The Demographics of American Psychotherapists: A Pilot Study

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Psychiatrists, psychologists, and social workers are doing equal numbers of hours of self-defined psychotherapy. The spread of psychotherapeutic services across these and at least four other professions has been accompanied by a growing ambiguity about the definition of psychotherapy. The basic elements of psychotherapy and the identity of its practitioners require clarification.

Practicing psychotherapists are aware that no profession dominates the practice of psychotherapy. Psychiatrists through the ideology of psychoanalysis once held the political and economic power, but due to historical forces and conceptual shifts have lost their grasp.[1] Now psychotherapy itself is in disarray as proponents of various schools continue to proclaim conceptual supremacy while the majority of practitioners struggle with attempts at pragmatic eclectism.[2,3]

Who are these modern-day psychotherapists? Where once the answer was to be found on the membership lists of the American Psychoanalytic Association and related organizations, now it must be sought from members of at least seven different professions (psychiatry, psychology, social work, counseling profession, the clergy, psychiatric and mental health nursing, and primary care medicine). Other groups are also involved depending upon the definition of psychotherapy used (e.g. mental health paraprofessionals, indigenous healers, astrologers, fortune tellers, and co-counselors).

Some might argue that effort to define the demographics of these groups of professionals and nonprofessionals is unnecessary, and might prefer simply to know that members of these groups are calling themselves psychotherapists. However, psychotherapy is now confused and confusing, disorganized and incomprehensible. Both its practitioners and its practice require a more defined structure for training purposes and improved patient care. Political, ideological and economic conflicts make the reorganization quite difficult, yet the need remains to clarify who is doing psychotherapy and to define the basic elements of their practice. A demography of psychotherapists offers a chance to define who is doing what in the name of interpersonal psychological

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assistance, thereby, creating the potential to increase the orderliness of psychotherapeutic practice. Who are these self-chosen professional psychotherapists? How did they choose to perform this function? How do they choose to do what number of hours per week? Is any one profession superior to the others or are personality, specific training or types of patients more critical variables? These questions await a more comprehensive study beyond this pilot project.

This paper reviews the historical forces and conceptual shifts that allowed psychotherapy to be practiced by nonpsychiatric professionals, offers a contextual definition of psychotherapy, and describes preliminary data concerning the percent of time spent by psychiatrists, psychologists, social workers and primary care physicians in self-reported psychotherapy. Additional evidence for the involvement of ministers, psychiatric and mental health nursing and professional counselors is also offered. Information concerning the nationwide psychotherapeutic activities of nonprofessionals is not included because these data are far more difficult to acquire. The implications of this pilot study are then discussed in terms of the ambiguous definition of psychotherapy and the need for further analysis of psychotherapeutic practitioners.

From Psychiatry to Many Professions

Neill and Ludwig[1] described the movements through which psychiatrists gained and then lost control over psychotherapeutics. They listed three steps: (1) the medicalization of psychotherapy, (2) psychiatric hegemony, and, (3) psychoanalytic dominance through which psychiatrists enjoyed control from 1945–1960. As a result of the following four upheavals psychiatrists gradually lost that dominion: (1) advent of controlled research studies, (2) diagnostic-specific psychopharmacological agents, (3) the mental health movement. In addition to these factors, (4) the increased influence of third-party payors has also been felt.

1. The application of scientific research methods allowed researchers to attack psychoanalysis where it was most vulnerable, at the inability of its practitioners to prove its most cherished assumptions. Wolpe's systematic desensitization[4] gave scientifically minded psychologists a conceptual lever through which to claim strength and distinction. Rogers[5] added statistics and simplicity to bolster the esteem of nonpsychiatric client-centered psychotherapists. Frank[6] placed psychoanalysis in a cross-cultural perspective, thereby reducing its uniqueness.

2. The advent of diagnosis-specific, effective psychopharmacological agents reopened the smoldering argument between organically based psychiatrists and psychoanalysts.

3. The mental health movement, which led to the establishment of mental health centers became the leading edge of psychotherapeutic populism.

During the 1960's Rioch's[7] work with housewives trained to become competent psychotherapists influenced the United States government to add the paraprofessional training branch to the already existing psychiatry, psychology, social work and nursing branches at NIMH. In addition, psychiatry was offered as a panacea for community ills—poverty, addiction—but failed to ameliorate these ills, thereby reducing faith in psychiatric power. New, humanistic therapists claimed to be able to train almost anyone to become a psychotherapist and the number of new schools of psychotherapy increased exponentially.

4. As insurance companies placed increasingly more restrictions upon the length of psychotherapy for which they would pay, psychoanalysis lost more influence. Therapists turned to shorter methods and other professions began to vie for a greater share of insurance payments. The current reduction in government allocation of funds for mental health may lead to a further reduction in psychiatric influence in psychotherapy.

The emergence of psychologists and social workers as psychotherapists is traced to the team approaches of the child-guidance movement of the 1930's and the development of inpatient psychiatric service teams. At first the roles of each member were clearly defined. Psychiatrists were team leaders, psychologists did the testing, and social workers worked with families. The psychiatrist treated the identified patient. Depending upon the interests of each team member, role definitions could change so that under the supervision of the psychiatrists, psychologists and social workers entered into psychotherapeutic relationships.[8]

According to Strean,[9] "What psychoanalysis did for social work was to help social workers appreciate the inner life of the client and the significance of family interactions, hitherto approached as a moral problem." Those social workers dealing with poverty-stricken people could apply notions of resistance and defense to clients anxious about change and could use psychodynamic formulations to understand poverty, not only in economic terms but as an end product of poor parent-child relationships, marital distress and other interpersonal difficulties.[9] Social workers then self-selected themselves for further professional experience and training in psychodynamic practice.

That professional counselors perform psychotherapy is difficult to argue against because there is no clear distinction betwen counseling and psychotherapy although attempts, however unsatisfactory, have been made in this direction. Forster[10] suggested that counselors differed from psychotherapists in three ways: (1) their nondoctoral preparation (but many counseling psychologists have Ph.D.'s); (2) their less dysfunctional client population (but many are in private practice and mental health settings; they are often not trained to diagnose clients who are relatively more dysfunctional and therefore may treat such clients without recognizing them; (3) their use of

techniques that support existing strengths rather than restructuring the whole personality. A large percentage of counselors practice within educational institutions[11] and perform a variety of services, including personal counseling which, as suggested, is quite difficult to distinguish from psychotherapy. Founded in the vocational guidance movement of the late 19th-century Boston,[12] the early counseling profession was joined by psychologists and social workers attempting to make vocational guidance an educational rather than simply a placement activity. Roger's *Counseling and Psychotherapy*[13] served to help this group discover, much as psychoanalysis did for social work, that "one counsels people rather than problems."[14]

The development of primary care physicians into psychotherapists has been partially the result of the continuing demand for responses by these helping professionals to the psychological problems of their patients. Psychiatrists see only 15 percent of those with emotional disturbance while more than 50 percent of this group is seen in primary care settings.[15] Through their increasing acceptance and understanding of the biopsychosocial model,[16] primary care physicians are increasingly more willing to address psychosocial issues.[17]

Like primary-care physicians, ministers have been performing what might be described as interpersonal psychological help, for centuries.[18] Their self-definitions as psychotherapists are relatively recent. Boisen in Boston in 1920 taught theology through the experience of human beings in distress, in addition to teaching from major religious works. He felt that psychiatric patients offered opportunities to study "living documents" whose internal struggles mirrored the conflicts faced by every person.[19] His students wanted to help them, not only study them.

Leaders of pastoral psychotherapy struggled with difficult questions: What is the difference between pastoral counseling and pastoral psychotherapy? Can a minister practice pastoral psychotherapy on a fee-for-service basis outside church influence and still remain connected to religion? What are the limits of psychotherapy and what are the limits of theology and where do they overlap? In 1964 those ministers dedicated to the practice of psychotherapy formed the American Association of Pastoral Counselors, the chief aim of which is to serve as an accrediting agency for pastoral counselors and psychotherapists.

The most recent entrant into the professional practice of psychotherapy is psychiatric and mental-health nursing. A number of federal legislative acts established the relationship of nursing to the treatment of mental illness. The 1946 Mental Health Act provided funds for the education of psychiatric nurses as part of a national program to provide care for the mentally ill. In 1956 the Health Amendments Act made funds available to educate psychiatric nurses in master's and doctoral-level programs. The Nursing Training Act of 1964 made funds available for teachers of psychiatric nursing in

university programs and helped to establish a faculty, which thereby solidified the place of psychiatric education nursing programs.

A Definition of Individual Psychotherapy

The difficulty with the term "psychotherapy" is that it has come to mean both one thing and many things. At one time psychotherapy meant the application of psychoanalytic principles to nonclassical treatment. Now it may mean almost whatever the user intends it to mean. In this looking-glass world, is there a way to define psychotherapy in its essence while also leaving room for its almost overwhelming diversification?

The term psychotherapy is derived from two roots, psyche and therapy. Psyche refers to the functioning of the mind or soul while therapy refers to healing or helping. Thus, in any psychotherapy, there are at least two persons involved: the person in need of help and the person committed to help. While examples such as Freud's self-analysis may stand as exceptions to this rule, generally an interpersonal relationship is required to define a situation as psychotherapy. Less directly implied is the idea that the person who is helped somehow learns something about some aspect of the mental-emotional functioning of the self or the self in relation to others.

Consider for a moment the fundamental psychotherapeutic situation: a person is talking about himself, his failures, his worries, his sense of vulnerability, his feelings. Another person is listening intently. They are alone in a room. Is this psychotherapy? That cannot be determined unless certain other parameters are defined. This may be a husband talking to his wife, two friends or a teacher and pupil. In each of these contexts however, the psychotherapeutic interaction is incidental to the primary relationship: it is not the reason they are together. If the helper is a lawyer and they have been meeting about the client's divorce and spending a good deal of time talking about his inadequacies, then this may be reaching the borderline between professional and incidental forms of psychotherapy. (Some lawyers are becoming more interested in learning psychotherapeutic skills and are taking courses to enhance them.)

The point of this discussion is to illustrate that, currently, professional psychotherapy is defined by the context and agreements which bind the two people together. If they call it psychotherapy, then, in today's confusing world of hundreds of forms of psychotherapy, who is to deny that it is?

Methods

The objective of this study was to determine how many people are doing "psychotherapy" in the United States. Because the definition can be very broad this inquiry was limited to national professional groups. National organizations representing psychiatry, psychology, social work, counseling, the ministry, and nursing responded to requests for demographic data.

Published surveys of psychologists, ministers, and primary care physicians supplied additional information. I surveyed 25 states which license psychologists and social workers in order to extrapolate from these figures a national estimate of the number of practitioners.

Results

National organizations provided estimates of the number of practitioners in psychiatry, psychology, and social work. L. Gurel of the American Psychiatric Association (personal communication) estimated that as of January 4, 1980, there were 24,000 members and 6,500 non-members or approximately 30,000 psychiatrists in the United States. A. Wellner of the National Register of Health Care Providers in Psychology (personal communication, 1979) estimated that there were approximately 30,000 licensed clinical psychologists. M. Johnson of the National Association of Social Workers (personal communication, 1981) estimated a membership of 85,000, 90 percent with MSW or higher, and a gross total of social workers in the United States of 170,000 (BSW, MSW, DSW). He estimated between 110–120,000 at MSW or above in the U.S. I have taken 100,000 as a more conservative estimate since it comes closer to my extrapolation from states reporting their numbers of licensed MSW's. In the survey of states, 16 responded for social work and 19 for psychology. Most states license psychology and a few states include master's level licensing. Approximately 20 states have licensing in social work at a variety of levels ranging from a voluntary registration to a five-tiered mandatory arrangement.

Estimates for the number of primary care physicians came from a variety of sources. In their overview of the practice of internal medicine, Girard, Mendenhall, Tarlow, et al[20] estimated approximately 60,000 primary care internists. J. Geyman, editor of the *Journal of Family Practice,* (personal communication, 1980) estimated approximately 60,000 family and general practitioners. Therefore, excluding pediatrics and obstetrics-gynecology each of which may be considered primary care specialties, there are approximately 120,000 primary care physicians in the U.S.

The 1979 edition of the *Year Book of American and Canadian Churches*[21] stated that there were approximately 500,000 ministers in the U.S., 290,000 of whom were heads of churches. From the American Nurses Association came an estimate of 39,000 psychiatric and mental health nurses,[22] 7,000 of whom were master's level or above.[23] Rosenbaum of the American Personnel and Guidance Association (personal communication, 1979) estimated 32,000 members at master's level or above.

A variety of national surveys provided information concerning the percentage of self-reported time spent doing self-defined psychotherapy, for psychiatry, clinical psychology, social work and primary care medicine. Regier et al[15] in 1975 reported that 44 percent of psychiatrists spent more

than 15 hours in office practice and 56 percent spent less than 15 hours. As a very rough approximation we may assume 15 hours per week as an average number of hours in office practice. According to the National Ambulatory Medical Care survey of 1975–76[24] 86 percent of office visits to psychiatrists were reported to be psychotherapy. Based on the assumption of a 40-hour week the percent of time psychiatrists spent doing psychotherapy is $15/40 \times .86 = 32$ percent.

Two different surveys of clinical psychologists yielded approximately the same figure. Garfield and Kurtz[2] surveyed clinical psychologists of the American Psychological Association and Wade, Baker and Hartman[25] surveyed members of the Association for the Advancement of Behavior Therapy, 80 percent of whom had Ph.D.'s. Each survey suggested that approximately 30 percent of the time of respondents was spent in psychotherapy.

T. Pratt of the National Association of Social Workers (personal communication, 1979) reported the results of a 1975 survey of members. They reported 10 percent of professional time was spent in psychotherapy.

Internists,[26] family and general practitioners[27] reported 3 percent of their office visits were spent in psychotherapy which was loosely defined. (3 percent is presumably then a low estimate of the percent of time because psychotherapy probably takes longer than the usual office visit.) In response to a question about percent of visits in counseling, the definition of which overlapped with psychotherapy, internists reported 17 percent of office visits while general and family practitioners reported 10 percent.

From these figures I am not able to state how many people within each profession were doing psychotherapy but rather what percentage of time members of each profession spent in psychotherapy. From these percent time figures actual numbers of hours may be derived, and these lead to the conclusion that of these four professions, psychiatrists, psychologists and social workers do approximately 30 percent each and primary care physicians do approximately 10 percent (see Table).

The accuracy of these estimates is open to question. Some of the surveys were taken before 1976 (part of the primary care data and part of the social-work data). The figures offered by national organizations are estimates, by their own admission. There is no way to estimate how valid these figures are at the time these results are published. How many practitioners are inactive, or retired is not known. I have assumed a 40-hour week for the reported percentages but there is no way to tell how valid this assumption may be. Most critically, the definition of psychotherapy varies with each individual person surveyed.

No percentage-time figures were available for ministers, psychiatric and mental health nurses or counselors, yet these groups appear to be heavily involved in psychotherapy. The fact that many ministers are now taking out

TABLE I

U.S. PROFESSIONAL PSYCHOTHERAPY PRACTICE

	Total Numberof Members in Profession	% Time of Self-Reported Psychotherapy	Total Number of Hours per Week in Self-Reported Psychotherapy (based on 40 hour week)	Percent of Total Number of Self-Reported Hours in Psycho-therapy
Psychiatrists	30,000	32%	387,000	30%
Licensed/ Certified Psychologists	30,000	30%	360,000	28%
Master's Social Workers	100,000–120,000	10%	400,000	30%
Primary Care Physicians	120,000	3%	144,000	11%
TOTALS	851,000	---	1,291,000	99%

malpractice insurance,[28] that a Gallup Poll suggested that 57 percent of Americans want their church leaders to help them with their emotional problems,[29] and that pastoral counseling centers now number 250 and mental health centers number 750 suggest that religious leaders are substantially involved.[30] Not only has the number of master's degree mental health nurses increased dramatically in 1970–1980 but evidence is building that they are actively entering private practice, much of which is presumed to be psychotherapy.[23] Counselor activity is most difficult to pinpoint because the distinction between personal counseling and psychotherapy is ambiguous. (For the purposes of this study they are considered to be equivalent.)

Implications

This collection of figures is analogous to a confrontation during psychotherapy in that it points toward a reality which most psychotherapists would prefer to deny although they know it. To truly become aware of the fact that there are many psychotherapists of various stripes and categories is painful especially to those who have worked long and hard to establish their own identity and self-acceptance in this ambiguous endeavor. To continue half-heartedly to acknowledge that psychotherapy is running in many directions may be dangerous because more and more people with less and less training are now designating themselves as therapists. How is the public, how are third-party payors, how are psychotherapists themselves to distinguish who is able and who is not, who has been adequately trained and who has not?

The ambiguity as to what constitutes effective psychotherapy is supported rather than dispelled by overviews of psychotherapy outcome studies. Luborsky[31] was convinced that all schools seemed to deserve praise. Smith, Glass, and Miller[32] reached a similar conclusion in their meta-analysis of the outcome literature. Neither researcher could clearly define specific technical requirements correlated with positive outcome. Many reasons could be offered for this failure, including the primitive nature of the various research studies themselves and the tremendous difficulty in defining outcome criteria. Nevertheless each group of over-viewers concluded that certain common factors must play a part in determining the lack of discernible variance across outcomes of different forms of therapy. Some effort has been undertaken to define these factors,[33] yet they still remain unclear as therapists contend with others for conceptual supremacy or borrow haphazardly from different schools.

The Commission on Psychiatric Therapies of the American Psychiatric Association has been charged with developing guidelines for practicing psychotherapy with specific patients, but is not attempting to define the basic elements of psychotherapy. Chaired by T. Byram Karasu, M.D., with members including other people on the editorial board of this *Journal*, the commission is operating under the assumption that the basic elements of psychotherapy are defined. What is important under this assumption is how to place techniques with diagnosis in order to maximize outcome. Furthermore, the title of the commission implies that what is to be described are psychiatric therapies when in fact psychiatrists perform less than one third of the psychotherapy practiced in the United States (see Table). Except in those therapeutic strategies which include medications, the procedures defined by the commission will be applicable to the professional activities of members of at least six other professions.

Psychiatrists may be able to lead psychotherapists toward a clear definition of expectable, adequate practice. In order to perform this task adequately two complementary studies are required: (1) The basic elements of psychotherapy must be clearly defined to provide teachers and students with guidelines for their knowledge and behavior. (2) The demographics of American psychotherapists must also be more clearly defined in order to enlist the aid of willing psychotherapists in bringing order to the now chaotic, misleading and ambiguous practice of psychotherapy. Although data are anecdotal, there are suggestions that many psychotherapists are poorly trained for their tasks (e.g. unfamiliar with borderline diagnosis, medication indications, countertransference pitfalls). Some will be interested in organized, effective consultation but first they must be identified.

The national organization most suited to lead these twin efforts is probably the Association for the Advancement of Psychotherapy because it is willing to entertain a variety of different psychotherapeutic approaches while