed interventionists for people with personal problems. So one conventional argument for the futility of psychotherapy is the unbridgeable gap between need and available resources. Enormous sums of money spent on treating the few might be better spent on other interventions affecting more people. Self-help groups, for example, reach many times the number seen in individual therapy (see Silverman, 1978, and also the *Surgeon General's Workshop on Self Help and Public Health*, 1987, for optimistic examples of groups of people helping each other in support groups). But we must remind ourselves that even if there were twenty times as many psychotherapists there would be no reduction in the incidence of problems, a majority of which are caused by poverty, powerlessness, exploitation and social injustice (see Joffe and Albee, 1981).

Our American fixation on high technology individual medical treatment is as irrelevant and as tragic as our fixation on individual psychotherapy. It is simply not credible to suggest that "spare parts" of bodies (from "organ donors") and mechanical body organ devices (artificial hearts) are the most promising medical treatments of the future in a world in which millions die of the infectious diseases of childhood and the specter of mass starvation haunts much of humankind. Fifteen million of the world's children die each year of preventable conditions like infant diarrhea from polluted water, infectious diseases and starvation. Four hundred million women live in regions where the soil is deficient in iodine and as a result give birth to retarded children. The rate of epilepsy is high in the third world from too much lead and too little iron (Musarrat, 1988). Millions of children live with preventable handicaps – the underdeveloped, malnourished bodies and minds.

Part of the logic of this irrational American medical effort reflects the "industrial machine model" of the human body that, like other machines, is seen as an interacting mechanical system where parts are damaged or wear out and can be fixed or replaced. The prohibitive expense of individual high technology medicine that has developed in the Western world as a result of this industrial model has driven up the cost of health care (now 11% of our gross national product), enriched the health industry, provided the mass media with striking human interest stories and, in the process, misled the general public about the questionable value of one-to-one high-tech repair methods. In a similar way the human personality is often described as an interrelation of parts that can get out of balance and that can be corrected by therapy. The very high cost of these one-to-one interventions, both surgical and psychological, make them available only to (a) the affluent, (b) those who have health insurance, and (c) those who know about and accept the potential benefits of therapy. These constraints clearly limit the number of potential clients. Thirty-seven million Americans have no health insurance of any sort; most of those who do have union negotiated insurance have no (or very limited) mental health coverage (Sharfstein, 1988).

Psychotherapy Is a Luxury for the Affluent

It does not seem to matter whether or not mental health benefits are available to Class IV (blue collar) and Class V (no collar) people. They do not find therapy available, appropriate, or understandable. Auto workers with coverage for mental health benefits do not use them and the poor, like the migrant farm workers without benefits, are not even aware of them. Therapy is also unavailable to the growing army of the homeless. It is clear that psychotherapy is restricted largely to segments of the middle and upper classes while the most serious mental and emotional disorders are more prevalent among the very poor. The likelihood of migrant farm workers or homeless people receiving psychotherapy is about the same as the likelihood that they will receive artificial hearts or liver transplants: zero. The Task Panel on Migrant and Seasonal Farmworkers (1978) spelled out in chilling detail the horrors of the lives of agricultural migrant workers and their children – their health hazards, their powerlessness, low self-esteem, isolation, exploitation, poisoning by toxic pesticides . . . the list of risks is endless. Unlike hostages in the Middle East or MIA's in Southeast Asia, the names of the hundreds of thousands of these migrant worker hostages are unknown to the general public and their chances for rescue through any kind of therapy are nil.

Dörken and Cummings (1986) have argued that the poor will use mental health services including psychotherapy. They base their argument in large part on utilization rates in Hawaii. Hawaii is one of very few states with fair-

ly extensive mental health service coverage in its Medicaid plan. It is also the only state with a universal health care program covering all employees and dependents for outpatient mental health visits. Referrals to a psychologist or psychiatrist must be made by a primary care physician, and so, not unexpectedly, psychiatrists provide more services than psychologists. It is interesting to note that the heavy users of basic health care are most often the ones referred by physicans for mental health care. It seems quite possible that those referred are the higher user chronic complainers and "character disorders," and that "the poor" in general do not seek mental health services directly on their own initiative. Only some of "the poor" get referred and they are a highly selective sample.

In an interview with a leading health care insurance expert and official for Blue Cross/Blue Shield, VandenBos (1983) elicited the following information. First, purchasers of group coverage for their employees do not typically ask for mental health coverage. Second, unions also do not ask for mental health coverage. Third, insurers worry about offering a benefit that will be attractive only to high risk or high user groups. Fourth, problems in defining appropriate "mental health services" make it difficult for insurers to predict utilization. For these and other reasons, currently emerging approaches to reimbursement for "psychiatric treatment" (see Sharfstein, 1988, for current thinking on this topic) are increasingly cool toward coverage of psychotherapy.

The training of psychotherapists makes them unsuited for most kinds of intervention except one-to-one psychotherapy with middle-class people like themselves. Therapists in training most often work in agencies that serve the less affluent; they learn that these clients are not valued by the high status professionals they emulate. On completion of their training they put such cases behind them or refer them to public mental health centers where the "therapists" are often poorly qualified and always underpaid. Most psychotherapists are drawn from the middle class and are familiar with middle-class problems. Middle-class people tend to be more conscience-laden and guilt-plagued than the poor. Such middle-class anxiety is often reduced by individual psychotherapy, and so the process is rewarding and reinforcing. Neurotic anxiety is less common among the poor who exhibit "reality anxiety." The real problems of poverty, unemployment, homelessness, exploitation, powerlessness, discrimination, poor housing, etc. are more urgent than interpersonal relationship problems or guilt over impulses.

The taxes and insurance deductions of the poor do, however, help support the psychotherapy of the affluent (Albee, 1977a). Senator Edward M. Kennedy (1975) pointed out this injustice. Kennedy sees new public programs of mental health care as "contain[ing] the apparent risk of subsidizing services to higher-income citizens directly from tax contributions of middle- and low-income Americans" (pp. 151–152).

Six Patients, Three Years, Little Change, Big Bucks

A television show in the late 1970s starring Bob Newhart as Dr. Hartley, a clinical psychologist, acquainted millions of viewers with a financially attractively, high status, and apparently undemanding career option. Dr. Hartley, a somewhat bumbling but well-meaning psychologist-therapist, saw the same small group of clients for three years. None of them got better, nor worse, but they (or their insurance) paid enough to allow him and his fashionable spouse to live in an obviously expensive high-rise apartment in an upper-middle class setting. Being a psychotherapist, it was clear, takes no more intellectual competence than being a real estate sales person, a stock broker, or a navigator of an airliner, and clearly has as high or higher social status.

In spite of the small number of therapists, there is no dearth of recruits to the field of therapy. And because of the importance of a protective professional guild to lobby for third party payments to cover or push for a whole range of interventions (including, recently, hospital privileges and psychotropic drug prescription privileges), the psychotherapists are quick to join state and national professional organizations (with ever increasing dues) that lobby to safeguard or advance their financial interests. Almost any bright student can get into a therapy training program. Failing to obtain admission to an accredited Ph.D. program, or to a Psy.D.-granting accredited professional school, need not end the quest. There are many other therapy programs with modest academic demands where, for a price, an aspiring therapist can obtain a degree. And a week of intensive drill (advertised regularly in the *APA Monitor*) is sufficient to master enough core knowledge of psychology to pass the national licensing examination. Psychology as it has existed traditionally – persons engaged in the scientific study of human behavior – is all but disappearing from view in the rising tide of psychotherapists.

Let us be clear that it is not sacrilegious, illegal or unconstitutional to choose a career as a psychotherapist in an affluent society. After facing the fact that doctoral level therapists serve primarily well-educated clients, that psychotherapy is rarely available to the poor, not much sought after by blue collar workers, and ineffective in rectifying social injustices, the choice of this "health profession" is no more blameworthy than the decision to become a dentist or a funeral director. Many people want or require the service and they or their insurance programs are willing to pay.

However, there is an ethical question worth pursuing about therapy. Rawls (1971) argues that in order to achieve social justice a society's efforts must be aimed at ensuring equality of opportunity. A just society must make every attempt to redress the social inequities that have led to disadvantage. This means more attention and effort in support of those in less favorable social

positions. Limiting psychotherapy to the affluent does nothing to advance the cause of social justice and may actually dull sensitivity to injustice. But even if psychotherapy were available to all, the cause of social justice would not be advanced. Only with radical social changes leading to a just society will there be a reduction in the incidence of emotional problems.

The Value of Psychotherapy

Psychotherapy is a window on the damage done to children by uncaring, thoughtless, hostile or disturbed parents, and the damage done to everyone by a social system that encourages mindless competition and implicitly embraces the philosophy of social Darwinism. Psychotherapy often reveals the human effects of an economic system that produces jobs of incredible boredom and meaninglessness and that periodically throws out of work millions of people who want to work. One of four preschool children in the United States is poor and the rate is growing. For them, poverty leads to school failure which leads in turn to crime and delinquency. For their parents, it results – among other calamities – in parenting problems, child abuse and neglect (Schweinhart and Weikart, 1987). Therapy also reveals the devastating personal consequences on both the perpetrators and the victims of sexism, ageism, racism, ethnocentrism, homophobia, and exploitation of workers. While psychotherapy uncovers the individual damage inflicted by all of these social problems, treating the victims does nothing to correct the basic causes. Only when the findings of psychotherapists are translated into well-formulated preventive actions to correct or change the social and economic structure will it have made a significant contribution to prevention. But most therapists, like most professionals in other fields, have a major stake in defending the social order, not in attacking it.

When it is recognized clearly that even successful therapy does nothing to reduce the *incidence* of distress in the population, further questions may be raised as to its social value. (*Incidence* is a public health term that refers to the number of new cases occurring in a given time period.) The goal of primary prevention is to reduce the probability of future new cases and the social value of any intervention activity may arguably be related to its success in reducing (down the road) the rate of distress in the population. Both dentists and psychotherapists relieve individual pain and suffering. But fluoridation of the public water supply is preventing more cavities than dentists repair. There is no comparable massive prevention program to ensure more consistent loving and caring parenting so as to prevent future psychopathology.

Is psychotherapy a form of primary prevention because persons successfully treated for emotional problems become better parents, better spouses, and better citizens? The answer is no, though therapy may achieve all these

desirable outcomes. For many years we have had successful individual treatment of gonorrhea with the result that persons cured do not pass on their infection to others. But there has been no reduction in the *incidence* of this disease in the society (see the United States Bureau of the Census, 1975, 1989). Early individual treatment is *secondary* prevention and has little or no effect on incidence. Early treatment often does reduce *prevalence*, the total number of cases in the population in a given time period. But early treatment resulting from early identification of both physical and mental problems may actually increase both measured incidence and prevalence. The identification of child abuse, or the borderline personality, as newly diagnosed conditions, has had this effect.

What Is To Be Done?

It is hard to see how the ongoing massive shift of psychology's focus toward the practice of psychotherapy can be arrested or altered very soon. In a society composed largely of lonely persons, and with the breakdown of the nuclear family and the decline of religion among much of the population, there is a widespread strong yearning for new guides and gurus. A craving for psychotherapy, and its increasing social acceptability, may be preferable to other addictions like drugs and alcohol, or even to the acceptance of religious ideas. If it is true that the task of the therapist in treating neurotics is to make unconscious material conscious, then the task of the preventionist in "treating" psychotherapists is to make their unconscious needs conscious. Therapists get gratification from their high social status, their generous income, and their satisfaction with seeing the positive results of their efforts in many of their clients. If therapists also face and accept the fact that they are having no effect on incidence – that not being part of the solution defines them as being part of the problem – and choose anyway to continue, they may not merit our unqualified admiration, but at least we can respect them for their honesty.

Psychotherapy often is a form of reparenting. I have frequent discussions, and arguments, with a friend who is in full-time practice of psychotherapy. He deals largely with "borderline" cases, some of the most difficult and damaged people. He often has achieved real success with a client after three or four years of weekly therapy. They stop acting out and stop showing clear symptoms of the negative consequences of early childhood damage. His case load averages 25 clients per week. Because of the stress and pain he experiences in reparenting his clients, who transfer onto him all their childhood anger and resentments, he becomes emotionally depleted, in danger of burnout. So he works four days a week and relaxes with his hobbies the rest of the time. If the average length of his intervention is three years then he has room in his practice for about eight new clients a year. He has taught me a great

deal about the findings of the ego psychologists, about the devastating lifelong consequences of bad parenting, and about the reversibility through therapy of even extremely serious psychological distress. But his experience has also shown me graphically that society will never be able to deal with the very large number of persons with borderline personalities by concentrating its energy and resources on individual psychotherapy. While he may be helping a handful of people a year, many, many times that number of new borderlines is being created in our community by the bad parenting that can be traced to social marginality, economic powerlessness and social pathology.

It is interesting to observe the widespread denial of parental responsibility for the emotional disturbances of today's adolescents and young adults. Jack Hinckley has established the American Mental Health Fund that denies the role of parenting in mental disorders. The Fund has acquired the powerful support of the National Advertising Council to trumpet its message: "All mental illness is a medical illness." A similar group, the National Alliance for the Mentally Ill (NAMI) lobbies for more long treatment (organic type) and even involuntary hospitalization. Both groups enjoy the strong endorsement of prominent biological psychiatrists and political conservatives.

But it is hard to deny the evidence that bad childhood experiences (physical abuse, sexual abuse, neglect, emotional abandonment) have long-term damaging consequences. We also know that the worst parents were damaged themselves. British poet Philip Larkin (1974) sums it up:

They fuck you up, your mum and dad.
They may not mean to, but they do
They fill you with the faults they had
And add some extra, just for you.

But they were fucked up in their turn
By fools in old-style hats and coats,
Who half the time were soppy-stern
And half at one another's throats.

Man hands on misery to man.
It deepens like a coastal shelf.
Get out as early as you can.
And don't have any kids yourself.[1]

In a way, psychotherapy is comparable to some of the efforts of Lyndon Johnson's Great Society and its War on Poverty. The argument was advanced

[1]"This Be the Verse" from HIGH WINDOWS. Copyright © 1974 by Philip Larkin. Reprinted by permission of Farrar, Straus, and Giroux, Inc.

that if we gave remedial training to the socially disadvantaged, if we took children reared in poverty and degradation, in broken homes and pathological neighborhoods, and gave them remedial education we would help them achieve equality. Such help has been described as giving better running shoes to people, but still forcing them to play on an uneven playing field. The Great Society program failed because it attempted to change individuals through individual remediation. The programs of the War on Poverty were designed by therapy-oriented professionals, not by public health people. Goldenberg (1988) clearly identified the reason for their failure: the War on Poverty did far too little to end societal injustice and inequality so as to affect the self-esteem of all those millions damaged by prejudice and discrimination. The civil rights movement and the women's movement were much more effective because they aimed at societal change – true primary prevention. Similarly, psychotherapy may partially reduce the handicaps of a few of the emotionally damaged but this kind of war on emotional poverty cannot succeed because it does nothing to alter the social forces that keep producing more victims than are helped.

The Answer is Primary Prevention

If psychotherapy has such little social value, what should take its place? The obvious answer, validated in history, is primary prevention. Primary prevention is an approach to reducing the future incidence of a condition through proactive efforts aimed at groups, or even at a whole society. While most historical examples of primary prevention from the field of public health involve the reduction in new cases of disease, the concept is applicable to a wide range of conditions – crime and delinquency, child abuse, alcohol and drug abuse, suicide and murder, racism and sexism, homophobia, etc. Historically primary prevention efforts in the field of public health have reduced the incidence of several major plagues that have afflicted humankind. One of the most important recent successes is the complete elimination of smallpox, a plague that once afflicted millions and now is gone, probably forever.

Most mental disorders are not diseases but the traditional methods of primary prevention apply: (1) discovering and controlling the noxious agents (like bad parenting and the stresses of sexism, racism, exploitation, etc.); (2) strengthening the resistance of the susceptable (like empowerment, social coping skills, political action to improve self-esteem of the disadvantaged, and developing social support networks); and (3) preventing transmission (controlling child physical and sexual abuse, neglect, exploitation, and emotional damage). Primary prevention efforts, being proactive, generally require social and political action.

Critics of primary prevention argue that these efforts have not proven their value with demonstrable results. The only objective response to such critics is to suggest they read the literature of the field. Primary prevention efforts, described in some detail in the *Report of the Task Panel on Prevention* (1978) to the President's Commission on Mental Health, in the *Report of the Commission on Prevention* of the National Mental Health Association (1986), in Kessler and Goldston's (1986) *A Decade of Progress in Primary Prevention* and in the American Psychological Association's *Fourteen Ounces of Prevention* (see Price, Cowen, Lorian, and Ramos-McKay, 1989) are shown to be the most logical and promising approaches to reducing the incidence of psychopathology. But extending such efforts by psychologists and social workers would require a conceptual reorientation of the field, a change that would occur only with major and revolutionary social and political changes (see Joffe and Albee, 1981).

One social change, not improbable to occur, would be a decision by the federal government and third party insurers to exclude from payment the non-physician professionals engaging in interventions with persons with mental/emotional problems. While such a decision would be based on the erroneous belief that mental conditions are real diseases, and that diseases should be treated exclusively by physicians, such a curtailment of reimbursement would be advantageous to psychologists and social workers in the long run. Earlier I argued (Albee, 1975) that reimbursement for *all* professional interventions (including treatment by psychiatrists) with persons with neurotic and functional psychotic disorders should not be covered by third party payments because these persons are not suffering from real illnesses. I proposed limiting reimbursement only to those professionals treating organic conditions. This step, I thought, would put psychologists and most psychiatrists (as well as social workers and counselors) out of the financial reimbursement health system, keep competition fairly equal and limit the growth of the field. But I failed to anticipate the elimination of the neuroses (those Freudian inventions) by organized psychiatry's DSM-III, the sacking of psychodynamic professors in psychiatry, and the redefinition of most human problems as "medical diseases," caused by biochemical imbalances and genetic defects. Still more redefinitions of problems in living as diseases can be expected in successive revisions of psychiatric diagnostic systems. Unfortunately, psychologists and social workers accepted meekly the DSM-III (and DSM-III-R) diagnostic system. Instead of fighting it as scientifically dishonest and logically defective, they fell on their knees and begged to be included for reimbursement. (A few notable exceptions in psychology severely critized DSM-III: Garmezy [1978]; Zubin [1978]; and Schacht and Nathan [1977] are outstanding examples.) Abnormal psychology textbook writers, however, also yielded and publishers actually boast about up-to-date coverage of DSM-III-R. And

psychologists are now lobbying hard for hospital privileges and for limited power to prescribe drugs for their "patients."

In addition to classifying most problems in living as illnesses, American psychiatry has joined forces with the reactionary citizens' groups described above to advance the position that "All mental illness is medical illness." This conservative message serves the dual purpose of raising more public funds for coverage of psychiatric drug treatment and reduction or elimination of support for social change as prevention. If all mental conditions are caused by organic, biochemical defects in the brain, then bad social environments are not to blame, parents and social exploiters are home free, NIMH can support only organic biological research, and the Establishment is not threatened. Whether we do it to ourselves, or have it done to us, psychotherapy has an uncertain future because of this rightward movement of American psychiatry and its citizen allies.

Psychologists whose careers are invested in helping people (through the medium of therapy) could join forces with the preventionists and social activists to fight for a social learning model of mental and emotional disturbances. Psychologists could turn to the study of social and economic origins of these disturbances and to strategies for developing a just society and a just world. It will happen eventually. Now is the time to begin.

References

American Psychiatric Association. (1952). *Mental disorders: Diagnostic and statistical manual.* Washington, D.C.: Author.

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (second edition). Washington, D.C.: Author.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (third edition). Washington, D.C.: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (third edition, revised). Washington, D.C.: Author.

American Psychological Association. (1988). *Fourteen ounces of prevention.* Washington, D.C.: Author.

Albee, G.W. (1975). To thine own self be true: Comments on insurance reimbursement. *American Psychologist, 30,* 1156–1158.

Albee, G.W. (1977a). Does including psychotherapy in health insurance represent a subsidy to the rich from the poor? *American Psychologist, 32,* 719–721.

Albee, G.W. (1977b). Problems in living are not sickness: Psychotherapy should not be included under national health insurance. *The Clinical Psychologist, 30,* 3–5, 6–8, 13.

Albee, G.W. (1985). The answer is prevention. *Psychology Today,* February, 60–64.

Brody, J. (1981). Guide through the maze of psychotherapies. *New York Times,* October 28, pp. C3, C8.

Dörkin, H., and Cummings, N.A. (1986). Impact of medical referral on outpatient psychological services. *Professional Psychology: Research and Practice, 17,* 431–436.

Eysenck, H. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology, 16,* 319–324.

Eysenck, H. (1964). The effects of psychotherapy. *International Journal of Psychiatry, 1,* 99–142.

Garmezy, N. (1978). Never mind the psychologists: Is it good for children? *Clinical Psychologist, 31,* 1–6.

Glasscote, R., Sanders, D., Forstenzer, H., and Foley, A. (Eds.). (1964). *The community mental health center: An analysis of existing models.* Washington, D.C.: American Psychiatric Association.

Goldenberg, I. (1988). The politics of timidity. In G.W. Albee, J.M. Joffe, and L.A. Dusenburg (Eds.), *Prevention, powerlessness, and politics. Readings on social change* (pp. 485–497). Newbury Park, California: SAGE Publications, Inc.

Henderson, J. (1975). Object relations and the new psychiatry: The illusion of primary prevention. *Bulletin of the Menninger Clinic, 39,* 233–245.

International classification of diseases, 9th revision. (1989). Clinical modification ICD-9-CM. Third Edition. Volume 1. *Diseases tabular list.* DHHS Publication No. (PHS) 89–1260, United States Department of Health and Human Services, Public Health Service, Health Care Financing Administration.

Joffe, J.M., and Albee, G.W. (Eds.). (1981). *Prevention through political action and social change.* Hanover, New Hampshire: The University Press of New England.

Joint Commission on Mental Illness and Health. (1960). *Action for mental health.* New York: Basic Books, Inc.

Kennedy, E.M. (1975). Commentary. In J. Marmor (Ed.), *Psychiatrists and their patients* (pp. 149–152). Washington, D.C.: Joint Information Service of the American Psychiatric Association and the National Association for Mental Health.

Kessler, M., and Goldston, S. (Eds.). (1986). *A decade of progress in primary prevention.* Newbury Park, California: SAGE Publications, Inc.

Kiesler, C.A., and Sibulkin, A.E. (1987). *Mental hospitalization. Myths and facts about a national crises.* Newbury Park, California: SAGE Publications, Inc.

Kramer, M. (1983). The continuing challenge: The rising prevalence of mental disorders, associated chronic diseases and disabling conditions. *American Journal of Social Psychiatry, 3,* 13–24.

Larkin, P. (1974). This be the verse. *High windows.* New York: Farrar, Straus, and Giroux.

Meehl, P.E. (1965). Discussions of Eysenck's "The effects of psychotherapy." *International Journal of Psychiatry, 1,* 156–157.

Musarrat, H. (1988, December). *Community mental health in Pakistan.* Paper presented at the 7th International Conference in Psychiatry, Karachi, Pakistan.

National Mental Health Association. (1986). *The prevention of mental-emotional disabilities. Report of the commission on prevention.* Alexandria, Virginia: Author.

Price, R.H., Cowen, E.L., Lorian, R.P., and Ramos-McKay, J. (1989). *Fourteen ounces of prevention.* Washington, D.C.: American Psychological Association.

Raimy, V. (1950). *Training in clinical psychology.* New York: Prentice Hall.

Rawls, J. (1971). *A theory of justice.* Cambridge, Massachusetts: Harvard University Press.

Regier, D.A., Myers, J.K., Kramer, M., Robins, L.N., Blazer, D.G., Hough, R.L., Eaton, W.W., and Locke, B.Z. (1984). The NIMH epidemiologic catchment area program. *Archives of General Psychiatry, 41,* 934–941.

Saxe, L. (1980). *The efficacy and cost-effectiveness of psychotherapy.* Office of Technology Assessment, Congress of the United States, Washington, D.C.: United States Government Printing Office.

Schacht, T.E., and Nathan, P.E. (1977). But is it good for the psychologists? Appraisal and status of DSM-III. *American Psychologist, 32,* 1017–1025.

Schofield, W. (1964). *Psychotherapy: The purchase of friendship.* Englewood Cliffs, New Jersey: Prentice Hall.

Schweinhart, L., and Weikart, D. (1987). Evidence of problem prevention by early childhood education. In K. Hurrelmann, F-X. Kaufmann, and F. Lösel (Eds), *Social intervention: Potential and constraints* (pp. 87–101). Berlin and New York: Walter de Gruyter.

Sharfstein, S. (1988). Financial incentives for alternatives to hospital care. *Proceedings of the Oklahoma Mental Health Research Institute 1988 Professional Symposium,* Volume 2, pp. 175–200. Oklahoma Department of Mental Health.

Silverman, P. (1978). *Mutual help groups: A guide for mental health workers.* DHEW Publication No. (ADM) 78–646. Washington, D.C.: United States Government Printing Office.

Strupp, H.H. (1986). Psychotherapy: Research, practice, and public policy (How to avoid dead ends). *American Psychologist, 41,* 120–130.

Surgeon General's Workshop on Self-help and Public Health (1987). Washington, D.C.: United States Department of Health and Human Services, Public Health Service.

Task Panel on Migrant and Seasonal Farmworkers. (1978, February). *Report to the President's commission on mental health*, Volume III, Appendix. Washington, D.C.: United States Government Printing Office.

Task Panel on Prevention. (1978). *Report to the President's commission on mental health.* Volume IV, Appendix. Washington, D.C.: United States Government Printing Office.

United States Bureau of the Census. (1975). *Historical statistics of the United States, Colonial times to 1970.* Bicentennial Edition, Part 2. Washington, D.C.

United States Bureau of the Census. (1989). *Statistical abstracts of the United States, 1989.* (109th Edition). Washington, D.C.

VandenBos, G.R. (1983). Health financing, service utilization, and national policy: A conversation with Stan Jones. *American Psychologist, 38,* 948–955.

VandenBos, G.R. (Ed.). (1986). Special Issue: Psychotherapy research. *American Psychologist, 41,* 111–214.

Wootton, B. (1959). *Social science and social pathology.* London: George Allen and Unwin.

Zubin, J. (1978). But is it good for science? *Clinical Psychologist, 31,* 1–7.