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**Mind Games: Psychological Warfare Between Therapists and Scientists**

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Recently, while lecturing to a large group of lawyers, judges, mediators, and others involved in the family-court system in Los Angeles, I asked how many knew what a "social psychologist" was. Three people shyly raised their hands. That response was typical, and it's the reason I don't tell people anymore that I'm a social psychologist: They think I'm a therapist who gives lots of parties. If I tell them I'm a psychological scientist, they think I'm a pompous therapist, because everyone knows that "psychological science" is an oxymoron.

In fact, in many states, I cannot call myself a psychologist at all -- the word is reserved for someone who has an advanced degree in clinical psychology and a license to practice psychotherapy. That immediately rules out the many other kinds of psychologists who conduct scientific research in their respective specialties, including child development, gerontology, neurobiology, emotions, sleep, behavioral genetics, memory and cognition, sexual behavior and attitudes, trauma, learning, language, . . . and social psychology, the study of how social situations and other people affect every human activity from love to war.

For the public, however, the word "psychologist" has only one meaning: psychotherapist. It is true that *clinical* psychologists practice therapy, but many psychologists are not clinicians, and most therapists are not clinical psychologists. The word "psychotherapist" is completely unregulated. It includes people who have advanced training in psychology, along with those who get a "certification" in some therapeutic specialty; clinical social workers; marriage, family, and child counselors; psychoanalysts and psychiatrists; and countless others who have no training in anything. Starting tomorrow, I could package and market my own highly effective approach, Chocolate Immersion Therapy, and offer a weekend workshop to train neophytes (\$395, chocolate included). I could carry out any kind of unvalidated, cockamamie therapy I wanted, and I would not be guilty of a single crime. Unless I described myself as a psychologist.

As a result of such proliferation of psychotherapists, the work of psychological scientists who do research and teach at colleges and universities tends to be invisible outside the academy. It is the psychotherapists who get public attention, because they turn up on talk shows, offer advice in books and newspaper columns, and are interviewed in the aftermath of every disaster or horrible crime -- for example, speculating on the motives and childhoods of the Washington snipers. Our society runs on the advice of mental-health professionals, who are often called upon in legal settings to determine whether a child has been molested, a prisoner up for parole is still dangerous, a defendant is lying or

insane, a mother is fit to have custody of her children, and on and on. Yet while the public assumes, vaguely, that therapists must be "scientists" of some sort, many of the widely accepted claims promulgated by therapists are based on subjective clinical opinions and have been resoundingly disproved by empirical research conducted by psychological scientists. Here are a few examples that have been shown to be false:

- Low self-esteem causes aggressiveness, drug use, prejudice, and low achievement.
- Abused children almost inevitably become abusive parents, causing a "cycle of abuse."
- Therapy is beneficial for most survivors of disasters, especially if intervention is rapid.
- Memory works like a tape recorder, clicking on at the moment of birth; memories can be accurately retrieved through hypnosis, dream analysis, or other therapeutic methods.
- Traumatic experiences, particularly of a sexual nature, are typically "repressed" from memory, or split off from consciousness through "dissociation."
- The way that parents treat a child in the first five years (three years) (one year) (five minutes) of life is crucial to the child's later intellectual and emotional success.

Indeed, the split between the research and practice wings of psychology has grown so wide that many psychologists now speak glumly of the "scientist-practitioner gap," although that is like saying there is an "Arab-Israeli gap" in the Middle East. It is a war, involving deeply held beliefs, political passions, views of human nature and the nature of knowledge, and -- as all wars ultimately do -- money and livelihoods. The war spilled out of academic labs and therapists' offices and into the public arena in the 1980s and '90s, when three epidemics of hysteria caught fire across the country: the rise of claims of "repressed memories" of childhood sexual abuse; the growing number of cases of "multiple-personality disorder" (MPD), from a handful before 1980 to tens of thousands by 1995; and the proliferation of day-care sex-abuse scandals, which put hundreds of nursery-school teachers in prison on the "testimony" of 3 and 4-year-old children.

All three epidemics were fomented and perpetuated by the mistaken beliefs of psychotherapists: that "children never lie about sexual abuse"; that childhood trauma causes the personality to "split" into several or even thousands of identities; that if you don't remember being sexually abused in childhood, that's evidence that you were; that it is possible to be raped by your father every day for 16 years and to "repress" the memory until it is "uncovered" in therapy; that hypnosis, dream analysis, and free association of fantasies are reliable methods of "uncovering" accurate memories. (On the contrary, such techniques have been shown to increase confabulation, imagination, and memory errors, while inflating the belief that the retrieved memories are accurate.) The epidemics began to subside as a result of the painstaking research of psychological scientists.

But psychotherapeutic nonsense is a Hydra: Slay one set of mistaken ideas, and others take their place. Recovered-memory therapy may be on the wane, but "rebirthing" techniques and forms of "restraint therapy" -- physically abusive practices that

supposedly help adopted or troubled children form attachments to their parents -- are on the rise. In Colorado, 10-year-old Candace Newmaker was smothered to death during rebirthing, a procedure in which she was expected to fight her way through a "birth canal" of suffocating blankets and pillows. The two therapists convicted in Candace's death are now serving time in prison, but efforts in Colorado to prohibit all forms of "restraint therapy" were defeated by protests from "attachment therapists" in the state and throughout the country. After Candace's death, one member of the Colorado Mental Health Grievance Board noted with dismay that her hairdresser's training took 1,500 hours, whereas anyone could take a two-week course and become "certified" in rebirthing. Yet the basic premise -- that children can recover from trauma, insecure attachment, or other psychological problems by "reliving" their births or being subjected to punitive and coercive restraints -- has no scientific validity whatsoever.

To understand how the gap between psychological scientists and clinicians grew, it is necessary to understand a little about therapy and a little about science, and how their goals and methods diverged. For many years, the training of most clinical psychologists was based on a "scientist practitioner" model. Ideally, clinicians would study the research on human behavior and apply relevant findings to their clinical practice. Clinical psychologists who are educated at major universities are still trained in this model. They study, for example, the origins of various mental disorders and the most effective ways to treat them, such as cognitive-behavior therapy for anxiety, depression, eating disorders, anger, and obsessive-compulsive disorder.

They have also identified which interventions are unhelpful or potentially harmful. For example, independent assessments of a popular post-trauma intervention called Critical Incident Stress Debriefing have found that most survivors benefit just as much by talking with friends and other survivors as with debriefers. Sometimes CISD even slows recovery, by preventing victims from drawing on their own wellsprings of resilience. And, sometimes, it harms people -- for example, by having survivors ventilate their emotions without also learning good methods of coping with them.

Unfortunately, the numbers of scientifically trained clinicians have been shrinking. More and more therapists are getting their degrees from "free-standing" schools, so called because they are independent of research institutions or academic psychology departments. In these schools, students are trained only to do therapy, and they do not necessarily even learn which kinds of therapy have been shown to be most effective for particular problems. Many of the schools are accredited by the American Psychological Association, and their graduates learn what they need to know to pass state licensing examinations. But that does not mean that the graduates are scientifically knowledgeable. For example, the Rorschach Inkblot Test has been resoundingly discredited as a reliable means of diagnosing most mental disorders or emotional problems; it usually reveals more about the clinician administering it than about the individual taking it. I call it the Dracula of psychological tests, because no one has been able to drive a stake through the cursed thing's heart. Many clinicians love it; it is still widely used; and it still turns up on licensing exams.

Of course, tensions exist between researchers and practitioners in any field -- medicine, engineering, education. Whenever one group is doing research and the other is working in an applied domain, their interests and training will differ. The goal of the clinician, in psychology or medicine, is to help the suffering individual; the goal of the psychological or medical researcher is to explain and predict the behavior or course of illness in people in general. That is why many clinicians argue that empirical research cannot possibly capture the complex human beings who come to their offices. Professional training, they believe, should teach students empathy and appropriate therapeutic skills. Good therapy depends on the therapist's insight and experience, not on knowledge of statistics, the importance of control groups, and the scientific method.

I agree that therapy often deals with issues on which science is silent: finding courage under adversity, accepting loss, making moral choices. My clinician friends constantly impress me with their deep understanding of the human condition, which is based on seeing the human condition sobbing in their offices many times a week. Nor am I arguing that psychological scientists, or any other kind, are white knights with a special claim to intellectual virtue. They, too, wrangle over data, dispute each other furiously in print and public, and have plenty of vested interests and biases. (For example, many scientists and consumer advocates are concerned about the growing co-optation of scientific investigators by the pharmaceutical industry -- which now finances the majority of studies of treatments for mental disorders and sexual problems -- because the result has been a pro-drug bias in research.)

It is not that I believe that science gives us ultimate truths about human behavior, while clinical insight is always foolish and wrong. Rather, I worry that when psychotherapists fail to keep up with basic research on matters on which they are advising their clients; when they fail to learn which methods are most appropriate for which disorders, and which might be harmful; when they fail to understand their own biases of perception and do not learn how to correct them; when they fail to test their own ideas empirically before running off to promote new therapies or wild claims -- then their clients and the larger public pay the price of their ignorance.

For present purposes, I am going to do an end run around the centuries-old debate about defining science, and focus on two core elements of the scientific method. These elements are central to the training of all scientists, but they are almost entirely lacking in the training of most psychotherapists, including clinical psychologists. The first is skepticism: a willingness to question received wisdom. The second is a reliance on gathering empirical evidence to determine whether a prediction or belief is valid. You don't get to sit in your chair and decide that autism is caused by cold, rejecting, "refrigerator" mothers, as Bruno Bettelheim did. But legions of clinicians (and mothers) accepted his cruel and unsubstantiated theory because he was, well, Bruno Bettelheim. It took skeptical scientists to compare the mothers of autistic children with those of healthy children, and to find that autism is not caused by anything parents do; it is a neurological disorder.

The scientific method is designed to help investigators overcome the most entrenched

human cognitive habit: the *confirmation bias*, the tendency to notice and remember evidence that confirms our beliefs or decisions, and to ignore, dismiss, or forget evidence that is discrepant. That's why we are all inclined to stick to a hypothesis we believe in. Science is one way of forcing us, kicking and screaming if necessary, to modify our views. Most scientists regard a central, if not defining, characteristic of the scientific method to be what Karl Popper called "the principle of falsifiability": For a theory to be scientific, it must be falsifiable -- you can't show me just those observations that confirm it, but also those that might show it to be wrong, false. If you can twist any result of your research into a confirmation of your hypothesis, you aren't thinking scientifically. For that reason, many of Freud's notions were unfalsifiable. If analysts saw evidence of "castration anxiety" in their male patients, that confirmed Freud's theory of its universality; if analysts didn't see it, Freud wrote, they lacked observational skills and were just too blind or stubborn to see it. With that way of thinking, there is no way to disconfirm the belief in castration anxiety.

Yet many psychotherapists perpetuate ideas based only on confirming cases -- the people they see in therapy -- and do not consider the disconfirming cases. The popular belief in "the cycle of abuse" rests on cases of abusive parents who turn up in jail or therapy and who report that they were themselves victims of abuse as children. But scientists would want to know also about the disconfirming cases: children who were beaten but did not grow up to mistreat their children (and, therefore, did not end up in therapy or jail), and people who were not beaten and then did grow up to be abusive parents. When the researchers Joan Kaufman and Edward Zigler reviewed longitudinal studies of the outcomes of child abuse, they found that although being abused does considerably increase the risk of becoming an abusive parent, more than 70 percent of all abused children do not mistreat their offspring -- hardly an inevitable "cycle."

Practitioners who do not learn about the confirmation bias and ways to counteract it can make devastating judgments in court cases. For example, if they are convinced that a child has been sexually molested, they are often unpersuaded by the child's repeated denials; such denials, they say, are evidence of the depth of the trauma. Sometimes, of course, that is true. But what if it isn't? In the Little Rascals day-care-abuse case in North Carolina, one mother told reporters that it took *10 months* before her child was able to "reveal" the molestation. No one at the time considered the idea that the child might have been remarkably courageous to persist in telling the truth for so long.

Because many therapists tend not to be as deeply imbued with the spirit of skepticism as scientists are (or are supposed to be), it is common for many of them to place their faith in the leader of a particular approach, and to set about trying to do what the school's founder did -- rather than to raise too many questions about the founder's methods or the validity of the founder's theories. If you go off to become certified in Eye Movement Desensitization and Reprocessing (EMDR), invented by Francine Shapiro while she was walking in the woods one day, you are unlikely to ask, "Why, exactly, does waving your finger in front of someone's eyes realign the halves of the brain and reduce anxiety?" Scientific studies of this method show that the successful ingredient in EMDR is an old, tried-and-true technique from behavior therapy: exposing people to a thought or situation

that makes them anxious, until the feeling subsides. The eye movements that are supposedly essential, the clinical scientist Scott O. Lilienfeld concluded, do not constitute "anything more than pseudoscientific window dressing."

Similarly, most clinicians are not trained to be skeptical of what a client says or to demand corroborating evidence. Why would they be? A client comes to see you complaining that he has a terrible mother; are you going to argue? Ask to meet the mother? Some clinicians, notably those who practice cognitive-behavior therapy, would, indeed, ask you for the evidence that your mother is terrible and also invite you to consider other explanations of her behavior; but most do not. As the psychiatrist Judith Herman explained in a PBS *Frontline* special on recovered memory: "As a therapist, your job is not to be a detective; your job is not to be a fact-finder; your job is not to be a judge or a jury; and your job is also not to make the family feel better. Your job is to help the patient make sense out of her life, make sense out of her symptoms . . . and make meaning out of her experience."

That remark perfectly summarizes the differing goals of most clinicians and scientists. Clinicians are certainly correct that most of the time it is not possible to corroborate a client's memory anyway, and that it isn't their job to find out what "really" happened in the client's past. Scientists, though, have shown that memories are subject to distortion. So, if the client is going to end up suing a parent for sexual abuse, or if the therapist's intervention ends up causing a devastating family rift, a little detective work seems called for. Detective work is the province of scientists, who are trained *not* to automatically believe what someone says or what someone claims to remember, but to ask, "Where's the evidence?"

For psychological scientists, clinical insight is simply not sufficient evidence. For one thing, the clinician's observations of clients will be inherently limited if they overlook comparison groups of people who are not in therapy. For example, many clinicians invent "checklists" of "indicators" of some problem or disorder -- say, that "excessive" masturbation or bed-wetting are signs of sexual abuse or, my favorite, that losing track of time or becoming engrossed in a book is a sign of multiple-personality disorder. But, before you can say that bed-wetting or masturbation is an indicator that a child has been sexually abused, what must you know? Many psychotherapists cannot give you the simple answer: You must know the rates of bed-wetting and masturbation among all children, including nonabused ones. In fact, many abused children have no symptoms, and many nonabused children wet their beds, masturbate, and are fearful in new situations.

Throughout the 1980s and '90s, many therapists routinely testified in court that they could magically tell, with complete certainty, that a child had been sexually abused because of how the child played with anatomically correct dolls, or because of what the child revealed in drawings. The plausible assumption is that very young children may reveal feelings in their play or drawings that they cannot express verbally. But while such tests may have a therapeutic use, again the scientific evidence is overwhelming that they are worthless for assessment or diagnostic purposes. How do we know that? Because

when scientists compared the doll play of abused children to that of control groups of nonabused children, they found that such play is not a valid way of determining whether a child has been sexually abused. The doll's genitals are pretty interesting to all kids.

Likewise, psychological scientists who study children's cognitive development empirically have examined the belief held by many psychotherapists that "children never lie" about sexual abuse. Scientists have shown in dozens of experiments that children often do tell the truth, but that they also lie, misremember, and can be influenced to make false allegations -- just as adults do. Researchers have shown, too, that adults often misunderstand and misinterpret what children say, and they have identified the conditions that increase a child's suggestibility and the interviewing methods virtually guaranteed to elicit false reports. Those conditions and methods were present in the interrogations of children by social workers, therapists, and police officers in all of the sensational cases of day-care hysteria of the 1980s and '90s. And those coercive practices continue in many jurisdictions today where child-protection workers have not been trained in the latest research.

I fear that the scientist-therapist gap is a done deal. There are too many economic and institutional supports for it, in spite of yearly exhortations by every president of the American Psychological Association for "unity" and "cooperation." That's why, in the late 1980s, a group of psychological scientists formed their own organization, the American Psychological Society, to represent their own scientific interests. Every year, the APA does something else to rile its scientific members while placating its therapist members -- like supporting prescription-writing privileges for Ph.D. psychologists and approving continuing-education programs for unvalidated methods or tests -- and so, every year, more psychological scientists leave the APA for the APS.

But to the public, all this remains an internecine battle that seems to have no direct relevance. That's the danger. Much has been written about America's scientific illiteracy, but social-scientific illiteracy is just as widespread and in some ways even more pernicious. People can deny evolution or fail to learn basic physics, but such ignorance rarely affects their personal lives. The scientific illiteracy of psychotherapists has torn up families, sent innocent defendants to prison, cost people their jobs and custody of their children, and promoted worthless, even harmful, therapies. A public unable to critically assess psychotherapists' claims and methods for scientific credibility will be vulnerable to whatever hysterical epidemic comes along next. And in our psychologically oriented culture, there will be many nexts. Some will be benign; some will merely cost money; and some will cost lives.

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