LOSING OUR MIND:

AMERICA'S FAILED MEDICAL MODEL OF PSYCHOTHERAPY

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Abstract:

The profession of psychotherapy, including its theory, research and practice, is becoming dangerously disconnected from its evidentiary base. It is being taken over and mismanaged by organized medicine and its medical model of diagnosis and treatment – a model which misrepresents psychotherapy by imposing upon it the simplistic, seductive fiction that psychotherapy's subjective, idiosyncratic and relational essence can be reduced to a medical specialty - a set of objectively measurable and controllable variables subject to the laws and procedures of biomedical science.

This increasing medicalization is damaging psychotherapy and alienating help-seekers. Yet the profession's stakeholders are failing to address this threat. Researchers and teachers of psychotherapy, whose articles tend to dominate the professional literature, operate at a distance which tends to insulate them from psychotherapy's front-line realities, while practitioners and clients – those who experience first-hand the medical model's constraints - tend to remain silent. To prevent continued erosion of psychotherapy's helping power, psychotherapy practitioners must articulate publicly their

private realities and alert the profession to take back from organized medicine control over its language, science and practice.

I. The Medicalization of Psychotherapy

"We have not lost faith, but we have transferred it from God to the medical profession."

George Bernard Shaw

"What I see in America today is an almost religious zeal for the technological approach to every facet of life….It's a value system, a way of thinking, and it can become delusional." Daniel Yankelovich

Psychotherapy today is conceptualized, discussed, researched and practiced as if it were a medical specialty. Both within the profession and in modern American society at large, we unquestioningly describe psychological functioning and its problems as "mental health" and "mental illness," and see the bearer of psychological problems as the "patient," who needs "diagnosis" and `"treatment." We forget that as recently as 100 years ago mental problems and their amelioration were generally viewed as spiritual or religious issues, not medical concerns (Caplan, 1998; R. Hunsberger, 1961).

In 1949 the leaders of the nascent American profession of clinical psychology made a fateful decision at their Boulder Conference, to train psychology graduate students at

medical internship sites. This alliance with medicine gave clinical psychology – and its treatment tool, psychotherapy – welcome prestige and financial rewards of identification with medical science (Abbott, 1988; Porter, 1995), but in the process it ceded to organized medicine control over the language, theory, and practice governing psychological services (Albee, 2000). Organized medicine now controls virtually all insurance reimbursement of professional services for psychological problems. Recent developments such as discoveries of new psychoactive medications, organized psychology's campaigns for hospital and prescription privileges, and mental health parity legislation, have increasingly framed the professions of clinical psychology and psychotherapy in medical terms. Organized medicine has achieved such dominance over psychotherapy research and practice (A. Bohart, Tallman, K., 1999) - that today our society takes for granted that psychotherapy is a medical specialty (Cummings, 2001; Hillman, 1975; Norcross, 2002).

The American Medical Association defines medicine as "the study of human diseases" (American Medical Association, 1989). Modern Western medicine recognizes and diagnoses specific diseases by their unique constellations of behavioral symptoms, and it defines their cure as the removal of theses symptoms, or their return to a normal level. Each unique symptom set is assumed to represent a specific physical pathogen or structural abnormality in the body (e.g. a bacterium, tumor or bone fracture).

Modern medicine studies a patient's disease not primarily in the context of its meaning to that patient, but rather in the context of similar behavioral symptoms in other patients. Assuming homogeneity across patients, a treatment is prescribed to the patient based on what has worked well with other patients. This treatment is objective, quantifiable and replicable (e.g., 750 mg. niacin twice a day to improve blood cholesterol profile).

Our medical establishment applies the same principles to psychological problems, assuming that since the mind – "the part of an individual that thinks, feels, perceives, wills and esp[ecially] reasons" (Merriam-Webster, 2004) is an outgrowth of the brain, totally dependent on it for its existence and functioning, therefore all mental processes and problems are ultimately explainable as pathology in the brain's chemistry or neurology (Caplan, 1998). It further assumes that psychological problems, like physical diseases, should be separated from their human context and understood by comparing them to similar problems in other patients, for effective diagnosis and treatment.

"Contemporary psychology's obsession with pathology" (Seligman, 2002) started at the 1949 Boulder Conference, where clinical psychology's leaders embraced the medical concept of "mental disease" (Albee, 2000). This concept views depression and anxiety, for example, as chemical imbalances in the brain, curable with appropriate medication (A. Horwitz, Wakefield, J., 2007). Nobel Laureate Francis Crick, co-discoverer of the structure of DNA, exemplifies this belief that mental problems can be defined in atomistic, biological terms:

> "you, your joys and your sorrows, your memories and your ambitions, your sense of personal identity and free will, are in fact no more than the behavior of a vast assembly of nerve cells and their associated molecules" (Crick, 1994).

Our society's widespread use of the term "mental *disorder*" to describe a psychological problem, rather than the more accurate term "harmful dysfunction*" (Frances, 1991; Wakefield, 1992),* reveals our assumption that a psychological problem, like a medical problem, is a concrete, structural disorder in the body (A. Horwitz, 2002). Likewise, in using the medical term "mental health *treatment,*" we assume that, as with physical medicine, the essence of psychological therapy is the application of problem-specific, concrete, interventions (such as a specific medication or behavioral program) to put the problem back in order (A. Bohart, 2006). The current trend among providers to redefine their mental health services as "behavioral health" services underscores America's increasing objectification of the mind and its problems.

In the United States all of the large Health Maintenance Organizations and insurance providers for psychological services, public and private - including Medicare, Medicaid, Blue Cross, Blue Shield, Group Health and Kaiser Permanente - are directed primarily by physicians and follow this medical model. All require for reimbursement a certification of "medical necessity" from a "mental disorder" diagnosis to be determined at the initial "intake evaluation" session. This diagnosis must be based upon specific symptom sets

listed in the medically proprietary *Diagnostic and Statistical Manual of Mental Disorders* (DSM) – a manual designed to conform to the World Health Organization's *International Classification of Diseases* nomenclature (American Psychiatric Association, 1994). With the exception of Post Traumatic Stress Disorder from severe trauma, only diagnoses considered to represent a distinct indwelling pathology in the patient are reimbursed. This excludes V-code diagnoses of psychological distress or dysfunction arising from "relational problems," "problems relating to abuse or neglect," "bereavement," or "academic," "occupational," "religious or spiritual," "acculturation" or "phase of life problems" (American Psychiatric Association, 1994).

Rather than accepting our current medicalized definition of psychotherapy as objective "treatments" of pathology diagnoses yielding behavioral changes, psychotherapy is viewed for the purposes of this article as structured communications between psychotherapist and client(s) designed to generate helpful changes in the client(s)' thoughts, emotions and/or behaviors.

Information Sources

This article relies mainly on the first-hand accounts of psychotherapists and their clients – those who directly experience psychological problems and the process of their resolution in therapy. It draws particularly from reported experiences of independent practitioners

(those in solo or small group practices) and their clients - the two constituencies which are assumed to provide the clearest and fullest view of the realities of psychotherapy.

Most of the other professional constituencies operate at a distance from the actual workings of psychotherapy, placing them at a distinct disadvantage. This includes psychotherapy researchers and teachers, whose articles fill professional journals, yet whose distance distorts their view, at times to the point of creating attitudes "antagonistic to the clinical enterprise" (Schedler, 2002).

Agency therapists, though first-hand participants in psychotherapy, are also flawed sources of information. Their work is much better documented than that of independent practitioners, since agencies routinely collect employee performance data. Yet most agency-based therapy suffers from severe, built-in restrictions on core therapy requirements, such as inability to assure confidentiality (with client records available to other staff members), little or no choice of therapist, and lack of control over the type and length of the therapy (Kremer, 2003). The expectations at many agencies for high client caseloads and rapid client turnover also impede therapists' ability to do their best work.

Independent practitioners also have the fewest conflicts of interest in serving their clients. In addition, in desirable and competitive practice environments such as Seattle they have the strongest incentives to do their very best work with every client, since their livelihoods are the most directly dependent on satisfied clients and the professional

reputation and referrals which ensue. They are also much more at liberty than the other stakeholders to speak openly about their realities, without fear of jeopardizing employment status, academic tenure, or research grants.

Ironically, despite being the two best sources of accurate information on psychotherapy, independent practitioners and their clients are the *least* represented in our professional dialogue. Clients' silence about their therapy is understood. Independent practitioners, despite their relative freedom from organizational retribution for speaking out about their work, also tend to remain silent. Researchers, teachers and managers of psychotherapy operate in a culture of communication. They are generally expected to discuss and publicize their work as a condition of their employment - in research reports, grant applications, case presentations and policy manuals. By contrast, most independently-practicing therapists operate in an atmosphere of silence regarding their professional work, and are generally not comfortable speaking out about it. They also have strong financial *counter*incentives to reduce paid clinical hours from professional schedules in order to engage in financially unrewarding writing or speaking about their work.

Demonstrating the dramatic under-representation of independent practitioners in our professional dialogue is the distribution of authorship in the American Psychologist (AP), the flagship publication of the American Psychological Association (APA). This journal is dedicated to "cover all aspects of psychology" (from each issue's Editorial Statement), and it is widely viewed as the most prestigious and influential journal in psychology and

psychotherapy. By this writer's tally, excluding APA awards, association reports and invited submissions, 339 authors contributed to independently-submitted major AP articles during the five-year period from January 2004 through December 2008. Each of these authors listed a primary professional affiliation on the title page. (When more than one primary affiliation was listed, only the first one listed was counted; secondary listings were all academic or large organizations). Of the 339 listings of primary professional affiliation, 286, or 84.4%, were academic (a school, college or university), and 47, or 13.9%, were large organizations (including human services agencies, research centers, hospitals and medical centers). 2 authors listed independent practice, 3 listed an organization which might represent a solo or small-group practice, and 1 listed location only. Even assuming that all authors in these last three categories are independent practitioners, they total 6 contributors out of 339, or only 1.8% of all contributors.

The AP's "Comment" section is much more accessible to practitioner contributors, since it welcomes short comments and limits reference citations. Of the 298 authors who contributed to articles printed in this section during the same five-year period, 252, or 84.6%, listed a primary academic affiliation, and 28, or 9.4%, listed a large organization. 6 authors listed independent practice, 3 listed an organization which might represent an independent practice, and 9 listed location only. Assuming, again, that all of the authors in these last three categories are independent practitioners, they total 18 contributors out of 298, or only 6.0% of all contributors. This is at best a dramatic under-representation.

A major source of this article's understandings and conclusions about psychotherapy is a professional peer consultation group (the "consult group") of Seattle psychotherapists. Of the seven current active members of this group, in which I have participated since its inception in 1985, five of us have a primary commitment to independent practice, one does full-time agency clinical supervision, and one has a mixed practice. Group members have an average of over 20 full-time years of experience as a therapist - including inpatient, agency-based and independent practice –as well as familiarity with the full range of client problems and levels of functioning. The group's professional disciplines include psychology, psychiatric nursing, social work, marriage and family therapy, and pastoral counseling. Group members' professional training encompasses the full scope of cognitive, behavioral, psychodynamic, humanistic and systems approaches.

This group is very stable and cohesive, with a rare level of honesty and openness about what occurs behind the closed doors of the psychotherapy office. The candid and unvarnished reflections of group members, aired during over 1000 weekly 90-minute meetings, thus provide a rare, detailed, close-up view of the realities of psychotherapy. These include my own experiences from the past 25 years of full-time independent psychotherapy practice as a psychologist working with adults, teens, couples and families.

I also cite published reports in the psychotherapy literature, drawn primarily from practitioners, but also from those in other stakeholder groups who seem to understand the

realities of psychotherapy practice. The intent in this effort is not to be systematic, but rather to indicate broad support for ideas presented in this paper, and to demonstrate a pervasive sense within the psychotherapy community that our current medicalized approach does not represent what psychotherapy is and what it needs.

II. The Medical Model's Failure in Psychotherapy Practice

"The great tragedy of Science – the slaying of a beautiful hypothesis by an ugly fact."

Thomas Henry Huxley

"For the great enemy of the truth is very often not the lie – deliberate, contrived, and dishonest – but the myth, persistent, pervasive and unrealistic."

John F. Kennedy

This medical model of psychology and psychotherapy is simple and appealing, but unfortunately it does not work. It does not reflect the fundamental realities of psychological problems and psychotherapy, as experienced first-hand by clients and therapists. If therapists adhered strictly to this approach, most psychotherapy would never get started, much less arrive at a successful conclusion.

In fact this appears to be happening: psychotherapy endeavors seem to be failing on a massive scale. At agencies - where the very limited data exist – reports of client dropout

after an initial psychotherapy session range up to 57% of clients (Pekarik, 1996). Privately-held data at large agencies over the past twenty years (L. Homans, 1999; Keyes, 2006; Talman, 1990), including Kaiser Permanente and Group Health, also show the modal number of client therapy sessions for each staff therapist to be stable at *one.* A recent national survey of outpatient therapy found that one third of psychotherapy patients received only one or two sessions, and concluded that "much of the psychotherapy in the United States is shallow and of limited benefit." (Olefson, 2002),

Some agency advocates justify the low modal number of sessions per client as successful single-session therapy (Keyes, 2006; Talman, 1990). Current agency practice, though, seems to belie this conclusion. Most present-day agency-based therapy, following the medical model, requires a significant amount of information from the client before therapy begins, including detailed personal, medical and problem history, to establish the requisite diagnosis and treatment plan. These preliminaries often consume the entire first session, delaying the start of therapy. Even in independent practice, where there is more flexibility than at agencies to defer information-gathering to spend the first session establishing a connection with the client, my colleagues and I have found that the client's concerns can almost never be presented and resolved at the first session. The conclusion, then, seems to be that agencies' reported low modal number of sessions per client shows a high rate of therapy failure, with many clients giving up the effort after the first session.

Conflicting Demands, Roles, Tools and Skills

Practitioners and clients experience crucial differences between psychotherapy and medical treatments. There is a unique and powerful stigma attached to psychotherapy (Corrigan, 2004). Many people identify with their mental problems more than their physical ones. For example, many say, "I *am* depressed, scared, nervous, (etc)," vs.: "I *have* a cold, a fever, a broken bone, (etc.)." As a young client recently remarked to me, "There *totally* is a stigma about going to counseling, because it is a reflection on m*e!*"

In addition, since the overt signs of psychological problems usually are not as concrete as those of medical problems (e.g. of the flu or a fracture), many people consider psychological problems less real or less justifiable (Gaylin, 2001), and believe they should therefore be able to handle them on their own. Coming to therapy, then, often feels to the client to be an admission of personal weakness and failure.

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Also unlike clinical medicine - which for most uncomfortable procedures either provides anesthesia or allows the patient to "tune out" (e.g. deliberately distracting oneself during a biopsy or an injection) - psychotherapy requires the continual active engagement of the client in the painful psychological material (A. Bohart, Tallman, K., 1999).

These unique demands of psychotherapy require the therapist to take a different role from that of the medical professional: a *relationship-focused, being-with* stance radically at odds with the medical professional's *problem-focused, doing-for* approach. The therapist

cannot assume patient compliance, as most medical professionals do. Practitioners have learned the hard way that, especially at the start of therapy, most clients are vulnerable to feeling shamed and rejected. In fact, many are at risk for quitting after even one inattentive or unsupportive statement by the therapist. Instead of focusing on history, diagnosis and treatment, therefore, practitioners have found that their initial energies are best spent helping the client to stay engaged in the anxiety-provoking therapy process (Havens, 1989).

Emphasizing the intensely relational and protective role of the therapist, John Bowlby, the originator of Attachment Theory, states, "the therapist's role is analogous to that of a mother who provides her child with a secure base from which to explore the world" (Bowlby, 1988). And Marsha Linehan, creator of Dialectical Behavior Therapy, states that the therapist must demonstrate "radical acceptance" (Linehan, 1993) of the person of the client as a necessary precondition to any meaningful therapeutic change.

Attunement, validating and *empathizing* with the client are the fundamental tools with which therapists of all schools provide psychological safety and encouragement to their clients. Successful therapists tend to use these so naturally and unconsciously that many do not realize they are using them or how important they are. Yet they are the foundation of all successful therapy. Each one, though, runs counter to the medical model's demands:

1) *Attunement* to the client conflicts with the medical model's demand that in both diagnosis and treatment the professional focus primarily on the *problem*, not the *person* of the client.

2) *Validating* the client requires seeing the sense – the reasonableness - of client thoughts, feelings or behaviors, some of which may appear nonsensical. This requires the therapist to step out of his or her own experiences and values, to understand the client's point of view (Linehan, 1997). As Bruno Bettelheim put it, "The patient is always right – that is, nonsensical as his behavior may seem to us, it makes excellent sense to him" (Bettelheim, 1974). To validate the client, the therapist's task is to see the client's responses as understandable, not pathological. The medical model's requirement of a diagnosis at the outset of the therapy forces the therapist to focus instead on what is *wrong* with the client. More broadly, the need for the therapist to accept multiple, equally-valid subjective truths runs counter to medicine's recognition of only one best objective truth - one best diagnosis and one "best treatment."

3) *Empathizing* with the client requires sensing how the client might feel about his or her situation. This can be done only by accessing one's own emotional responses to similar situations (Bettelheim, 1974), and by assuming a fundamental similarity of response between oneself and the client. Eminent psychiatrist Harry Stack Sullivan called this the assumption that "everyone is much more simply human than otherwise" (Evans, 1996). This process requires an emotional connection to the client which is discouraged by the realities of medical training (see medical

> training section) and the current managed care environment, both of which foster instead a task-focused, emotionally-detached professional stance. The assumption of fundamental similarity based on a shared humanity also runs counter to medicine's view of the patient as a member of a pathological "clinical population" rather than primarily a fellow human being.

The divergent roles of therapist versus medical practitioner call for different skills. Success in medicine depends fundamentally on what one knows and what one can do. The clinical medicine practitioner needs, at a minimum, extensive factual knowledge (Chen, 2007; Stein-Ratzker, 2006) and robust information-sorting skills. He or she must be able to retain, access and integrate massive amounts of data on human physiology, pathology and medical treatments – and must also have reliable skills at performing medical procedures.

Success in psychotherapy, in contrast, is based not on factual knowledge and technical skills, but personal attributes: who one is as a person. As psychiatrist Stephen Bergman notes, "It's not the method you use, but the person you are" (Shem, 1997). Keeping clients engaged in the therapy process usually requires the therapist's personal warmth, genuineness, empathic skill (Havens, 1989; Rogers, 1951; J. Smith, 1993), comfort with and access to a wide range of emotions and experiences; and ability to engage effectively with a wide variety of people - traits which require a high level of personal maturity. (Norcross, 2002; Strupp, 1995)

The comprehensive review of psychotherapy research by Hubble, Duncan and Miller reveals that "the personal qualities of individual therapists contribute as much as three times more to the variance of psychotherapy outcomes than the model or theoretical orientation that is used" (Hubble, 1999). Their own more recent research, studying thousands of therapists working with tens of thousands of clients, corroborates this finding. They conclude, "The evidence is incontrovertible. *Who* provides the therapy is a much more important determinant of success than *what* treatment approach is provided (italics theirs)." They further report that, regardless of the treatment approach used, "clients of the best therapists in the sample improved at a rate at least 50% higher and dropped out at a rate at least 50% lower, than those assigned to the worst clinicians in the sample" (Miller, 2007).

The Therapeutic Relationship

> "all successful therapies provide social support by creating a warm and empathic relational context. When these elements are present, therapy will succeed; when they are absent, therapy fails. Therapists who possess these qualities, regardless of their allegiance to a particular mode of therapy, will be successful."
>
> Allan Horwitz, *Creating Mental Illness*

The *therapeutic relationship* – also called the *alliance* or *rapport* between therapist and client(s) - is "the medium through which the process of therapy is enacted and experienced" (Miller, 1997). It is the crucible in which the therapist's abilities are put to the test. Its purpose is to provide a container, or holding environment, with enough safety, structure and encouragement to enable the client to face painful thoughts, emotions and/or experiences, and to activate inner creative resources to resolve them. Practitioners of all schools find that psychotherapy's success depends on this relationship. We find that the stronger the therapeutic relationship, the more willing clients are to dare to face their inner fears and painful experiences, the more responsive they are to any specific interventions, and the faster and more effectively any therapy will proceed.

Therapists describe this relationship in different ways. Some see it as a tightrope walk with the client across a high wire, with the therapist responsible for keeping their balance (Linehan, 1997). In this regard, most therapists have found from bitter experience that if we become too symptom- or goal-focused, even momentarily forgetting the client's emotional equilibrium, the therapy can abruptly lose its balance and crash. As noted psychologist Eugene Gendlin states, "Priority must always be given to the person and to the therapist's ongoing connection with the person" (Gendlin, 1996).

In his article entitled, "If it ain't got that swing, it don't mean a thing," my late colleague Fred Wardenburg, MSW (Wardenburg, 1988) likened the therapeutic process to a jazz jam session between therapist and client, in which the client plays the initial musical

themes, and the therapist restates these themes in his or her return riff, modulating them according to the therapeutic goals and the client's receptivity. This apt analogy highlights the uniqueness of each therapy encounter, its intensely context-dependent, process-focused and co-creative nature, and the impossibility of capturing and replicating this process in any treatment manual.

The central role of the therapist's receptive and supportive stance to the success of any psychotherapy is largely ignored in today's quantifying, medicalized healthcare environment. Yet this *relational stance* and *process focus* have been key elements of psychotherapy since its inception a century ago, when Sigmund Freud developed psychoanalysis, his "talking cure" (Gay, 1988), which reversed medical tradition by giving the patient the initiating, "talking" role, and the professional psychoanalyst the responsive, listening role (R. Hunsberger, 1961). Fifty years later another seminal practitioner, Carl Rogers, elaborated on this theme, making the therapist's receptive, relationship-focused stance the core of his Client Centered Therapy (Rogers, 1951). In articulating an approach based not on any specific treatments, but instead on therapist relational qualities of personal warmth, genuineness and accurate empathy, Rogers was in fact identifying core elements of all successful therapy.

Voluminous research over the past 50 years has corroborated what successful therapists have always known, demonstrating beyond credible challenge that the therapeutic alliance is "critical," (L. Beutler, Clarkin, J., 1990), "all-important" (Hubble, 1999) to

success in therapy. In their comprehensive study of the various factors contributing to successful therapeutic outcomes, Hubble, Duncan and Miller (Hubble, 1999) found that apart from client factors (at 40% of explained variance), the therapeutic relationship (at 30% of explained variance) is the most powerful factor over which the therapist has any control, fully twice the power of treatment effects (at 15% of explained variance). Lambert and Barley corroborated these findings in their meta-analysis of over 100 studies of psychotherapy (Lambert, 2002).

While impressive, this statistic, like most therapy research, understates the centrality of the therapeutic relationship to positive therapy outcomes, by examining only successful therapy. When we include failed and aborted therapy attempts, such as our clients' reports of failed connections with other therapists, we find that almost all unsuccessful therapy can be traced to an inadequate therapeutic relationship. Practitioners' experiences underscore noted psychologist Hans Strupp's dictum that "the quality of the interpersonal context is the *sine qua non* in all forms of psychotherapy" (Strupp, 1995).

Over the years, all of us consult group members have received far more appreciation from clients for our support, encouragement, and belief in them as people, than for any specific techniques or approaches we may have used. This finding suggests that much of psychotherapy's benefit is misattributed to specific approaches or techniques, resulting instead from the relationship between therapist and client.

III. Concrete vs. Symbolic Levels of Operation: The Medical Model's Failed Theory

Our medical approach to psychotherapy fails because the theory underlying modern Western medicine does not transfer to the study of the human mind. It attempts to reduce the mind's abstract, subjective nature to the concrete, objective level of brain and biology. This reductionism fails because, although all mental events have biological aspects (D. Siegel, 1999), the mind cannot be understood on the biological level alone, "just as the property of wetness cannot be derived from the properties of hydrogen and oxygen alone" (Jaynes, 1976), and just as the meaning and power of a work of art cannot be understood by studying the physical materials out of which it was created.

As Nobel Laureate Peter Medawar observes, "each tier of the natural hierarchy makes use of notions peculiar to itself.…In each plane or tier of the hierarchy new notions or ideas seem to emerge that are inexplicable in the language or with the conceptual resources of the tier below." (Medawar, 1984). In these terms, one could say that medicine's claim to the turf of psychology and psychotherapy fails because medicine, limited to the concrete level of operation, lacks the language and conceptual resources to understand the human mind's abstract, symbolic and subjective nature (P. Hunsberger, 2007).

Medicine's reductionistic theory rests on the flawed nomothetic premise that treatments which have worked for other, similar patients will work for the current patient. In psychotherapy the largely idiosyncratic makeup of each person's mind, based as it is on

personal experiences and unique meanings derived from these experiences, requires the therapist to adopt instead a more individualized, idiographic approach (Allport, 1961; Koocher, 2004). While recognizing commonalities with other clients, this approach is fundamentally *person-specific, not problem-specific:* it tailors all communications and interventions to the client's unique personality, preferences and relational style (M. Smith, Glass, G., and Miller, R., 1980). The spoken words of therapy, which serve as its main vehicle, must be customized for each recipient, since language is by its very nature abstract and symbolic, defying quantification (Dossey, 1991; Taylor, 2000), and involving differing connotations and meanings for every user and recipient (Orlinsky, 1986; Wachtel, 2008).

Another flaw of medicine's reductionism is its assumption of concrete, inner mental pathology. As Thomas Szasz aptly noted almost 50 years ago (Szasz, 1961), since the human mind has no physical existence, it cannot have a physical illness or disease, thus the medical notion of "mental illness" or "mental disease" is a deceptive misnomer. Our psychotherapy delivery system's requirement of an assumptive inner pathology to justify insurance reimbursement excludes many potential clients. Approximately half of all psychotherapy clients (by consult group estimates) seek therapy for psychological problems which arise not from a diseased or defective brain but from normal "difficulties in living" (Kovitz, 1998), such as personal losses, relationship conflicts, employment stresses, and troubling experiences, including childhood abuse or neglect (Rodgers,

2001). These problems do not by themselves qualify for insurance reimbursement, though their resulting pain and dysfunction often exceed those of problems which do.

Even with psychological problems which seem to represent brain pathology - such as schizophrenic and bipolar conditions, Attention Deficit Hyperactivity Disorder (ADHD), and many cases of chemical dependency and longstanding depression or anxiety - our medical mindset understands only the biological aspects of the problem, focusing on symptom reduction while misunderstanding and minimizing psychological aspects. As consult member Katharine Wilmering, MSW, ARNP points out, "once the biology has been addressed, the results of it in the client's life need to be addressed." (Wilmering, 2008).

For example, it does little good to manage the schizophrenic client's intrusive thoughts with medication, without also helping the client in psychotherapy to build back lost social skills and self-esteem, so the client has a chance to live a decent life. And it is of little value to provide the bipolar client with essential mood-managing medication, without also building crucial self-awareness and self-control skills to maintain the medication during the dangerous manic phase. Or to give euphoria-blocking medication to the chemically-dependent client without also providing psychotherapy to help the client find more appropriate sources of self-soothing and satisfaction in life.

Every psychological problem, no matter how prominent the biological component, includes dysfunctional learnings and inappropriate meanings attached to these learnings. The more severe the biological element, in fact, the greater the need for psychological-level work to mitigate its damage to the client's life. To use a computer analogy, all psychological problems involve both hardware and software elements, and the medical model offers expertise only at the hardware level.

In this regard, researchers seeking to understand the mind using new technologies such as PET, fMRI and SPECT scans, while making valuable discoveries about the effects of mental events in the brain, can never uncover the nature, or essence, of these mental events, because the thoughts, feelings and beliefs which constitute psychic life are not observable or explainable objectively (Damasio, 1999). Studying brain events to explain the mind risks confusing the message with the messenger. It assumes that psychological problems are located in the brain and behaviors - while in most cases they are located in the mind, and are merely being expressed through the brain and behaviors.

Ironically, the medical model is inadequate even in physical medicine. Organized medicine's (and especially managed care's) mechanistic reduction of medical care to symptom assessment and packaged treatments discounts the crucial doctor-patient relationship and overlooks possible symbolic meanings of physical symptoms, contributing to medicine's current low level of treatment compliance (Skidmore, 2008).

While harmful to the practice of clinical medicine, this reductionism is disastrous to psychotherapy.

IV. Specific Damages

Misdiagnosis: Seeing the symptoms, missing the problem

Operating at the literal, biological level of analysis, our medical model takes psychological symptoms at face value, assuming that they are the problem which must be removed (A. Horwitz, 2002). This approach often misunderstands these symptoms, leading to unsuitable and even harmful treatments. Its DSM enforces this conflation of symptoms and problems, by specifying a diagnostic pathology code for each specific symptom constellation. Psychotherapists observe, to the contrary, that far from being diagnostic, symptoms often disguise and distract from the real problem.

A common clinical presentation serves as an example: consider a teenager who for the past few months has had low energy, boredom with life, irritability and anger outbursts with family and friends, and declining grades in school. The medically-oriented psychotherapist would focus on these presenting symptoms, and, given an unremarkable medical workup and history, would probably diagnose a depressive disorder (A. Horwitz, Wakefield, J., 2007). The therapist might treat this depression by recommending

antidepressant medication and/or increased familial, social and physical activity for the teenager.

In seeing the concrete symptoms as the problem, the medical model blinds itself to the context and meaning of the symptoms in the patient's life (Wampold, 2001). The teenager's symptoms may be operating symbolically, not literally. They may function as a *psychic alarm*, analogous to a smoke alarm – a cry for help with a problem which the teenager cannot express directly, such as physical, emotional or sexual victimization, family violence or drug abuse. Or they might represent an important *release valve* for situation-based frustrations, such as a transitory and self-limiting grief reaction to the loss of a friend or to a social or romantic rebuff. They might also represent a crucial *developmental learning opportunity*, presenting emotions which the teen needs to learn to understand, regulate, and integrate into his/her personality, removal of which may deprive the teen of an important growth opportunity.

A specific problem can also present with a variety of different symptoms. For instance, a deep inner sense of worthlessness - perhaps stemming from an emotionally barren or traumatic childhood - can masquerade in later life in such compensatory behaviors as workaholism and overachievement (as attempts to create value for oneself), alcoholism or drug abuse (efforts to soothe inner pain or fill inner emptiness), or social withdrawal (to protect against further rejection).

Relying on medicine's symptom-based diagnostic approach to understand our clients' psychological problems is both irresponsible and dangerous. In mistaking surface symptoms for underlying problems, this approach risks missing the client's true problems. In viewing as pathology the client's efforts to cope with problems, it also risks undermining the client's trust in his or her own responses, thereby compounding the problem. Well-known psychiatrist Irvin Yalom notes, "diagnosis is often *counterproductive* (italics his) in the everyday psychotherapy of less severely impaired patients." (Yalom, 2002). Symptom-based psychotropic medication may also sabotage the therapy by covering up symptoms before their meaning in the client's life can be assessed, and masking emotions which need to be expressed and managed.

Pathologizing the client: the failed DSM

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, used by virtually every mental health practitioner in the United States for insurance reimbursement – highlights the failures of the medical system it represents (L. Beutler, Malik, M., 2002; Follette, 1996; Kutchins, 1997; Wakefield, 1992) in three specific ways:

1) *Objectification*: It follows medicine's reliance on objective surface symptom patterns to define problems. These symptom patterns correlate only poorly and unreliably with underlying psychological problems (Follette, 1996; Persons, 1986; Swartz, 2004).

2) *Decontextualization:* As is done in medicine, it isolates symptom patterns from the context of clients' lives. This strips them of their personal meaning to the client and their significance to the client's problems (A. Horwitz, Wakefield, J., 2007).

3) *Categorization:* It distorts human life's naturally-occurring continua – of less or more depression, anxiety, impulsivity, assertiveness, etc. – by forcing them into arbitrary, mutually exclusive, medically-based diagnostic categories. Though these categories may be helpful for research, or for mental patient inventory purposes for which the DSM was originally designed, they tend to confuse rather than clarify an understanding of the client. (A. Horwitz, 2002; Persons, 1986; Reed, 2006). There is no clinical difference, for instance, between a client whose chronically depressed mood qualifies for a DSM diagnosis of Dysthymic Disorder because it has lasted the minimum two years, with symptom-free intervals lasting no longer than two months, and a client whose depressive course has lasted just under two years and/or involved a symptom-free interval just over two months – which would rule out this diagnosis.

Not surprisingly, despite great efforts to improve its relevance to psychotherapy, especially with the 1980 Third Edition, the DSM continues to suffer from poor reliability and validity (Hubble, 1999; Reed, 2006), and has "absolutely no predictive power in terms of treatment outcomes" (Hubble, 1999). As a result, most therapists use it mainly or exclusively as a reimbursement tool – "a fiscal formality unrelated to treatment" (Duncan, 2004).

Misunderstanding and misusing treatments

Our medical model makes the same error in treatment that it does in diagnosis, in assuming that improved outcomes depend on increased specificity and precision of focus. The healing power of modern allopathic medicine rests on the literal precision of its treatments – for example the exact types and dosages of antibiotic for a specific infection, or of radiation for a specific cancer (Grady, 2008). Organized medicine assumes that in psychotherapy, as in medicine, greater specificity will lead to improved outcomes. With the support of the American Psychological Association (American Psychological Association, 1995), it is increasingly requiring specific competency certifications for work with specific populations - such as alcoholics, drug addicts and sexual offenders - and it is working to require therapists to use diagnosis-specific, "empirically supported treatments" (ESTs): formulaic intervention protocols codified in treatment manuals, which purport to represent the best approach for a specific diagnosis (Chambless, 2006).

While specialized knowledge is helpful, and some approaches seem to work better than others for certain problems - such as expressive therapy for bereavement, and Eye Movement Desensitization and Reprocessing (EMDR) for trauma - our psychological services delivery system's focus on specific training and treatment for specific problems is counterproductive. Unlike bodies, minds do not respond predictably to specific treatments. Since minds operate symbolically and contextually, not literally as do bodies

(Wachtel, 2008), the same treatment protocol will be experienced differently by each client, and even by the same client at different times.

Responsiveness to the client, not formulaic precision of delivery, is the key to effective therapeutic interventions. For most clients, the opportunity to talk freely about their concerns to a person who is attuned and responsive to them seems to provide most of the benefit of psychotherapy. For many clients this suffices, without the need for any more specific treatment approach (Richert, 2007; Rogers, 1951).

Modern medicine's categorization methodology, which sorts diseases and their treatments into mutually-exclusive categories, does not transfer well to the psychological arena, as we have seen with diagnosis. A treatment example of this is our medical insurance system's discontinuous coding for length of an individual therapy session. To obtain insurance reimbursement, all therapists must use a Current Procedural Terminology (CPT) code indicating the length of each therapy session. There are only three available coding choices for individual therapy: 90804 for 20-30 minutes, 90806 for 45-50 minutes, or 90808 for 75-80 minutes. Inexplicably, a session which lasts less than 20 minutes is not reimbursable, and there is no CPT code for a session between 30 and 45 minutes or 50 and 75 minutes in length. This is true even though many therapists find it helpful to hold sessions ranging from 5 minutes to 2 hours (Hoyt, 1995), and insurance-accepted protocols such as clinical hypnosis and EMDR frequently require more than 50 minutes but less than 75 minutes per session.

There is no conceivable clinical rationale for denying clients and therapists appropriate reimbursement for sessions whose duration is less than 20 minutes, or between 30 and 45 minutes or 50 and 75 minutes. Much more helpful than forcing therapy into arbitrary, discontinuous time categories would be to code psychotherapy continuously on the time dimension, with each provider reporting - and being reimbursed for - the actual session length, according to each insurer's own preferred reimbursement formula. With both diagnosis and treatment, then, medicine's categorization methodology ill fits the realities of psychotherapy.

Also remarkable is providers' silence on these glaring CPT coding gaps. For example, Lucy Homans, Ed.D., the Professional Affairs Officer for the over 700 psychologists in the Washington State Psychological Association, who is responsible for handling member concerns regarding insurance billing matters, has received not a single question or complaint about these CPT coding gaps in her 17 years in this role (L. Homans, 2008). Needed reforms of our psychotherapy services delivery system seem unlikely unless practitioners speak out about problems in the system.

The incompatibility of medical training with psychotherapy

An examination of standard American medical training helps to explain how physicians, who write and publish the DSM, and who direct our psychological healthcare delivery

system and federal psychotherapy research funding, could fail so badly in understanding and managing psychotherapy. Several physicians, including some who are involved in training of medical students, describe a recent pattern of medical school, internship and residency training in the United States which imbues physicians with attitudes and attributes antithetical to those of the successful psychotherapist, and selects and trains out key qualities and skills needed for successful psychotherapy (Spiro, 1993; Hollenbeck, 2005).

Yale Medical School Professor Howard Spiro and others note that medical school selection committees place far less importance on the character and personal maturity of applicants than on their grade point averages, entrance test scores and proven devotion to natural science (Spiro, 1993; Wear, 2000). Spiro's colleague, Professor of Medicine Shimon Glick, states, "The selection process, which favors the brilliant and competitive students, is not geared to discover the empathetic and sensitive human" (Spiro, 1993). Medical schools strongly prioritize verbal intelligence (Spiro, 1993; Wear, 2000), which correlates only approximately .35 with the emotional intelligence essential for the successful psychotherapist (Goleman, 1994; J. Mayer, Salovey, P., Caruso, D., 2008) – too weak an association to assure an emotionally equipped student body.

The medical career path starts with arduous pre-med and medical school coursework - described by one physician as "like memorizing a telephone book" (Chen, 2007). Physicians report that this arduous coursework severely restricts the student's personal

and social development during critical growth years, placing incoming medical students behind their contemporaries emotionally and socially. For example, Phyllis Hollenbeck, M.D. characterizes typical medical training as "essentially an enforced adolescence," producing a graduate who "still has no inter-human skills." (Hollenbeck, 2005).

"Then there is the dehumanizing and alienation that occurs during the stressful years of medical school." (Spiro, 1993), which encourage keeping one's emotions "bottled up inside" (Dossey, 1991). In their first-year cadaver dissection class, "students first learn to harden themselves against empathy" (Spiro, 1993), in order to distance themselves enough from the person of the cadaver to do the dissection. Thus starts a dissociation from "human dimensions" (Damasio, 1994), which continues throughout their training (D. Siegel, Hartzell, M., 2003; Zuger, 2007).

Following medical school, Spiro continues, "Residency training quenches the embers of empathy [with] isolation, long hours of service, chronic lack of sleep…" Another physician, Allan Peterkin, reflects, "The professional stresses of residency may adversely affect or postpone personal developmental milestones because of lack of time to reflect and explore creatively (Peterkin, 1998). In addition, as Glick notes, "Since few of the professors have received training in the field of human interactions, they may not be the appropriate role models" (Spiro, 1993). Reflecting on their medical training, psychiatrist Stephen Bergman observes, "Medical school is a liability in becoming a psychotherapist"

(Shem, 1997), and psychiatrist Bessel van der Kolk notes that psychiatrists learn to be effective therapists *despite* their medical training (van der Kolk, 2007).

Improvements are being made to humanize medical schools' incoming students and their training (Kliff, 2007; Mauksch, 2006). The fundamental differences in attributes and training required for the medical versus the psychological practitioner, however, will always make medical education - no matter how humane - a problematic training ground for psychotherapy professionals.

None of this discussion is intended to impugn the therapeutic abilities of any particular physician. And lest psychologists start to feel smug, standard psychology PhD training programs, also being highly competitive and academically-focused, tend to suffer from the same failings as medical training, in terms of therapist development (O'Donovan, 2005).

V. Conclusions:

The data are in. Our dominant medical model of psychotherapy has failed. It is "fatally flawed" (Fishman, 1994). Incontrovertible evidence from the experiences of therapists and their clients, supported by voluminous outcome research, reveal successful psychotherapy to be based not on precision of diagnosis and specificity of treatment, as

organized medicine would have us believe, but rather on personal attributes of the participants and the quality of their relationship with each other.

No credible scientist would ignore a large volume of evidence simply because it happens to contradict his or her deeply held beliefs. Yet this is exactly what American medicine, psychology, psychotherapy and society at large are doing, by continuing to believe that the broad range of psychological problems are DSM-defined "mental disorders" which need formulaic, diagnosis-specific "treatments." This approach, based on our society's deep and unquestioning faith in medicine to solve our life problems, is more accurately termed "scientism masquerading as science" (Fox, 2006), since it lacks the critical scrutiny of data and the honest consideration of disconfirming evidence which are the foundation of the scientific method (Stricker, 2000; Voegelin, 1948; Zilboorg, 1941).

In pursuing this unquestioning use of a natural sciences approach inappropriate to its psychological subject matter (Dilthey, 1977) we are continuing to look under the proverbial street corner lamppost, in the relatively well-lit and easy-to-see medical terrain of the objective and the quantifiable. Meanwhile, the answers to understanding and resolving psychological problems lie down the road, in the much murkier and harder-to-discern terrain of the abstract, the subjective, and the unquantifiable.

In attempting to replace the human mind – the seat of psychological life and its problems – with the concrete brain and biological science, we are losing our mind, both literally

and figuratively. Not only are we mindlessly supporting a system of psychological health care which fails to engage with approximately half of those seeking help, and discourages countless others from even seeking help by its stigmatizing focus on "mental illness," but in the process we are allowing medicine to redefine the human mind out of existence (Frattaroli, 2001).

Expanding from Medical Science to Psychological Science

Stakeholders who are speaking out (e.g., see Cushman, 2000; R. Smith, 2001; and Suarez, 2004) are failing to persuade organized medicine to undertake the reforms needed to reverse its ongoing erosion of psychotherapy. Instead of waiting for medicine to change, the profession of psychotherapy needs to renegotiate its relationship to medicine, from medicine's adopted child to its partner in health care, with each profession doing what it does best in attending to people's physical and psychological well-being. Such a partnership would free psychotherapy to develop its own model of psychological science which "incorporates the analytic observation of the brain within a larger synthetic perspective on the soul" (Frattaroli, 2001): a "science of the heart" (Schneider, 1998) which goes beyond the natural sciences to appreciate not only the biological bases of psychological life, but also what it means to be human (Georgi, 1970; M. Smith, 2001).

This inclusive science would restore the term "empirical" from its current, overly restrictive, quantified medical usage to its original and core meaning as "based on

experience" (Honderich, 1995), including the subjective and unquantifiable essence of human experience (E. Mayer, 2007). Prioritizing subjective experience in this way would re-anchor *research, teaching and management* of psychotherapy in the *experience* of psychotherapy, recognizing that - as consult group member Glen Paddock. Ph.D. notes - evidence-based practice requires practice-based evidence (Paddock, 2008).

Reforms needed:

Freeing psychotherapy from medicine will require radical changes in practice, research and training. Some of the most important reforms seem to be:

In practice, we need to remove the requirement for a pathologizing diagnosis for insurance reimbursement. This would allow therapists to focus their energies where they are most needed - on their connection with their clients, especially during the crucial initial sessions. This should increase the therapy's efficiency and lower its cost. It would also go far to normalize and de-stigmatize therapy, encouraging many prospective clients who are now staying away out of shame and embarrassment. It would also allow for more preventive therapy in areas such as addictions and anger management, before behavioral problems become destructive at huge cost to the client and society.

In research, we must discard the "efficacy studies" mode of psychotherapy research, and any research conclusions based on it. Efficacy studies do not represent psychotherapy.

They are artificial laboratory simulations using client volunteers screened to represent only specific DSM diagnostic categories, and therapist volunteers who present highly controlled, replicable treatment approaches. They constitute the bulk of the research on psychotherapy, due to the relative ease and simplicity of staging such enactments - in contrast to "effectiveness studies" of real-life psychotherapy - but their very structure prevents the formation of the therapeutic alliance essential to successful psychotherapy.

"Effectiveness studies" of real-life psychotherapy must be re-evaluated. Most effectiveness studies do not control for the quality of the therapeutic relationship, thus washing out this key variable, showing psychotherapy to be much less effective than it truly is. In order best to compare different psychotherapy interventions, or to demonstrate the potency of psychotherapy as compared to medications, future effectiveness studies need to assure a strong therapeutic relationship for all psychotherapy test groups, using at least a client measure, such as the Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1986). This should significantly improve demonstrated psychotherapy effectiveness.

Also, qualitative methods appropriate for clinical practice (Hill, 2006; Hurst, 2006; Silverstein. L., 2006) need to be further developed and more widely used, which offer scientific rigor without losing the idiosyncratic, subjective and relational essence and "feel" of the psychotherapy process.

In selection and training, we cannot expect to attract and develop the best potential psychotherapists, or the best leaders of our psychological services delivery programs, with our current standard medical school and PhD psychology training programs. We need more practitioner-focused training programs which prioritize personal maturity and emotional and relational skills in selection and training, along with analytic abilities, and which are staffed with teachers who themselves exemplify these qualities.

Psychotherapy is too valuable and too needed a resource to our society to continue to be hobbled by the medical model. Space has permitted only brief discussion here of some of the practical and theoretical incompatibilities between psychotherapy and our medicalized mental health system. Clarifying these and reforming our profession will require many other stakeholders to speak their truths. It is hoped that this article will stimulate them to do so.

The stakes are high. The United States is now in the process of making far-reaching decisions on comprehensive health care reform. We can either remain quiet and allow psychotherapy to become reified as a subspecialty of medicine, or seek for it its own place alongside medicine in our new healthcare delivery system - a place which respects its true nature and works to develop its full potential for healing and personal growth.

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