Issues in Psychotherapy as the Practice of Psychology

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Sechrest and Smith provide a well-reasoned argument that psychotherapy is not, as it should be, an integral part of the science of psychology; and that, conversely, the science of psychology is not an integral part of psychotherapy. Many of their philosophical and empirical points are well taken, but my own view is that they have overlooked or downplayed the work of investigators, going back at least thirty years, which exemplifies the kind of research and applied psychology they properly advocate. Domains include depression, anxiety, sexuality, schizophrenia, and in particular the cognitive and behavioral therapies. However, the heuristic role of clinical hypothesis formation and awareness of complex clinical realities must also be appreciated if contributions from primarily laboratory-based psychology are to be realistic and relevant. Their exhortations to make psychotherapy and clinical psychology a truly applied psychology may be very timely, given increasing pressures from third party payers that the services provided to patients enjoy empirical support. Overall, their paper can serve as a reminder that the scientist-professional model is alive and well, or at least should be resuscitated and invigorated.

KEY WORDS: psychotherapy; practice; integration; education and training.

INTRODUCTION

Sechrest and Smith (1994) have provided a lively argument that (a) basic, core psychology is not relied upon enough in the design of psychotherapeutic interventions, and that (b) it should be. Although many years have passed since contemporary behavior therapy stipulated that therapeutic interventions should be based on empirical research—and the important 1966 book by Goldstein, Heller, and Sechrest was prophetic in the directions these efforts should and would take—it cannot be denied that psychotherapy as a whole is not yet the practice of psychology. Their paper, then, is a timely reexamination of how far we have come and especially of how far we have to go.

Since its very beginning as a subspecialty of psychology following World War II, clinical psychology has espoused the point of view that what we believe to be true about psychopathology, how we assess it, and how we design interventions is supposed to be based on psychological science. If our field means nothing else, it certainly means that. Sechrest and Smith are to be commended for reminding us of these scientific roots and taking us to task for not being as true to them as our rhetoric implies.

Sechrest and Smith are quite right to lament the failed promise of psychotherapy to have become by now a true application of basic psychological principles. However, in spite of a favorable nod in the direction of cognitive behavior therapy, they neglect to mention several trends in theory and research that would seem to meet the very criteria they stipulate. Some of these relate more to psychopathology than to intervention, but the two domains are hardly separate (though much psychotherapy is unfortunately formulated without due regard for the causes, past and present, of the problems to be dealt with therapeutically). While one is always on safe ground to assert that "more research needs to be done," it is important to acknowledge scholarly efforts that already demonstrate that the theories, methodologies, and findings of psychological science have already been brought to bear in trying to understand psychological disorder and its prevention or amelioration. A few noteworthy examples follow.

EXPERIMENTAL-COGNITIVE RESEARCH IN HUMAN SEXUALITY

As argued many years ago by Gagnon and Simon (1973), human sexuality must be understood within a cognitive framework. We do not respond solely in a reflexive fashion to tactile stimulation; rather, we endow certain patterns of sensory input with sexual meaning. It is obvious that we are able to feel sexual without any tactile or other exteroceptive stimulation at all, as when the thought of a loved (or lusted after) individual arouses us sexually.

In the early 1970s, Geer (Geer & Fuhr, 1976) initiated a program of laboratory research into cognitive factors in human sexuality, employing genital plethysmographic measures as dependent variables and a variety of...
visual and auditory input as independent variables. Over the past 20 years, Geer and his colleagues have demonstrated both the empirical and heuristic utility of employing information-processing concepts (e.g., attention-distruction) and techniques (e.g., dichotic listening tasks) to further our understanding of human sexuality, with implications for how to intervene with sexual dysfunctions (Geer, Lapour, & Jackson, 1993). Related theory and research have been reported by Barlow and associates (Barlow, 1986), and the information-processing approach has been employed more generally by Lang (1979) and Bandura (1986) in their theoretical and empirical work on emotion and behavior.

EXPERIMENTAL-COGNITIVE RESEARCH IN DEPRESSION, ANXIETY, AND SCHIZOPHRENIA

Also notably missing in the Sechrest-Smith paper is any mention of the experimentally based work of Beck and associates on the cognitive aspects of depression (e.g., Beck, 1967, 1976; Haaga, Dyck, & Ernst, 1991), of Barlow and associates on anxiety (e.g., Barlow, 1988; Craske, Brown, & Barlow, 1991), and of Foa and co-workers on posttraumatic stress disorder (e.g., Foa, Feske, Murdock, Kozak, & McCarthy, 1991; Foa & Kozak, 1986). All this empirical work demonstrates how an understanding of cognition facilitates the design of effective psychotherapeutic interventions.

Noteworthy in the Beckian literature is research by Hammen and others (e.g., Hammen, Marks, Mayol, & deMayo, 1985) on relationships between particular schemata and the nature of life stressors, research that draws on theorizing and procedures in experimental cognitive psychology. To be recognized here also is the work inspired by Seligman’s learned helplessness perspectives on depression. Recall that Seligman’s original reports (e.g., 1975) came from research on dogs who were deprived of effective instrumental responses to escape from shock. Several modifications based on his seminal work continue to enhance our understanding of depression and to provide directions for improved therapeutic interventions (e.g., Abramson, Metalsky, & Alloy, 1989).

Finally, over the past 30 years, psychopathology researchers have employed experimental-cognitive theory and methodologies in studying cognitive aberrations in schizophrenics, shedding light on the nature of schizophrenia (e.g., Broen & Storms, 1966; Dokeki, Polidoro, & Cromwell, 1965). In a recent summary of cognitive and neuropsychological studies of schizophrenic children, for example, Asarnow, Asanen, Granholm, Sherman-Vasse, Watkins, & Williams (in press) show that schizophrenic children manifest impairment on cognitive tasks that make extensive demands on information-processing capacity.

BEHAVIOR AND COGNITIVE THERAPY

Originally proposed as the application of basic psychology to therapeutic intervention, cognitive and behavior therapy would seem to exemplify the kind of “psychotherapy is the practice of psychology” that Sechrest and Smith argue for. Yet their paper makes only passing mention of the tremendous volume of research and theorizing in the behavior therapy field over the past 40 or so years. If they find fault with, for example, the social skills training work of Liberman and his colleagues (e.g., Liberman, DeRisi, & Mueser, 1989) and of Paul and Lentz (1977) with chronic schizophrenics, it would have been informative for them to discuss it. Does not a recognition of serious skills deficits in schizophrenics, like filling out a job application or making eye contact during conversation, and attempts to remediate such deficits by modeling and operant shaping, represent an application of laboratory research? Other examples abound in the literature, and while there is sometimes a conceptual “stretch” between an experimental principle and a clinical application, we must remind ourselves that one always has to fill in gaps (“place meat on the theoretical skeleton”; Lazarus & Davison, 1971) when extrapolating from highly controlled experimental situations to the more complex and less controllable clinical domain. The design of laboratory analogue research is no less “artistic.”

While Sechrest and Smith probably find such efforts as these wanting (page 2-3), they neglect to be specific as to why. It would be useful if they would provide some detailed examples from their own or others’ research on what they consider to be proper integration of psychotherapy into psychology (or vice versa).

BASIC RESEARCH AND CLINICAL REALITIES-A TWO-WAY STREET

As we and others have argued for many years (e.g., Davison & Lazarus, 1993; Lazarus & Davison, 1971), the traffic can and should flow in both directions. If analogue research is seen by clinicians as irrelevant to the challenges in the applied arena, this may be due to the lack of appreciation among nonapplied researchers of the heuristic value of clinical data as well as to their insufficient knowledge of clinical realities. There is a time-honored and central role for clinical innovation in providing ideas for
researchers who are able to exert more experimental control in their laboratory research settings than is typically possible either practically or ethically in the applied context. In other words, and to extend the many good points made by Sechrest and Smith about the need to make psychotherapy more of a truly applied psychology, controlled research is likely to be of limited conceptual as well as practical utility and relevance if it is not informed by knowledge of clinical phenomena. Most of the research that Sechrest and Smith urge us to be more cognizant of is analogue in nature relative to the clinical situation. The methods and findings of such research may have limited generalizability to the complex, "noisy" clinical domain. At worst, such experimentation may be naive, irrelevant, and misleading.

A NOTE ON EDUCATION AND TRAINING

Sechrest and Smith argue well for interdisciplinary collaboration. Pointing out that psychotherapy research pays scant attention to the circumstances of people's lives once they leave treatment-issues such as poverty, discrimination, and other factors typically relegated to other fields such as sociology or social work-they urge psychotherapy "to get a life." Good point, both scientifically and morally. Their observations could and should have been extended to how we select, educate, and train our graduate students. How many graduate clinical programs value, encourage, or even passively support a student's interests in intellectual domains other than psychology, both at the undergraduate and graduate levels? Do we, for example, make it part of our graduate curriculum that students take X units of course credit in departments other than psychology? Indeed, do the accreditation criteria of the American Psychological Association allude to the desirability, even the necessity, for future health professionals to be encouraged to integrate knowledge and ideas from other disciplines even as they are immersed in what we define in the 1990s as psychology? And do we insist that what we teach in assessment, psychopathology, and intervention be the survivors of rigorous empirical scrutiny and not merely those modalities that many internship sites and licensing boards require of our students?

CONCLUSIONS

Having tried to make the case that there is more integration of basic psychology into clinical psychology than Sechrest and Smith assert, I close with much more agreement than disagreement with their brief. For the past 50 years clinical psychology has been wrestling with the challenge of applying basic research to the complex clinical problems that are our scientific and applied domain. As we all know, this is a daunting task. It is obvious to anyone in touch with clinical reality that clinicians and clinical instructors often act and teach in ways that are unsupported by empirical research. Sometimes this is necessary, given the limits of what psychological science has to offer. Indeed, given the complex social, political, and ethical context in which psychotherapy exists, it is doubtful-and probably unrealistic and inadvisable-to assert that psychotherapy can or should be nothing but the practice of psychology. However, if for no other reason than the growing insistence of health insurers for empirically supported treatments, it is appropriate for us to emphasize and promote the empirical foundations of clinical psychology in general. Influenced myself by some of Sechrest's seminal writings in the 1960s, my colleagues and I have striven to make our clinical and instructional activities as consistent as possible with controlled data (cf. Davison & Neale, 1994; Goldfried & Davison, 1976). Articles such as the one by Sechrest and Smith are useful reminders of how far we have yet to go if we would fully realize the potential of the scientist-professional model.

REFERENCES


