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Contextualizing psychotherapy as a healing practice: Culture, history, and methods

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Abstract

The histories of modern medicine and psychotherapy are examined to situate psychotherapy in the array of healing practices. Although modern medicine relies on specificity as its central organizing concept, psychotherapy has consistently produced results that are not consistent with a medical model. Moreover, the development of research methodologies used to validate treatments, although useful in the medical context, ignores the experience of the patients as well as the provider of services. It is demonstrated that psychotherapy is a culturally imbedded healing practice and shares similarities with healing practices other than modern medicine. Psychotherapy shares one important feature with modern medicine, however: empirical support for efficacy. Various theories of placebo effects are examined to propose explanations for the effects of psychotherapy. Finally, issues and paradoxes are presented for future consideration.

Key words: Common factors, Culture, Medical model, Psychotherapy, Specificity

He cures most in whom most are confident.
—Galen, second century Roman physician

Heaven knows, the medical profession is the only one in which anybody professing to be a physician is at once trusted, although nowhere else is an untruth more dangerous. We pay however no attention to the danger, so great for each of us is the seductive sweetness of wishful thinking.
—Gaius Plinius Secundus (Pliny the Elder), first century Roman scientific encyclopedist

Psychotherapy has been characterized as a healing practice, most notably by Jerome Frank in the various editions of *Persuasion and Healing* (e.g., Frank & Frank, 1991). Healing practices have developed over time and within cultures, creating a myriad of methods of healing, some with which psychotherapy is closely aligned and others from which psychotherapy is quite different. In this article, the boundaries of psychotherapy as a healing practice will be explored, exposing how psychotherapy is imbedded in cultural contexts and explaining, albeit tentatively, why psychotherapy appears to be beneficial.

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Healing practices are endemic to societies since the origins of human societies:

> According to Sir William Osler (1932), the desire to take medicine is one feature that distinguishes hominids from their fellow creatures. . . . Although nothing is known about the earliest medications or about the first physician, historians date the earliest portrait of a physician to Cro-Magnon times, 20,000 B. C. (Haggard 1934; Bromberg 1954). This horned tailed, hirsute, and animal-like apparition had great psychological effect, and it is likely that the treatment used was simply a vehicle for the psychological or placebo effect and was without any intrinsic merit (Model 1955). (Shapiro & Shapiro, 1997b, p. 3)

Indeed, it is impossible to identify historically a civilization in which medicines, rituals, and healers were (are) not central features of the culture. As societies evolved, the human mind was predisposed to generate explanations of physical, mental, and somatic phenomena. Healers not only claimed to cure various disorders but they provided the reassurance that there was an explanation for the disorder. These explanations were generated by the prevailing meta-physical Zeitgeist of the society. According to the Pythagoreans, matter was composed of four basic elements: earth, air, fire, and water and analogously, the body was composed of four humors: blood, phlegm, yellow bile, and black bile. Personali-

ties were manifestations of mixtures of humors (temperament from the Greek *termperamentum,* meaning blending of humors); for example, "the choleric person, driven by hot yellow bile, was inclined to great anger" (Shapiro & Shapiro, 1997b. p. 7). The humors, which were thought to be affected by diet, weather, climate, created health when balanced and illness when unbalanced—a disharmony between the microcosmic bodies and the divinely ordered macrocosm (Morris, 1997). The Apache shaman, whose power derived from special status among the spirits or from possession of a sacred object, administered complex rituals consistent with the cultural beliefs of the Apache people. The rituals were designed to replace evil spirits with protective ones and involved dance, drums, rattles, prayers, and chants, led by the shaman elaborately dressed in animal skins and masks. The shamans would tend directly to the patient, often sucking on the afflicted part of the body to draw out evil spirits, sometimes spitting out a stone for dramatic effect (Morris, 1997). Traditional Chinese medical practices, described in the *I Ching (Book of Changes)* and the *Huang Ti Nei Ching Su Wen (The Yellow Emperor's Classic of Internal Medicine)*, postulated five elements: water, fire, wood, metal, and earth and combinations of the yin and yang. Diseases were treated with five tastes, five types of grain, and five flavors (e.g., pungent food was used to prevent disintegration of the liver and sour food to drain the liver), supplemented by acupuncture, which has persisted as a Chinese treatment for more than 2,500 years (Shapiro & Shapiro, 1997b).

There is extensive variation among healing practices of various societies as well as over time, as there are for religions, meta-physics, and political systems (Cohen, 2001). In a sense, the healing practices define, in part, the culture and therefore cannot be considered separately from other predominant aspects of the culture. The culturally imbedded nature of healing practices suggests that members of the society will believe in the rationale for the healing practice and little effort will be needed to explain the precepts of the healing practice. It was not necessary to explain to ancient Greek patients the intricacies of mythology and their relation to health, as their understanding of the world was saturated with mythology. The rituals involved in temple healing practices were used not so much to "convert" patients but to convince them that the practices were consistent with cultural beliefs. Indeed, healers would have a difficult time convincing patients of a practice that was inconsistent with current epistemological and meta-physical systems.

Some social practices as well as proscriptions against others are found in all societies because they have clear survival value. For instance, incest taboos are ubiquitous because of the benefits to the society of having healthy children (Cohen, 2001). As Cohen notes, however, many important belief systems and practices, such as religion, are relatively immune from an objective evaluation of their benefits for the society and are only marginally determined by evolved predispositions. There is a romantic notion that healing practices indigenous to various societies were (or are) beneficial. Frank and Frank's (1991) discussion of healing leaves the distinct impression that the healing context, the provision of a contextually imbedded rationale, the administration of a ritual consistent with the rationale, and an emotionally aroused and involved patient in a relationship with a healer are sufficient for change or improvement. Although this model has been proposed to explain the efficacy of psychotherapy (see also Wampold, 2001), there is no guarantee that healing practices that contain these components effectively heal or cure.

Indeed, contrary to the romantic ideal, there is much evidence that many healing practices were ineffective and probably dangerous. Hippocrates prescribed a diet that excluded vegetables and fruits, resulting in vitamin deficiencies. Acupuncture, as a result of unsterilized needles, caused homologous serum jaundice, a deadly disease that was prevalent in China for centuries and killed many. Bloodletting induced dehydration and, along with other dehydrating procedures, (e.g., induced vomiting, enemas, leeching) "killed more patients than any other treatment in the history of medicine" (Shapiro & Shapiro, 1997b, p. 18). George Washington was no doubt killed by his physician, who treated an abscessed tonsil with a variety of dehydrating procedures.

There has been a tendency to bolster support for ancient medical practices by citing the active ingredients in some compounds. However, Shapiro and Shapiro (1997a, 1997b) have discussed how the active medications contained a dosage that was not therapeutic and were used regardless of the diagnosis of the patient. For example, the amount of opium in theriac (a mixture of as many as 100 substances that appeared in the pharmacopeias of many Western cultures until the end of the 19th century) was insufficient to treat pain or anxiety. Foxglove, which contains digitalis, was used to treat hysteria, pneumonia, and many other complaints for which it was ineffective, as well as to treat heart problems, for which it was effective.

Another problem with establishing the efficacy of many healing practices is that miraculous cures were often occasioned in patients who had been erroneously diagnosed, were used to treat disorders that spontaneously remitted (e.g., dysphoria, rhinitis), or were used as prophylaxes for disorders that occurred rarely. With regard to acupuncture, Shapiro and Shapiro (1997b) noted,

> Although Veith (1972) concludes that "the maintenance of these cumbersome and probably painful methods of treatment must indicate that they posses healing power," the Yellow Emperor inadvertently proposed a better explanation. "The ancient sages did not treat those who were already ill, [only] those who were not ill." (p. 17)

For the most part, the cures of cancer by hope or by placebos have occurred in cases in which the diagnosis of cancer was either never made or made incorrectly. The story of Norman Cousins, whose cure by large doses of vitamin C and the

power of affirmative emotions (and who wrote the foreword to the 1991 edition of *Persuasion and Healing,* [Frank & Frank, 1991]), is well known and often cited, despite the fact that documentation of a life-threatening disease has never appeared (Spiro, 1998).

Finally, it should be recognized that the efficacy of healing practices may be specific to the maladies experienced in the culture. The Apache rituals were sufficient to prevent snake bites but had no effect on the deadly small pox virus introduced by the immigration of European Americans.

Healing practices exist in every society. The rationale for the benefits of these practices are imbedded in and are indistinguishable from the culture itself. The degree to which healing practices have produced benefit is unknown, although many of the treatments caused harm. Yet, in spite of the harmful effects of many healing practices, participation in these practices flourished. It is unclear whether patients participated in healing rituals because they expected to benefit or because treatment was a cultural norm. Where is psychotherapy located in the array of healing practices, why do patients avail themselves of this service, and why does it work, if indeed it works at all? To address these important questions, attention is focused on the origins of scientific medicine and the development of psychotherapy.

The Evolution of Scientific Medicine, The Origins of Psychotherapy, And Specificity in Psychotherapy

Evolution of Scientific Medicine

The origins of scientific medicine began with Hippocrates and Galen, who, despite their advocacy of untested healing substances and procedures, searched for empirical relationships between various observable events and began systematic investigations of anatomy and physiology. In the 17th century, Descartes aided the scientific quest by emphasizing mind–body dualism, which in effect led to the separation of anatomy and physiology from meta-physics and what was to become psychology, as well as the need to find the answers to questions by observation and facts rather than debate among philosophers. As science and the scientific method were evolving in Europe, advances in medicine included recognizing that certain medications were effective for particular diseases (e.g., foxglove for congestive heart conditions and cinchona bark for malaria). Very gradually, keen observation was replaced by controlled experiments.

As science emphasized observation and the temporal relationship between cause and effect, physicians began to recognize that most of their compounds were worthless. In 1785 the term "placebo" (from the French *to please* or *placate*) entered the medical lexicon to denote treatments that were known to be ineffective physiochemically but were administered to satisfy the patient's desire to be treated (Shapiro & Shapiro, 1997b). Gradually, medicine sought to identify those treatments that worked psychochemically. Caught in the changing times was Mesmer, often mentioned in discussions of the origins of psychotherapy. Mesmer, a physician and scientist (e.g., member of the Bavarian Academy of Science), became interested in purported cures by animal magnetism. Mesmer garnered a reputation as an effective healer, publicly demonstrating many cures. Mesmer's work was conducted during the period following Sir Isaac Newton's development of the calculus and Newtonian physics and science were in their ascendancy. Mesmer firmly believed that his methods involved state-of-the-art science, which he extended to medicine. Although his treatments were valued by the elite in Paris, King Louis XVI appointed a special committee of scientists (including Benjamin Franklin, Antoine Lavoisier, and Joseph Guillotine) to investigate the treatment. The committee found that although the treatment was effective, there was no scientific basis for animal magnetism and that the cures resulted from internal states and the patient's imagination (Darnton, 1968). (Ironically, Franklin, chair of the committee, experimented with static electricity as a treatment for paralysis, although Franklin admitted that the benefits were caused by the motivation of the patients.) Stephen Jay Gould (1989), a solid advocate of science and the scientific method, has described the discrediting of Mesmer as an historic event in the history of science because it demonstrated the use of the scientific method to reveal a charlatan. On the other hand, there are those who believe that Mesmer's induction of hypnotic trances were at the origins of psychological treatments (Crabtree, 1993). Mesmer's treatments were similar to those of the healers and physicians that he followed—the rationale for the treatment was consistent with the predominant cultural thought (viz., Newtonian physics, which involved the study of magnetism) and the treatment was popular and valued regardless of whether the efficacy of the treatment was established. However, the duality of mind and body, the rise of science, and an increasing distrust of charlatans added a new requirement for medical treatments in the West—the treatment was now required to work through the purported physiochemical mechanism and not because of the faith, hope, or imagination of the patient.

Although the Mesmer example described how scientific medicine was beginning to require a demonstration that the effects of medical procedures were caused by demonstrable physiochemical mechanisms, the growth of the methodology to accomplish this task systematically took over 200 years to develop. Presently, the randomized double-blind placebo control group design is the standard procedure to establish that the effect of a medical treatment results from the purported physiochemical components of the treatment, rather than psychological effects. An examination of the history of the development of the randomized double-blind placebo control group reveals the veracity of the claim by some philosophers of science that research methods and theory are inextricably linked (e.g., Latour, 1999).

Danziger (1990) identified three strands that intertwined to

result in the development of the randomized treatment comparison design, which was a precursor of the randomized double-blind placebo control group. The first strand emanated during the second half of the nineteenth century from Wilhelm Wundt, in whose laboratory studies were conducted on a few participants undergoing various experimental conditions. The participants, who included Wundt and his students, were called *observers* because they conceived of themselves as trained scientists who could report on and interpret aspects of the mind, much in the way that natural scientists could report on and interpret physical phenomena. The goal of such experiments, which primarily were limited to simple sensation and perception tasks, was to identify general laws that governed the mind. The second strand involved British investigators of mental abilities, such as Sr. Francis Galton and Karl Pearson, who considered distributions of scores in order to compare the abilities of people. The importance of the mean of distribution was that it represented the central tendency of the distribution—a numerical representation of normality. Deviations from the mean were considered individual differences and a means to classify individuals (e.g., as mentally defective). Mental ability was considered a trait and no attempt to intervene or treat the person was considered in this paradigm. At the same time Wundt was initiating his laboratory studies, a group of French scientists began studying hypnosis in the medical context. These studies differed in an important way from Wundt's—the French scientists were the experimenters and the subjects were patients, a clear departure from the Wundtian tradition in which the scientists (viz., Wundt and his students) exchanged the roles of experimenter and observer (what is now called "subject") and both experimenter and observer were authors of the research reports. Moreover, the French desired to compare groups of subjects, primarily pathological and normal subjects.

To develop the randomized clinical trial, all that was needed was the concept of random assignment. Wundt had introduced the idea of extracting general rules, the British group provided the statistical theory related to deviations from the mean, and the French researchers devised designs in which the experimenter subjected research participants to various conditions. The impetus for randomization came from the desire to provide pragmatic knowledge to various consumer groups. Academic psychologists, managing the development of a nascent discipline, desired to apply psychological knowledge to education. In the early 1920s, the treatment group methodology was "being sold to American school superintendents as the 'control experiment' and was touted as a key element in comparing the 'efficiency' of various administrative measures" (Danziger, 1990, p. 114). Shortly thereafter, McCall (1923) published *How to Experiment in Education,* which systematically presented randomized control group experimentation in education. At about the same time, Sir Ronald Fisher, seeking employment after finding it difficult to have his statistical work published because it was not well received by Karl Pearson (the imperious leader of British statistics and Editor of *Biometrika*), took a position at an agricultural station where he developed the analysis of variance and various other procedures for comparing crop yields (Gehan & Lemak, 1994). Fisher's work in experimental design, most prominently *The Design of Experiments* (1935), was useful to medical researchers eager to show the efficacy of various medications (Gehan & Lemak, 1994; Shapiro & Shapiro, 1997b).

There was one additional step in experimental design that was strategic to its use in medicine. Although the methods developed in education, psychology, and agriculture were used in medical trials, the goal of modern medicine was to establish that the benefits of any medical treatment were the result of the physiochemical properties of the medication and not the patient's expectations, hopes, or other psychological processes, thereby establishing the specificity of the purported active ingredients of the medication. In order to accomplish that goal, a placebo-control condition was added to the design; to ensure that psychological effects were ruled out, neither the patient nor the administrator of the treatment were informed of the condition (i.e., the study was double-blind). In the late 1930s, the first double-blind placebo studies were used in medicine in the United States and independently in the United Kingdom, but the method did not quickly take root, apparently because "placebo" carried a negative connotation (Gehan & Lemak, 1994; Shapiro & Shapiro, 1997a, 1997b). Those who developed the double-blind placebo study felt that it was absolutely necessary that the inert placebo be absolutely indistinguishable from the medication, with the exception that the placebo did not contain the ingredient purported to be efficacious physiochemically and that neither the subjects, the administrators of the medication, nor the evaluators knew which patients were receiving the medication and which were receiving the placebo. Because patients could distinguish placebos by the taste, the pharmaceutical industry was requested to manufacture placebos that were identical to the medications in taste, shape, color, and form.

Gradually, the acceptance of the randomized double-blind placebo design spread. Harry Gold, a pharmacologist who developed the design in the United States, participated in several conferences at Cornell University on the subject in the late 1940s and early 1950s; he became the first professor of clinical pharmacology, a new discipline. As noted by Shapiro and Shapiro (1997b):

> Gold advocated a comparison between "an allegedly potent agent and a blank of such physical properties as to render a distinction between the two impossible except through some pharmacologic potency which may exist . . . [the recommended] double-blind procedure which calls for an investigation in which neither the patient nor the doctor is aware of the identify of the two agents until the results are in and analyzed. This is imperative to avoid the influence of subconscious bias . . . " (Gold, 1954, p. 724). The statement by Gold culminated twenty years of pio-

> neering study of methods with which to reliably and validly evaluate the effectiveness of new drugs. (p. 148)

By 1980, the FDA required that evidence for the effectiveness of a drug be obtained from randomized double-blind placebo trials. The Cartesian dualism of mind and body was now scientifically accomplished as the design was adequate to eliminate any mental process (e.g., expectation, conditioning, imagination) from the calculation of the effect of the drug on the body!

To return to the intimacy between design and theory (and in this case practice), the development of the randomized control-group design reveals two important aspects of this design that determine the nature of knowledge claims. First, the shift from the introspective tradition of Wundt in Germany and Tichener in the United States represented a momentous shift in the epistemics and pragmatics of psychological research: "What was desired was knowledge of individuals as *the objects of intervention rather than as the subjects of experience*" (Danziger, 1990, p. 67); thus a research paradigm was created that was unable to assess what was considered unimportant, the experience of subjects. Second, in all three applied contexts (viz., education, agriculture, and medicine), the persons who applied the treatments were ignored as a legitimate source of variance. Research design was sold to educational administrators who possessed both money and power—the teachers, predominantly low-paid women, who implemented the programs in schools, were considered interchangeable and unimportant. In agriculture, variations among farmers were not considered as the practice of scientific farming emphasized the agricultural methods, which presumably could be applied uniformly by the farmer. The double-blind in medicine further reduced the role of the provider of services, as the physician or physician proxy were unaware of whether they were providing an active medication or a placebo. Ignoring the provider of the treatment in each of these applications was not due to the lack of a research design that could accomplish the goal, as nested and crossed designs were available—rather, the consumers of this research were focused on identifying optimal treatments, or in the case of medicine, ruling out psychological effects and identifying physiochemical effects. Although the knowledge claims generated by clinical trials satisfied the needs of the consumers and have been heralded as a major scientific advance (Gehan & Lemak, 1994), they become troublesome when applied to psychotherapy research, as will be demonstrated in the next section.

It has been demonstrated that specificity has distinguished modern medicine from other healing practices. The randomized double-blind placebo control group was instrumental in the development of modern medicine because it controlled for the psychological effects that had plagued attempts to validate particular medical treatments that were specific for particular disorders. However, medicine would not have advanced without the concurrent development of germ theories of disease, which provided the physiochemical mechanisms to generate the effects detected by clinical trials. In medicine, specificity is also established by demonstrating that the ingredient works through its intended mechanism. For example, antibiotics outperform placebos for the treatment of bacterial pneumonia; moreover, a demonstrable decrease in the bacteria count and the toxins they produce precede the reduction of symptoms in the treatment group, where such reductions do not occur in the placebo group. Moreover, as expected, antibiotics are ineffective for the treatment of viral infections.

A postscript is needed to this short history of the development of "scientific" medicine. As successful as modern medicine has been, citizens of the United States are not satisfied and have sought a variety of alternative treatments, including folk medicine, herbal medicine, diets, faith healing, homeopathy, new-age healing, chiropractic, acupuncture, and massage, among others. Clearly, modern medicine does not provide sufficient cultural opportunities for the citizens to satisfy their need to make sense of and treat their disorders. In a postmodernism inspired move, the U.S. Congress authorized the creation of the National Center for Complementary and Alternative Medicine (NCCAM) within the National Institutes of Health. NCCAM "is dedicated to exploring complementary and alternative healing practices in the context of rigorous science, training CAM researchers; and disseminating authoritative information" (National Center for Complementary and Alternative Medicine, 2001). Interestingly, NCCAM requires clinical trials to validate the use of alternative methods and seeks to find explanations for the benefits of such treatments within the confines of modern medicine. For example, acupuncture is indicated by NCCAM only for the treatment of postoperative and chemotherapy nausea and vomiting and in postoperative dental pain; "findings from basic research have begun to elucidate the mechanisms of action of acupuncture, including the release of opioids and other peptides in the central nervous system and the periphery and changes in neuroendocrine function" (Acupuncture, 1997). Modern medicine's experiment with alternative procedures has changed the five humors and yin and yang into opioids and thus inevitably changed how patients will view this treatment (i.e., how the mind will be involved).

Evolution of Psychotherapy—Psyche, Soma, and the Medical Model

Mental disorders caused particular problems for the medical establishment in the United States at the end of the 19th century and the beginning of the 20th century. Struggling to be accepted as a legitimate profession based on scientific principles, medicine emphasized physiochemical (i.e., somatic) processes. The prevailing attitude toward mental health problems was one of psychophysical parallelism in which mental states corresponded with physical states and it was hypothesized that mental disorders were caused by some physiochemical process, as yet undetected. Many disorders of that

time were functional (i.e., the cause unknown) rather than structural (i.e., cause known); mental disorders were assigned to the former category. The context of emergent scientific medicine disallowed consideration of mental therapeutics or psychosocial causes of disorders.

Several events, however, made medicine's stance toward mental disorders untenable (Caplan, 1998). First, technology produced the train, which had the mass to create catastrophic collisions, producing a condition known as "railway spine." This condition had a constellation of symptoms that could not be attributable to a specific injury; moreover, witnesses to the mass casualties manifested many of the same symptoms, creating a debate about the etiology of physical and mental disorders. Second, neurasthenia became a prevalent disorder in the United States, recognized by most physicians but with unknown physiochemical etiology. Although there was optimism that a physical basis would be found, physicians' treatments ranged broadly, a fact that interested some prescient physicians:

> How was it, certain physicians asked, that so many different modalities of somatic therapies ranging from electricity and hydrotherapy to diet, rest, nutrition, and medication could achieve identical results? Might they not share a common ground? Deducing from the variegated experiences of a wide array of somatic treatments, the Boston neurologist Morton Prince declared, "I think if these treatments are carefully analyzed it will be found that there is one factor common in them all, namely, the psychical element" (Caplan, 1998, p. 45)

Third, the Cartesian duality of psyche and soma created an unfilled need to attend to the psyche, generating a plethora of "mind cures," including the Christian Science and the New Thought movements. Medicine was able to dismiss these movements, for the most part, as unscientific attempts to minister to the mind, when disorder was caused by the body, and as quasi-religious activities that had no place in medicine. Gradually, the legitimacy of mental cures grew, due in part to an organization that went by the name of the Boston School of Psychotherapy, which included the psychologists William James and G. Stanley Hall, as well as neurologists and psychiatrists as members. In 1906, the Emmanuel movement was initiated as a collaboration between physicians who recognized the importance of the psyche and Christian ministers who recognized the moral aspect to behavior. The popularity of the Emmanuel movement, however, posed a perspicuous threat and professional medicine was presented a dilemma: Reject the emerging psychotherapeutics because it treated psychic disorders with nonmedical means (viz., talk) or absorb the lucrative professional practice of mental therapeutics. Medicine asserted its professional privilege to conduct psychotherapy in a contentious battle reminiscent of future ones between various mental health professional groups. When Freud gave his lectures at Clark University in 1909, psychotherapy was established as a legitimate medical practice in the United States, and thus medicine was eager to locate and adopt a coherent theory of mental disorder, which Freud was more than happy to provide.

Freud began his work in talk therapy in order to treat the hysterics that presented to his medical practice. Early on, he developed a system of treatment that involved the following premises: (a) hysteric symptoms are caused by repression of some real or imagined event, (b) the nature of the symptom is related to the event, and (c) the symptoms could be relieved by insight into the relationship between the event and the symptom. Although Freudian analysis was to undergo dramatic developments, the important point here is that it fit both the cultural context of Freud's Vienna as well as the medical context. Mesmer had been discredited by a demonstration that the fluids of animal magnetism were not responsible for the benefits of the treatment; no such proofs could be obtained for Freud's complicated constructs. He had a coherent system to explain a disorder (hysteria) and a method for effecting its cure. His evidence of success was not too different from that for most diseases and disorders of the time. Although Freud has many contemporary critics, there is no debate about the influence that he had on psychiatry and psychotherapy.

Freud was very particular about the theory and procedures and, when others in his Vienna circle altered the theory and procedures, bitter feuds developed. Essentially the argument was over what constituted the particular aspects of the treatment that were leading to the cures—a discussion similar to the one concerning the important constituent ingredients of various medications. In 1936, Saul Rosenzweig noticed that in spite of the differences among the various therapies of the time, the outcomes were generally similar:

> The proud proponent, having achieved success in the cases he mentions, implies, even when he does not say it, that his ideology is thus proved true, all others false. . . . [However] it is soon realized that besides the intentionally utilized methods and their consciously held theoretical foundations, there are inevitably certain *unrecognized* factors in any therapeutic situation—factors that may be even more important than those being purposefully employed. (Rosenzweig, 1936, p. 412)

Referring to a race in *Alice and Wonderland* (Carroll, 1865/1962) in which contestants started when they wanted and ended when they wanted, Rosenzweig used the metaphor, "At last the Dodo bird said, 'Everybody has won and all must have prizes.'" Thus reference to the general equivalence of the benefits of psychotherapy has been called the *Dodo Bird Effect.* The history of medicine evolved, to a large extent, as an attempt to distinguish treatments that were effective from those that were banal or harmful. If all medical substances and procedures were equally effective, the evolution of scientific medicine would surely have gone differently.

During the 1920s and 1930s, behaviorism was prominent in psychology. Based on the work in classical conditioning of Pavlov, Watson, Rayner, and Jones, in the 1950s Joseph Wolpe developed the treatment of *systematic desensitization,* the first behavioral treatment for psychological disorders. The adaptation of Skinner's work in instrumental conditioning to psychological treatments added to an increasing set of behavioral treatments. Many claimed that behavioral treatments were "scientific" because they eschewed mentalistic constructs and applied principles gleaned from scientific investigations of behavior. Hans Eysenck was the most vocal opponent of traditional psychotherapy (psychodynamic and eclectic) and supporter of behavioral treatments. In the 1950s and 1960s, Eysenck, following in the footsteps of medicine, realized that efficacy of treatments (or lack thereof) could be scientifically established by comparisons of outcomes. In a series of publications, Eysenck reviewed the literature on psychotherapy and showed that the remission rate of patients treated with psychotherapy was no greater than that which would occur spontaneously (i.e., without treatment) and declared that psychotherapy was not beneficial and probably harmful (Eysenck, 1952, 1961, 1966, see also Wampold, 2001). Although the treatments were not compared directly to control groups and his conclusions were unjustified, Eysenck's opinions about the worthlessness of psychotherapy held sway with the public as well as with many psychotherapists until the late 1970s (Wampold, 2001). Essentially, Eysenck's argument was that psychotherapy (as opposed to behavior therapy) was a healing practice with no scientific basis, was ineffective and probably harmful, and should be used as often as one would take theriac for cancer.

Realizing that randomized designs could be used in psychotherapy and perhaps spurred by Eysenck's attacks, psychotherapy researchers began to use randomized control-group designs to study the efficacy of psychotherapy. Two comparison groups were used initially—no treatment or another treatment. It was realized, however, that comparing psychotherapy with a no-treatment control could not rule out placebo effects—the attention of the therapist, the expectation for improvement, the opportunity to focus on one's problems, and so forth—and thus it was suggested by Rosenthal and Frank (1958) that the randomized placebo control group design be used for the study of psychotherapy. This was psychology's attempt to elevate the effects of psychotherapy above those of healing practices for which the effect might be due to aspects of the treatment other than those hypothesized to be remedial and to place psychotherapy on par with medical treatments (Wampold, 2001).

Borrowing the placebo control group from medicine, however, is problematic and will be discussed briefly here (see Wampold, 2001, for a more complete discussion). The first problem is revealed by examining the purpose of a placebo. In medicine, the placebo controls are used to disentangle the effects caused by the mind from effects caused by the body, so to speak. In traditional modern medicine, the researcher strives to control the psychological effects so that the physiochemical effects can be identified and measured. Psychological effects are a nuisance, as the short history of medicine presented previously has shown. In fact, to say that a benefit results from placebo (i.e., is a placebo effect) is to denigrate the procedure or medication. Mesmer was ridiculed not because his procedure was not beneficial, but because it did not occur by the physiochemical process he hypothesized. On the other hand, in psychotherapy studies, the placebo cannot be used to control for all psychological effects, as the purpose of psychotherapy is to cause psychological change. As discussed by Wampold (2001), the placebo control (and other control groups, often called nonspecific controls, supportive counseling, common-factor controls) attempts to control for the common factors, such as the therapeutic relationship, expectations, attention, and remoralization, so that the effect resulting from what is specific to that particular treatment can be identified. For example, in studies of cognitive therapy for depression, the placebo control group is used to rule out the effects of the common factors so that the benefits of the treatment can be attributed to the specific ingredients related to changing irrational thoughts and developing adaptive core cognitive schema. In psychotherapy both the specific effects and the placebo effects, which are more aptly called *general effects* (Wampold, 2001), are the result of psychological processes and therefore are difficult to disentangle. Exacerbating the situation is that the specific ingredients cannot be delivered without the common factors and these two aspects of therapy are intimately intertwined. One cannot effectively provide any therapeutic technique without an adequate therapeutic relationship; that is, the quality of the common factors affects the delivery and effectiveness of any specific ingredient or therapeutic technique, as we know from the study of the working alliance (Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Ironically, the effects caused by the placebo controls are often denigrated, just as they are in medical research, even though these effects are psychological in nature and should be of prominent interest to psychological researchers! Nevertheless, as Parloff (1986) noted:

> Some mechanisms of change are, *ipso facto,* less acceptable than others. If the seemingly positive effects of psychotherapy are attributable primarily to such mechanisms as "suggestion," "placebo," "attention," or "common sense" advice, then the credibility of psychotherapy as a profession is automatically impugned. (pp. 523–524)

The other major issue with placebo controls in psychotherapy research is that they cannot be designed or administered in a fashion such that they control for the nonspecific effects (Wampold, 2001). Recall in medicine that the placebo must be indistinguishable from the active medication, the only difference being that the medication contains the active ingredients, and that the medication and placebo

must be delivered in a double-blind context. The placebo control groups typically used in psychotherapy research do not resemble the active treatments, however. Typically they involve nondescript nondirective counseling and support; also, the therapists are proscribed from using typical therapeutic interventions. Often, no rationale is provided to the subjects for the benefits of the placebo treatments. However, most pernicious is that the therapists delivering the placebo treatments are cognizant of the fact that they are delivering a treatment that is not intended to be therapeutic, thus removing the critical blind that has become the hallmark of placebo studies in medicine (Wampold, 2001; Wampold et al., 1997). Rosenthal and Frank (1958) described the logic of placebos in psychotherapy:

> It may be possible to study the possible specific effects of any particular form of therapy by the use of a matched control group participating in an activity regarded therapeutically inert from the stand point of the theory of the therapy being studied. That is, it would not be expected to produce the effects predicted by the theory. The "placebo psychotherapy" in a sense would be analogous to placebos in that it would be administered under circumstances and by persons such that the patients would be expected to be helped by it. (pp. 299–300)

How can patients generate equal expectations for a treatment that the therapist knows is not intended to be therapeutic? Cognisant of this problem, Rosenthal and Frank provided examples in which not only must the active treatment be more beneficial than the placebo psychotherapy, but it must show that the treatment achieves its benefits in the anticipated manner, a point that will be discussed later. Interestingly, the use of placebo psychotherapies peaked in the 1970s and are almost nonexistent today (only five could be found in the 1990s; see Stevens, Hynan, & Allen, 2000), opposite to the trend in medicine where the placebo control group design is *de rigeur.*

As applied to psychotherapy, the limitations of clinical trials mentioned earlier become problematic. First, psychotherapy is a treatment of the psyche, yet the development of the clinical trial was such that the experience of the subjects is unimportant and ignored. Recall that the goal of clinical trials is to identify optimal treatments or to rule out illegitimate effects (viz., placebo effects); forgotten in the process is the subject's experience of the therapeutic process. Second, in education, agriculture, and medicine, provider (teacher, farmers, or physician) effects were assumed to be nil and unimportant, yet, the person of the psychotherapist is central and vital to the therapeutic process. Failure to consider therapists effects have costly consequences, both statistically and theoretically (Wampold, 2001; Wampold & Serlin, 2000).

The scientific standing of psychotherapy came to a head in the 1960s and 1970s. Eysenck's claims that psychotherapy was ineffective were taking their toll. It was estimated that there were hundreds of distinct therapeutic approaches, many offered as a panacea without regard to diagnoses or presenting problem. Clearly, the landscape of psychotherapy was drastically different from its counterpart in medicine, to wit:

> Rivalry among theoretical orientation has a long and undistinguished history in psychotherapy dating back to Freud. In the infancy of the field, therapy systems, like battling siblings, competed for attention and affection in a "dogma eat dogma" environment. . . . Mutual antipathy and exchange of puerile insults between adherents of rival orientations were much the order of the day. (Norcross & Newman, 1992, p. 3)

Gordon Paul (1967, p. 111), a staunch behaviorist who wanted to place psychotherapy on a scientific foundation, stated that researchers should be driven by the question, "What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances, and how does it come about?" Answers to this question would provide evidence similar to that obtained in medicine, but unfortunately the answers have been few and far between. Not coincidentally and perhaps in response to Paul's question, technical eclecticism was finding increasing popularity toward the end of this period (Beutler & Clarkin, 1990; Lazarus, 1981).

In the last few years of 1970s, Gene Glass and his colleagues (Glass, 1976; Smith & Glass, 1977; Smith, Glass, & Miller, 1980) developed the method of meta-analysis and applied it to psychotherapy. Meta-analysis is a method of aggregating the results of many studies that address the same question in order to make a conclusion that is robust. Although meta-analysis originally was extremely controversial, it has become the primary data-synthesis method in psychology, education, and medicine (Hunt, 1997; Mann, 1994). The primary purpose of these early meta-analyses was to determine the efficacy of psychotherapy. Aggregating the results of nearly 400 studies, Glass and his group found that psychotherapy, when compared to no treatment, was remarkably efficacious. Subsequent meta-analysis has confirmed these findings and the debate about whether psychotherapy benefits patients is considered settled (Wampold, 2001).

Another vital conclusion made by the early meta-analyses was that psychotherapy approaches were about equally efficacious, suggesting that Rosenzweig's contention that "all must have prizes" was correct. At around the same time, evidence for the uniform efficacy came from nonmeta-analytic sources as well. In a study that used a remarkably sophisticated design for its time, Sloane, Staples, Cristol, Yorkston, and Whipple (1975) compared analytic therapy and behavior therapy and found them equally effective on almost every measure. In the same year, Luborsky, Singer, and Luborsky (1975) conducted a review of studies that compared two psychotherapies and found few differences among treatments. From a scientific standpoint, the uniform efficacy of psy-

chotherapy casts doubt on the specificity of the treatments. If the benefits of psychotherapy are caused by the specific ingredients of the individual therapies, and some of the ingredients are more potent than others, then there should be variation among therapies relative to their efficacy. Treatments with more potent ingredients should be more beneficial than other treatments. So, the uniform efficacy of treatments suggests that the commonalities among treatments are responsible for the benefits.

Despite the initial empirical evidence that the Dodo bird was correct, the result was not well accepted by the psychotherapeutic research community, particularly the behaviorists:

> If the indiscriminate distribution of prizes carried true conviction . . . we end up with the same advice for everyone—"Regardless of the nature of your problem seek any form of psychotherapy." This is absurd. We doubt even the strongest advocates of the Dodo Bird Argument dispense this advice. (Rachman & Wilson, 1980, p. 167)

Nevertheless, meta-analytic evidence throughout the 1980s and 1990s supported the contention that all psychotherapies intended to be therapeutic produce equivalent outcomes. Moreover, this finding appears to extend to particular disorders, such as depression and anxiety disorders (Wampold, 2001, chapter 4). The National Institute of Mental Health Treatment of Depression Collaborative Research Program (NIMH TDCRP), the most comprehensive study to compare two psychotherapies (viz., cognitive behavior therapy, CBT, and interpersonal therapy, IPT) ever conducted for a particular disorder (depression), found that the benefits of the two treatments were nearly identical (Elkin et al., 1989).

The uniform efficacy of psychotherapy outcomes suggests that the common factors are the important determinants of the benefits of psychotherapy. Research in the 1980s and 1990s provided additional empirical evidence that the specific ingredients of treatments were not responsible for the outcomes. This research will be reviewed briefly here (see Wampold, 2001).

Several types of designs can be used to isolate the effects of specific ingredients, should they exist. Dismantling designs involves the comparison of an established treatment to the treatment without one or two of the critical ingredients, whereas additive designs involve a comparison of an established treatment to the treatment with the addition of one or two ingredients that are thought to augment the effects of the treatment. These two designs, which together are called component designs, best approximate the experimental standard of isolating the effects resulting from specific ingredients (Borkovec, 1990). Ahn and Wampold (2001) meta-analyzed all component studies published in the past 10 years and found that the treatment without the theoretically specified ingredients was equally beneficial to the treatment with the ingredients. One of the studies in this meta-analysis showed that the behavioral activation component of cognitive behavior therapy (CBT; no cognitive components) for depression was equally as effective as CBT (Jacobson et al., 1996).

If specific ingredients are responsible for the benefits of psychotherapy, then predictable change in mediating processes should be detectable, as suggested by Rosenthal and Frank in 1956. For example, CBT should reduce dysfunctional thoughts, which in turn should reduce depression, whereas other treatments for depression should not similarly reduce dysfunctional thoughts. The NIMH TDCRP revealed no evidence for mediating processes: "Despite different theoretical rationales, distinctive therapeutic procedures, and presumed differences in treatment processes, none of the therapies produced clear and consistent effects at termination of acute treatment on measures related to its theoretical origins" (Imber et al., 1990, p. 357). Wampold (2001), in a review of studies that examined mediating processes, found no evidence to support the effects of specific ingredients more generally.

Many attempts have been made to answer Paul's (1967) question related to interactions between treatments and personal characteristics. It is important to consider the interaction between a patient's deficit and a particular type of treatment; for example, if the specific ingredients of the treatment are active, then CBT should be particularly effective with depressed patients with dysfunctional attitudes, whereas interpersonal therapy (IPT) should be particularly effective with depressed patients with social deficits. Through the 35 years since Paul asked his question, no evidence has been found for theoretically derived interactions between patient deficits and the treatments intended to address those deficits (Wampold, 2001).

Advocates of specific ingredients often cite studies that compare a treatment to a placebo type control group and find that the treatment is superior to the placebo (e.g., see meta-analyses of Barker, Funk, & Houston, 1988; Bowers & Clum, 1988; Stevens et al., 2000). As discussed previously, however, placebos in psychotherapy are not equivalent to treatments without active ingredients and therefore it is expected that the treatment will outperform the placebo, regardless of whether the specific ingredients are active (Wampold, 2001).

A final source of evidence against specificity in psychotherapy is revealed by examining the variance in outcomes resulting from the therapists. As the development of the clinical trial has shown, provider effects were considered unimportant and, for the most part, therapist effects have been ignored in psychotherapy studies as well (Wampold, 2001). Nevertheless, there is very strong evidence that therapist effects are large and need to be considered for methodological as well as substantive reasons (Wampold & Serlin, 2000). Wampold (2001) showed that at least nine times more variability in outcome was accounted for by therapists within a treatment than was accounted for by differences among treatments—and this result was found for therapists who were trained to adhere to treatment manuals and were super-

vised in the context of clinical trials. The particular therapist is much more important that the particular type of treatment administered, exactly opposite to the prototypic situation in medicine. Relatedly, it is clear that the allegiance of the researcher in clinical trials produces a strong effect (see e.g., Luborsky et al., 1999; Wampold, 2001), quite probably because the therapists, who are often trained by the researchers (or who are the researchers!), have an allegiance to the favored therapy (Wampold, 2001).

Despite the overwhelming evidence that specificity is absent in psychotherapy and that common factors are the powerful agents, in the 1990s an attempt was made to emulate medicine and the medical approach to mental illness: "If clinical psychology is to survive in this heyday of biological psychiatry, APA must act to emphasize the strength of what we have to offer—a variety of psychotherapies of proven efficacy" (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 3). Thus began the empirically supported treatment (EST) movement (see Chambless et al., 1996; Chambless et al., 1998; Chambless & Hollon, 1998). The relative merits of the ESTs have been discussed elsewhere (e.g., Beutler, 1998; Borkovec & Castonguay, 1998; Calhoun, Moras, Pilkonis, & Rehm, 1998; Davison, 1998; Elliott, 1998; Garfield, 1998; Henry, 1998; Wampold, 1997), but the interesting feature of the EST is that the concepts were patterned after medicine. The initial criteria for designation as an EST were based on the Food and Drug Administration (FDA) criteria for approving drugs and emphasized comparison of treatment to placebo treatments and standardization of treatments with manuals. Ironically, advocates of pharmacological treatments quickly saw through the transparent similarities of drugs and psychotherapies:

> It is remarkably hard to find differences between the outcomes of credible psychotherapies or any evidence that a proposed specific beneficial mechanism of action has anything to do with therapeutic outcome. . . . [The results of the TDCRP] are inexplicable on the basis of the therapeutic action theories propounded by the creators of IPT and CBT. . . . The bottom line is that if the Food and Drug Administration (FDA) was responsible for the evaluation of psychotherapy, then no current psychotherapy would be approvable, whereas particular medications are clearly approvable. (Klein, 1990, p. 82)

Conclusions

An abbreviated history of the development of the scientific method in medicine and psychotherapy has been presented to emphasize the differences between the two endeavors. Medicine fit nicely into the scientific positivistic paradigm, aided by Cartesian dualism, and the development of medicines and procedures that acted specifically. Psychotherapy strived, and is still striving, to copy the medical model. Nevertheless, the research clearly demonstrates that psychotherapy is not a medical analogue, primarily because the effectiveness of psychotherapy is not due to the specific ingredients of various treatments. Several questions need to be answered: What type of healing practice is psychotherapy? How does it work? How should it be conceptualized?

Implications: Toward a Contextual Model of Psychotherapy

The review of the history of healing practices and the development of modern science and psychotherapy allows some conclusions about the nature of psychotherapy.

Cultural Context of Psychotherapy

Psychotherapy is a relatively new healing practice, especially when considered in the context of the genesis of healing practices at the origins of civilization. It has all of the characteristics that Frank and Frank (1991) ascribe to healing practices: (a) an emotion-charged, confiding relationship with a healer; (b) a healing context in which the patient presents to a healer who the patient believes has the power, expertise, or ability to help and is entrusted to work on the patient's behalf; (c) a rationale, conceptual scheme, or myth that explains the patient's symptoms or complaints; and (d) a procedure or ritual that is consistent with the rationale, conceptual scheme, or myth provided to the patient. Of course, this explanation is so broad that it encompasses medicine as well; the rationale and procedures are based in physiology, anatomy, cellular microbiology—that is, in science. A postmodern view of medicine is that it is one of many ways of healing and should not be elevated above the others.

How can psychotherapy be distinguished from other healing practices? Conceptually, it could be argued that psychotherapy is the first healing practice designed particularly for the psyche as separate from the soma, given the Cartesian mind/body distinction. Another distinction is that psychotherapy has been documented to work. The vast research that consistently shows that psychotherapy is effective distinguishes it from almost all other healing practices that have been used in the history of the world—simply stated, people who participate in psychotherapy benefit. As a general class of healing practices, medicine and psychotherapy are in the elite, if empiricism is the criterion for grading healing practices.

On the other hand, psychotherapy is closer conceptually to nonmedical healing practices than to medicine. Specificity is the hallmark of Western medicine—medical procedures are valued because they work on the body (not the mind, although increasingly on the brain) in carefully specified and documented ways. As was discussed previously, the overwhelming evidence shows that the specific ingredients of psychotherapy are not active—that is, the particular therapeutic actions of the therapist are not responsible for the benefits.

As might be expected, the appearance and disappearance of various approaches to psychotherapy are unrelated to sci-

entific evidence, as the evidence shows that they produce equivalent outcomes. Why do some therapies come into existence and others disappear? The reason often given is "popularity." But popularity is a cultural consensus about what is in vogue. It has been argued that the appearances of various psychotherapies reflects the ethos of the society at the time (Cushman, 1992) in the same way that all healing practices, including medicine, are imbedded in and are products of the culture: Asclepius and Greek mythology; Galen and the four humors; acupuncture and the Chinese belief systems; Apache shaman rituals and spirits, laying on of hands, and religious mysticism; Mesmer, animal magnetism, and Newtonian physics; Freud and the Victorian age; CBT and the preeminence of cognitive science; humanistic treatments in the post–World War II era and existential philosophy; eye movement desensitization and reprocessing (EMDR) and emphasis on neuroscience; medicine and the development of the scientific method; and multicultural counseling and the postmodern period.

The cultural contextualism of healing practice is not meant to trivialize healing practices as epiphenomena. In the survival of the fittest, healing practices will be used to the degree to which they appeal to patients. As we have seen, the appeal appears to be unrelated to effectiveness and more related to beliefs—various healing practices, including psychotherapy, will be used if the underlying conceptual scheme is consistent with the patient's beliefs about the world. Thus, it is not surprising that healing practices do not endure any longer than other aspects of cultures.

The origins and development of healing practices, however, are not spontaneous events. The sociology of science has shown that the utopian idea of good ideas rising to the top on their merits is a myth (Latour, 1999). Rather, scientific communities come to a consensus about ideas, based partly on the political influence of various people and institutions. Often healing practices are accepted because of a charismatic healer, advertising, and institutional support. Freud's legacy was certainly advanced by his efforts as much as by his thinking. Pharmaceutical companies are well aware that they can influence the practice of medicine when they advertise prescription medications on television; indeed, not only does the sales of such medications (often more expensive than equally effective alternatives) increase, but the prevalence of disorders for which they are indicated increases also (e.g., social phobia). Through its funding priorities the National Institute of Mental Health shapes the nature of psychotherapy as has managed care by identifying services to be covered.

Psychotherapy as a healing practice is a Western phenomenon, with origins in Europe and the United States. The idea of sitting in a room with the healer, confiding in the healer, responding to questions, and following the implicit or explicit ritualistic expectations of the psychotherapeutic protocol, whether it is expressing one's feelings, monitoring one's thoughts, forming a contingency contract, or looking at the rapidly moving hands of the therapist, would be an absurdity in 99% of the societies past or present. On the other hand, participating in some healing practice is universal. As a healing practice, psychotherapy shares commonalities with medicine, but also with laying-on-of-hands, theriac, and shaman rituals. Psychotherapy is not universal; it has existed, in widely different forms, in some (but not all) Western cultures for about 100 years.

How Psychotherapy Works

To a large extent, we don't know how psychotherapy works, although we have some clues. It is important to note that psychotherapy does work, so the search for mechanisms of change is not in vain.

The evidence clearly indicates that the efficacious aspects of psychotherapy are not the specific ingredients so revered by advocates of particular therapies. Psychotherapy is often characterized as the application of psychological principles to treat mental disorders. Clearly, a narrow interpretation of this characterization is incorrect. There is no convincing evidence that the benefits of systematic desensitization are the result of classical conditioning, that the benefits of CBT are caused by changes in cognition, that the benefits of psychodynamic treatments are due to making the unconscious conscious, and so forth (Wampold, 2001). Psychotherapy works, however, and clearly the mechanism is psychological—the goal is to elucidate the nature of the change process.

Some insights on the change process can be gleaned from examining placebos in medicines. Recall that the traditional view of placebo effects is to denigrate them as a nuisance to be controlled in a randomized double-blind placebo control group design. For many years, however, there have been medical and psychological researchers who wish to understand the placebo effect in medicine (Harrington, 1997).

To understand the placebo effect it is necessary to make the distinction between disease and illness. According to Spiro (1997), "For most physicians, *disease* is what the doctor sees and finds, *illness* is what the patient feels and suffers" (p. 45). A few examples will clarify the distinction. Pneumonia is a disease, identifiable from physical exam, X-rays, and laboratory tests. Cancer similarly is a disease. Acute pain reflects actual tissue damage. For diseases for which the course is relatively certain and the physiochemical effects well understood, placebos will have little effect (Shapiro & Shapiro, 1997a, 1997b; Spiro, 1997). The Apache healing practices were quite effective in treating the disorders endemic in their society; however, the practices had no effect on the smallpox virus introduced from Europe, for which the Apaches had no natural immunity. Although techniques to control bodily functions with the mind are popular, there is little hard evidence that they work. Indeed, a recent meta-analysis of placebos showed that their utility seems to be limited to the treatment of pain and other disorders for which subjective assessment of the patient is important (Hróbjartsson & Gøtzsche, 2001).

Illness, as the term is used by Spiro (1997), is the patient's

reaction to disease, to the stresses in life, to life itself—the patient's attempt to make sense of his or her world, including physical sensations, mental activity, and so forth. In the medical context, "Illness, then, is a patient's complaint, regardless of whether the origin is biologically detectable" (Spiro, 1998, p. 53). The term "illness" encompasses most of the nonorganic mental disorders. Placebo medical treatments are particularly effective for illnesses, as is psychotherapy. Indeed, illness, as defined by Spiro, is the focus of psychotherapy.

Of course, there are disorders that fall between disease and illness, such as irritable bowel syndrome, eating disorders, fibromyalgia, and depression. If a patient presents to a physician with any of these disorders, the patient is likely to be subjected to diagnostic tests and studies and will receive medication. If the physician is a specialist and the patient's tests are negative, the patient is likely to be referred to another specialty. On the other hand, if the patient presents to a psychotherapist (and organic disease has been ruled out), the patient has the opportunity to examine aspects of his or her life that are related to the complaint.

The distinction between illness and disease brings forth the debate about the conceptual status of mental illness. On the one hand, there are those who consider disorders, both physical and mental, to be scientific categories that can be rigorously defined. For example, Wakefield (1992; 1999) defines a disorder as a "harmful dysfunction, where dysfunctions are failures of internal mechanisms to perform naturally selected functions" (1999, p. 374). Whether a dysfunction is harmful is a value decision and is culture dependent, whereas determination of dysfunctionality is a matter of knowledge (i.e., a determination of whether the harm is caused by an internal mechanism that fails to perform its naturally selected function). According to this definition, structural conditions that are harmful are clearly disorders, whereas functional conditions would be classified as a disorder depending on the etiology being related to a failure of a system that performs a naturally selected function. This definition clearly would not classify all conditions for which a patient would seek psychotherapy (e.g., marital discord) as a disorder, however. Moreover, this system begs the question of whether or not psychotherapy treats the symptoms of a disorder or one's demoralization. Anxiety, according to Wakefield, is a disorder because it involves failure to regulate the fear response—but do clients present to psychotherapy because of the consequences of the regulation function or because they are discouraged by the interruption of their lives, the meaning attributed to such responses, and so forth? Does psychotherapy work because the fear-response system is rehabilitated or because the patient is remoralized, has a reasonable explanation of the disorder (which may have nothing to do with the evolution of the fear response), puts the response in the proper perspective, is a member of a family system that has changed and no longer maintains the behavior, or has a renewed sense of self-efficacy to face life's challenges. Wakefield's definition of disorder, however, clearly takes into account that harm caused by dysfunction is culture dependent—what is problematic in one culture might be accepted or even revered in another.

Others have discussed mental disorders as sociopolitical categories invented to oppress individuals (e.g., Foucault, 1964/1965; Szas, 1974) or as Roshian categories characterized by similarity to a prototype (e.g., Lilienfeld & Marino, 1995)—in either case, mental disorder is seen as problematic because it is conceived as deviation from a desired norm rather than as a distinct entity. However, psychotherapy is a useful treatment for distress caused by a disorder, condition, deviation from normality, or any other source. A useful example is homosexuality, which is no longer considered a disorder, but may cause significant distress because of family, cultural, or internalized values—yet, to the patient trying to make sense of his or her homosexuality, psychotherapy could be an immensely beneficial experience.

Several models have been proposed for the benefits produced by placebos for patients suffering from an illness, including neurobiological models, conditioning models, meaning models, psychological models incorporating desire and expectancy constructs, and biocultural models (Harrington, 1997). Each of these models will be considered briefly, with indication of the research in psychotherapy that supports the model.

The neurobiological model of placebos has been applied primarily to the treatment of chronic pain. Essentially the model explains how placebos are related to the release of opioids in the brain, which are naturally occurring analgesics (Fields & Price, 1997). Of the models, the neurobiological model has the least relevance for psychotherapy, although changes in brain chemistry have been detected after psychotherapy (e.g., Baxter et al., 1992). The major problem with the neurobiological models is one of reductionism. Even if a reliable effect of placebos (either pills or psychotherapy) on brain chemistry can be detected, the question of how the inert substance or a psychological treatment creates the biological phenomena remains.

The conditioning model also has been investigated primarily in the medical context. The conditioning model stipulates that in the course of taking medications, a pill becomes a conditioned stimulus for benefits (Ader, 1997). For example, if one takes an analgesic pill (the unconditioned stimulus) and experiences pain reduction (the unconditioned response), then the pill itself (without the active analgesic) becomes a conditioned stimulus for pain reduction. Although this model may have some relevancy with regard to taking medications in the context of modern science, it cannot explain the continued use of placebos throughout history that have produced harmful effects. Moreover, it is difficult to extend the conditioning model to psychotherapy, as the analogue of the unconditioned stimulus in unclear.

The meaning model consists of three components: (a) provision of an understandable and satisfying explanation of the illness, (b) demonstration of care and concern, and (c) antic-

ipation of control or mastery of symptoms (Brody, 1980, 1997). Brody (1997) claimed that making meaning of an illness experience (in the constructivist sense) goes well beyond the symptoms:

> It seems plausible that when persons try to construct meaning to explain or understand illness experiences, they commonly relate these to the larger meanings about mortality, the origins of evil, and so on. . . . It seems clear that when we ask about the "meaning of an illness experience," there is no object "out there" in the world that could be pointed to by way of an answer. Biomedical science has reified "disease" so that we often imagine it to exist as an object; but it does so only at the cost of removing from "disease" almost all understanding of what the patient experiences phenomenonologically. (p. 81)

Brody's conceptualization of the relationship between the phenomenological experience of illness and general considerations of meaning would explain the intimate connection between healing practices and meta-physics, religion, spirituality, and other meaning systems. In other words, patients seek treatments that make sense in their epistemology. There is evidence that the compatibility of the explanation for a psychotherapeutic approach with the worldview of the client is related to the outcomes of psychotherapy (Chilvers et al., 2001; Elkin, Yamaguichi, Arnkoff, Sotsky, & Krupnick, 1999; Lyddon, 1989). Elkin et al. (1999) found that the match between a patient's beliefs about the cause of his or her illness and what will be helpful with the theoretical basis of treatments was related to continuation in therapy and engagement with the therapist (outcomes were not considered). Chilvers et al. (2001) found that patients who preferred generic counseling to medication for depression benefitted more from counseling than those randomly assigned to counseling.

Brody (1980, 1997) emphasized the role of the healer as a caring and concerned individual and a symbol of healing. The evidence that the working alliance is critical for the success of therapy would support the importance of the relationship between patient and healer (Horvath & Symonds, 1991; Martin et al., 2000; Wampold, 2001). Interestingly, patients acknowledge the importance of the relationship with the therapist, whereas the therapists give primacy to therapeutic techniques (Eugster & Wampold, 1996). The role of the healer in psychotherapy is critical when the evidence that much of the variability in outcomes results from the particular therapist (Wampold, 2001).

The meaning model of placebos fits the psychotherapeutic context well. Patients come to psychotherapy attempting to make sense of their problems and the meaning that these problems have for their life. Clearly, some patients are focused solely on their symptoms and may prefer pharmacological treatment (e.g., an antidepressant); most, however, come to therapy for demoralization, the depression about being depressed, to reduce the effects of the illness on their lives, and to understand the meaning of the illness (Brody, 1980, 1997; Frank & Frank, 1991).

There are a variety of psychological explanations for placebo effects that involve expectations, motivation, and desire. Price and Fields (1997) propose that two factors are related to placebo effects: (a) desire for relief, and (b) the expectation that a given procedure or agent will provide the relief. Kirsch (1985, 1997) has proposed models that involve *response expectancies,* which are anticipations of nonvolitional responses. Much of the experimental literature on placebos for medical conditions is consistent with an expectancy model. Although a complete explanation of expectancy models is beyond the scope of this article, one aspect of the models is particularly informative. Many psychological disorders are subjective reactions to distress or other events. Fear is the immediate and unmediated expectation of an aversive or harmful event, sadness is the consequence of the belief that one has lost something of value, many anxiety reactions involve "fear of fear," depression is the subjective expectation that the symptoms will be debilitating, and so on. Kirsh (1997) claims that subjective experience is the consequence of expectations and that placebos are particularly effective because they change expectations and thus subjective experiences.

The final model of placebo action takes into account the cultural context (Atkinson, Bui, & Mori, 2001; Frank & Frank, 1991; Kleinman, 1980; Kleinman & Sung, 1979; Morris, 1997). Diseases are constants from one culture to another; illness is a culturally dependent phenomenon. Indeed, the most rigorous definitions of disorder take into account the notion that harm is a culturally determined component (Wakefield, 1992, 1999). The conceptualization of illness and the emotional and somatic reactions to it vary dramatically from one culture to another or even within a culture (see, e.g., Kleinman, 1980 for differences between the United States and Taiwan and within Taiwan). In many cultures depression is expressed only as somatic ailments, in other cultures it is a revered sign of suffering, to many in the United States, it is a set of symptoms that can be removed easily by taking Prozac. Symbols of healing differ as well. A physician in a white coat is a healing symbol in a society that reveres medicine; to a newly immigrated Hmong, it is a strange sight indeed. It is beyond the scope of this article to discuss the differences in conceptions of illness, the manifestation of symptoms, the attitudes toward specific illnesses, the multiple symbols of healing, and so forth. Much of this article has focused on the cultural imbeddedness of healing practices. Taking into account the expectancy model, the cultural context determines the expectancies. In the United States, a placebo injection is more effective than a placebo pill, a large pill more effective than a medium-sized pill, and a small pill more effective than a medium-sized pill. In Taiwan, herbal medicines may be more powerful than injections or pills. For many in the United States, psychotherapy is a healing practice; for others, it is ludicrous.

The cultural contextual model has implications for multicultural counseling and psychotherapy. The need to consider culture in counseling and psychotherapy is obvious as the cultural diversity of the United States increases—and the topic has been discussed thoroughly (see e.g., Ponterotto, Casas, Suzuiki, & Alexander, 2001). The implication of the cultural model discussed here is that adapting psychotherapy for various cultural groups may be insufficient if psychotherapy is not considered a viable healing practice by the patient. Psychological services that take culture into account may find that psychotherapy is not a valid intervention for some patients of some cultural groups. Whatever the case, the therapist or healer must listen carefully to discern not only what is the problem, how it is conceptualized, and what the goals of the intervention are, but also *how the patient wants to heal.*

Issues and Paradoxes

The cultural contextualization of psychotherapy creates several issues, some of which create paradoxes, which are presented in lieu of conclusions. In the West, paradoxes create uneasiness and attempts to reconcile the contradictions, whereas in the East multiple truths and contradictions are natural (Cohen, 2001). Taking an Eastern perspective, the paradoxes are presented recognizing unreconciled and unreconcilable issues.

Skepticism and Belief

The history of healing demonstrates that many often-used practices were harmful. Moreover, the history of healing is also littered with quack and frauds (Shapiro & Shapiro, 1997b). As well, the advocates of various practices present confidently and charismatically that their treatments are absolutely powerful (e.g., Galen, Freud, Aaron Beck and CBT, Francine Shapiro and EMDR). Finally, the lack of specificity suggests that any psychotherapy intended to be therapeutic will be therapeutic (but see Wampold, 2001, for limits to which treatments are allowable for psychologists), although psychotherapy has its share of failures (e.g., the treatments involving recovered memories of abuse). Therefore, we have to be skeptical of the claims made for psychotherapy and particularly for ones that have not been studied. On the other hand, the effectiveness of psychotherapy is dependent on the practitioner's beliefs and communication of those beliefs to the patient.

Lack of Specificity and the Use of Specific Ingredients

The evidence clearly indicates that the specific ingredients in psychotherapy are not responsible for the benefits of psychotherapy. It is a fallacy to then conclude that viable psychotherapy need only contain the common factors, however (see Wampold, 2001; Wampold, Ahn, & Coleman, 2001). Clients expect an explanation for their disorder and procedures that are consistent with that explanation; moreover, they prefer and do better when the rationale is consistent with their worldview. A therapist cannot form a working alliance, which involves agreement on tasks and goals (Horvath & Luborsky, 1993), without doing so around the delivery of a sensible, consistent, and meaningful treatment. That is, the therapy must contain specific therapeutic actions. The therapist knows that these ingredients in and of themselves, are not therapeutic, however. Slavish adherence to a treatment protocol is unnecessary but a treatment must contain strategies and interventions consistent with the explicit or implicit treatment rationale (Wampold, 2001). Given the evidence that allegiance to a treatment is vital, a therapist delivering ingredients they know are not therapeutic creates a therapeutic paradox.

Science and Psychotherapy

Is psychotherapy based on science? The answer to this question is dependent on one's definition of science. If science is construed narrowly to imply that psychotherapy is analogous to medicine the answer is no; psychotherapy is not the scientific application of experimental psychological knowledge. Specificity does not exist. However, if science were defined broadly enough to include anthropology, sociology, history, and other social sciences, however, then psychotherapy is scientific. People change as a result of psychotherapy —which makes it psychological, but understanding the change will not be found using a narrow application of science. Keep in mind that the efficacy of psychotherapy has been established scientifically—no apologies need to be made for the practice of psychotherapy.

These comments are not meant to imply that psychotherapists do not need to be knowledgeable of psychology and medicine. For one thing, psychologists must be able to recognize physical diseases that cause behavioral problems. Understanding the patient and his circumstances requires an understanding of psychology, although the cultural nature of illness must never be ignored. As well, psychology has provided the knowledge to weed out unjustified practices; for example, treatments based on recovered memories were discredited by basic research that showed that such memories could be induced (e.g., Loftus & Pickrell, 1995, see also Wampold, 2001).

Psyche, Soma, and Mind/Body Treatments

Although it is beyond the scope of this article to make conclusions regarding the implications of mind/body dualism, there are some implications of the preceding material for this issue. Prior to the Cartesian separation of psyche and soma, little distinction was made between mental and physical disorders, either in their diagnosis or treatment. The attention to soma allowed the evolution of modern medicine that focused predominantly on diseases that had physiochemical substrata. Despite the fact that medicine acquiesced for primarily professional reasons (Caplan, 1998) to providing a treatment of the psyche by means of talk therapy, the pressure continued to conceptualize mental illness in the

same way as physical illnesses. The 1950s and 1960s saw a resurgence of the soma in treatment of mental illness. In 1952, the American Psychiatric Association published *The Diagnostic and Statistical Manual of Mental Disorders* (1952), thereby classifying mental disorders on the bases of symptoms and signs. In this period attention also returned to physical substrata that could account for mental disorders and psychotropic medications for mental disorders were developed and began to be used extensively (S. Fisher & Greenberg, 1997). Clearly, biological psychiatry is making appreciable progress toward identifying the neurochemical processes of several major mental disorders. Directionality of causation is always problematic in such investigations, however; placebo treatments have demonstrable effects on neurochemistry (Fields & Price, 1997).

There are unreasonable extremes in the mind/body area—from Christian Scientists who believe that all physical ailments are products of the mind and should be cured by faith to biological extremists who want to cure all mental disorders by altering neurochemistry. For now, psychotherapy is reasonably situated in a middle ground. Many disorders, such as depression, can be approached biologically as well as psychotherapeutically. Said a bit facetiously, until the neurochemists can find the substrata of the meaning of life, psychotherapy will be a reasonable and effective healing practice.

Where Does Psychotherapy Belong?

Clearly, the foundation for the healing practice of psychotherapy is different from that of medicine. Does it belong as an alternative treatment? No, because if the NCCAM were to incorporate psychotherapy as an alternative treatment, it would have to pass the test of rigorous randomized double-blind placebo clinical trials and demonstrate specificity, which as discussed previously are not appropriate for psychotherapy. Clearly, the livelihood of psychologists depends on managed-care coverage of psychotherapy services and thus psychotherapy will exist necessarily in a medical context. Psychotherapy, a nonmedical treatment, living in the medical environment creates a paradox (see Wampold, 2001, for possible ways for medicine and psychotherapy to coexist). It would be remiss not to mention that physicians are reimbursed for services that are not medical, in the prototypical conceptualization. Many of physicians' cases involve illnesses rather than diseases. When a physician orders diagnostic procedures when the absences of an illness is clear in order to reassure the patient that he or she is not sick, managed-care pays for a placebo. When a physician prescribes a medicine requested by a patient in the absence of disease responsive to the medication (e.g., antibiotics for ear infections), managed care is paying for a placebo. Physicians often work with illnesses rather than treat diseases, in much the way that we used to think of physicians as healers rather than technicians (Sprio, 1997, 1998).

Psychotherapy, a powerful healing practice in some Western settings, is an enigma. The cultural context of psychotherapy as healing practice as well as the cultural context of the patient and the healer are critically important to understanding the remarkable benefits that it produces.

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