ejom
Vol.9. No.3. 2019

The Therapeutic Relationship

Psychotherapy, Chinese Medicine and Eastern Spiritual Traditions

Comparing the roles and perspectives of psychotherapists and TCM practitioners, acknowledging the importance both attach to the therapeutic relationship, and exploring the parallels between psychotherapy and Eastern philosophies such as Daoism and Buddhism.

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ABSTRACT

This article is a wide-ranging exploration of the ways in which the worlds of Chinese medicine (CM) and psychotherapy intersect and diverge. It links the greater focus on emotional imbalance by CM practitioners in the West compared to those in China – and the marginalised status of psychotherapy in the latter – to the different cultural contexts. It compares the roles and perspectives of Western practitioners and psychotherapists and the ways in which they interpret and respond to emotional imbalance. It looks at the limits of their expertise and problems that might arise through straying outside their domain of competency. It explores differing views as to where to locate the site and cause of Illness – in the mind or in the body. It examines the importance both usually attach to a strong therapeutic relationship, seen as an integral part of the treatment process, and questions the tendency of the scientific establishment to devalue the therapeutic contribution of this relationship by dismissing it as part of the 'placebo effect'. Finally, it considers Alan Watts's view that there are parallels and crossovers between psychotherapy and Eastern 'ways of liberation' such as Daoism and Buddhism (on which much of CM is based).

Keywords: Emotional imbalance, psychotherapy, Chinese medicine, 'psychologisation', somatisation, CBT, psychoanalysis, domain of competency, therapeutic relationship, 'problem parking', homeostatic mechanisms, placebo, random controlled and pragmatic trials, psychosomatic, Bioenergetics, Eastern 'ways of liberation', spiritual traditions, social conditioning, spontaneity, paradoxical intention, Daoism, Buddhism, Confucianism.

This article looks at the different ways in which emotional expression and imbalance are seen and responded to in the West and China. It compares the roles and approaches of Western practitioners of Chinese medicine (CM) and psychotherapists, looking at the limits of their expertise and the limitations of their respective therapies. It also considers Alan Watts's view – particularly with respect to its therapeutic implications – that psychotherapy and Eastern spiritual traditions such as Daoism and Buddhism (on which much of CM is based) are engaged, at least ideally, in the same essential endeavour: that of liberating individuals from the adverse effects of social conditioning and providing openings to new, transformative ways of experiencing the self and world. Psychotherapy is defined as the treatment of mental or emotional disorder by psychological as opposed to medical means. 'Psychotherapist' is used broadly to also include psychoanalysts and psychodynamic therapists; cognitive, behavioural, humanistic and integrative therapists; qualified emotional counsellors; clinical psychologists and hypnotherapists as well as psychiatrists in so far as they also engage in psychotherapeutic activity.

The cultural shaping of responses to emotional imbalance

The different ways in which emotional experience, expression and imbalance are perceived and responded to in China and the West are shaped by their distinctive cultures. The transposition of CM to a Western context has involved bridging a considerable cultural and linguistic divide. This has necessitated substantial changes to adapt it to the different world views, orientations and demands of Western CM practitioners and potential patients. In the same way, attempts to transplant the uniquely Western institution of psychotherapy into the Chinese context have met with considerable bridging problems, including much fiercer resistance than that to CM in the West.

Chinese classical texts see emotions as an important cause of disease, and CM is used in psychiatry in Chinese hospitals. However Western CM practitioners are much more likely to focus on treating emotional imbalances than their counterparts in China, and to give them more significance as symptoms and causes when treating physical illnesses. This partly reflects an

attempt to adapt CM to a Western setting where physical causes of disease have declined, and emotional sources of suffering and disease such as stress, social isolation and comfort eating have assumed a greater significance. It also reflects the more pronounced focus on psychological issues in modern Western society and in particular the relatively high value placed on emotional fulfilment and self-expression. In the West there has been more licence and encouragement to express emotions especially since the emergence of the rebellious, good time, 'youth culture' – and the relaxation of media censorship – in the late 1950s and 'swinging sixties' that started to erode the repressive conformism hitherto rife in Western societies. This culminated in the 'flower power', baby-boomer 'Me Generation' and the 'New Age Movement' which celebrated and legitimised self-expression and self-exploration along with psychotherapy, meditation and other self-enhancement practices, once the preserves of the eccentric or privileged few.

Just as psychotherapy grew in popularity in the 1970s and 1980s (and with it the view that suppressing feelings was unhealthy), so did CM. Medical anthropologist Linda Barnes, who conducted a case study of CM practitioners and patients in Boston, Massachusetts in the early 1990s, talks of the 'psychologisation' of Chinese healing practices, as they were transposed to the West, having been 'filtered' through a foreign language and way of thinking.(1) Adapting CM to fit the tendency of Westerners to think about their experiences in more explicitly psychological ways, non-Chinese practitioners blended or overlaid Western psychological concepts with Chinese ones. These included Freudian and 'New Age' notions of emotions and energy being 'blocked', 'stuck' and 'suppressed' and needing to be 'released' – and the Reichian view that repressed emotions could be locked into the body in the form of muscular 'armouring'. These were linked to Chinese concepts of *qi* flow and stagnation with illnesses being explained as the result of stagnant or disturbed *qi* whose source lay to a large extent in blocked or unbalanced emotions.

In addition, psychospiritual concepts, purged from the TCM orthodoxy by the Communist regime as 'superstition', were resurrected from classical texts. These included those drawn from the demonology tradition such as Sun Si Miao's 'ghost points' but, though applied to treating 'diseases of the spirit', they were usually stripped of their overtly mystical associations to become psychological constructs. Worsley, for example, applied the notion of 'possession' to those who seem to have been taken over by external forces – including worldly fixations like money making or sex – such that they were no longer in control of their lives.(2)

In her case study, Barnes found some practitioners saw acupuncture as an alternative to conventional, talking-style psychotherapy – 'Chinese Medicine as body oriented psychotherapy' as Müller puts it (3) – whilst others combined acupuncture with Western emotional counselling. However, there were some non-Chinese practitioners who distinguished between the role of acupuncturist and psychotherapist and chose not to blend the two, preferring, like Chinese-born ones, the more clinical, emotionally disengaged style practised in China, with the focus on physical problems (though these nonetheless sometimes felt pressure from patients to address their psychological issues). The different way CM is practised in the West, with much longer sessions held in less clinical, more private settings has given much more opportunity to explore patients' emotional life and personal relationships.

In China, both the political and cultural climate have tended to discourage individuals from owning to or seeking therapy for emotional imbalance, although the situation is beginning to change. Under Mao, psychotherapy was first discouraged and then, during the Cultural Revolution, banned. It is also incongruent with more deep-seated, traditional attitudes based on Confucianism which value ritual propriety (*li*), self-composure and social harmony, and regard the intense experience and uninhibited expression of emotion as unseemly; injurious to health and moral integrity; and a threat to harmonious relationships within the family and wider society.

According to Maciocia, Confucianism sees emotions (particularly anger which might promote rebelliousness) as 'disturbing factors that sway us from the path of *ren* (benevolence) and *li* '. More fundamentally, psychotherapy relies on the Western concept of 'self', one that is traditionally alien to the Chinese. 'The concept of an individual self as an autonomous psychological centre of consciousness and whose emotional life is influenced by the complex of past experiences of such an individual, autonomous self, simply did not exist in Confucian philosophy and, by extension, Chinese medicine. The Chinese self is a social construct and the result of family and social relationships.' The Western view that 'emotional life is affected deeply by childhood experiences is absent' and so

probing an individual's psyche searching for these makes no sense. Maciocia claims Western CM practitioners inevitably approach a patient with a Western concept of 'self' along with an associated set of popularised, Freudian-derived psychological conceptions, resulting in a – as yet unbridged – 'gap between our concept of "self" and Chinese medicine's view of the emotions as pathological factors that need to be "rectified".'(4) In this respect, CM as practised in the West can be seen as a hybrid form with psychological concepts drawn largely from psychotherapy grafted on.

In terms of rudimentary Daoism, mental illness represents a lack of harmony with Nature which is taken to imply moral failure, shame and disloyalty to family. There has been a tendency to somatise it with the archaic Western disease category 'neurasthenia' (meaning 'weak nerves'), for instance, being retained well into the late 20th century due to its emphasis on physical symptoms such as headache, fatigue and insomnia and its implication that the depression and anxiety associated with these are due to overwork or genetic make-up rather than moral failure or, as in the Maoist era, 'wrong political thinking'. The tendency of mentally ill patients to emphasis physical symptoms when seeking medical help – reinforced by doctors who collude in this process – is partly an attempt to avoid 'loss of face' and adverse social reaction.(5) Several studies have shown that Chinese patients with depression tend to refer more to physical symptoms and less to psychological ones than their Western counterparts. (6) However, this probably not only reflects the former feeling less comfortable referring to emotions, particularly when problematic, but also a genuine tendency to link psychological states to bodily ones, based on a more integrated view of the body and mind.

The pronounced social stigma attached to mental illness in China has discouraged sufferers from seeking treatment for which there is very sparse provision, the number of psychiatrists per capita being only ten per cent of that of other developed countries. Psychotherapy is however starting to become popular among younger, educated individuals – a development some have called a 'psycho-boom' – but there is a dearth of well-trained psychological counsellors.(7) The Mental Health Law passed in 2012 recognised psychotherapy as effective and required all medical facilities to provide it but there are few psychiatrists qualified or willing to provide it and hospitals are not keen to employ psychotherapists.(8)

Comparing roles and approaches

When it comes to differentiating the roles, perspectives and strategies of the psychotherapist and Western CM practitioner, there are no clear or generally accepted demarcation lines. Although a consensus among practitioners is unlikely, it is worth attempting to identify and explore what these differences might be, particularly with respect to considering the limits of either's expertise and the limitations of their respective therapies. The relatively strong emphasis placed on psychological problems and factors by Western practitioners – often matched by their patients – tends to bring them into competition with psychotherapists, blurring boundaries and making this task difficult.

The roles of CM practitioners and psychotherapists cannot be definitively differentiated on the basis of the types of problems they treat because here there is a considerable overlap. Another possible, seemingly obvious way of doing this might be on the basis of their distinctive techniques and their level of intervention, with the role of CM practitioners distinguished by their use of techniques that work on and through the body and that of psychotherapists by their exclusive use of psychological ones. However, in practice, the differences are not so clear cut. Some forms of psychotherapy such as Bioenergetics use bodywork techniques such as massage and exercises that parallel CM ones; Emotional Freedom Technique (EFT) actually involves tapping on acupuncture points. Equally, CM practitioners use the psychological technique of counselling, even if only to offer practical suggestions about what patients should do to help resolve or alleviate a particular condition. At the other extreme, some devote considerable energy to emotional counselling, substantially duplicating the role of the psychotherapist.

Some very general differences can be discerned but none that are definitive or universal. For instance, CM practitioners, although interested in identifying emotional imbalances and interpersonal problems where appropriate, are in general not so exclusively focused on these as psychotherapists are, being also interested in other potentially unbalancing aspects of patients' lives such as eating and bowel habits, exercise levels and work stresses and strains. Interest in these body-related aspects reflect, in general, a greater tendency to ascribe a somatic basis to emotional disharmony. In taking a broad view of patients' lives, practitioners resemble life coaches more than psychotherapists.

Psychotherapists, especially psychoanalytically oriented ones, often tend to delve into the patients' earlier lives to unearth traumas and other formative experiences that might underpin the patterns or emotional templates in which their present problems are seen as largely rooted. Since this process can sometimes unleash some powerful, hitherto repressed psychic content, they need to be sufficiently trained and experienced to handle the potentially damaging knock-on effects. In the course of counselling or merely questioning patients about emotional issues, Western CM practitioners may sometimes stray into this and other problematic areas which they are not qualified to handle and may find themselves out of their depth. Without appropriate training and supervision practitioners may also fail to recognise signs of emotional instability in patients (including suicidal tendencies) and continue to treat them when their conditions need to be managed by more suitably qualified personnel. Transference (and countertransference) can increase the tendency for the relationships with patients to become overly close and dependent, particularly when emotionally charged areas are explored. CM practitioners, unlike psychotherapists, are not specifically trained to anticipate and pre-empt any possible adverse consequences. However, apart from the odd instance of sexual involvement, there is no evidence available to suggest these potential pitfalls might constitute a significant problem, but cases where patients suffer by becoming destabilised or not being treated by more appropriate methods or personnel may be unlikely to surface.

Cognitive Behavioural Therapy (CBT) is one form of psychotherapy that avoids digging into early life to find the roots of depression and anxiety and instead tries to manage symptoms by teaching patients psychological tricks to limit the damage these can do. It seeks to identify self-critical or upsetting thoughts – 'negative thought cycles' – with a view to helping patients replace these with more 'helpful' and 'realistic' ones. In terms of symptom reduction and everyday functioning, there is considerable evidence to suggest that, in the short term, it may be one of the most effective treatments for anxiety and depression. It has attracted generous NHS funding. At the other extreme, the psychoanalytic old guard, discredited and sidelined for being 'unscientific', is fighting back, with recent studies suggesting that psychoanalytic therapies such as the shorter-term, less intensive 'psychodynamic' form can be effective and, more significantly, that their benefits last longer than those of cognitive ones.(9)

CBT has been heavily criticised – and perhaps unfairly caricatured – for being 'mechanistic'; providing a quick fix or sticking plaster whose effect wears off after a year or so; invalidating painful feelings, seeing them as 'negative' alien entities to be eliminated or tolerated rather than understood and explored as valuable clues to more deeply-rooted fears and traumas; and measuring success overly narrowly in terms of mood management and symptom relief to the exclusion of other criterion such as authenticity, self-understanding and finding meaning in life. It is also accused of failing to fully acknowledge the crucial part the therapeutic relationship (between therapist and patient) can play in the healing process.(10) However, in terms of its limited aims and more superficial level of intervention, CBT is closer to the approach of CM practitioners whose remit is usually limited to helping patients become aware of any emotional disharmony and suggest ways it may be reduced and contained by changes in attitude and lifestyle (rather than discovering its deeper, underlying psychological causes).

One recent British large-scale study of psychological therapies found one in twenty recipients reported 'lasting bad effects'.(11) Other studies have shown around ten per cent, on average, get worse after psychotherapy, but it is difficult to estimate whether such deterioration was due to the therapy (or incompetent therapists) or might have occurred anyway.(12) Psychotherapies that probe too deeply may not be appropriate at times of crisis as they can open up old wounds that can increase the potential for anxiety and depression and so further destabilise patients at a time when they need to concentrate on holding their selves and present lives together. Psychotherapy can also become all-consuming such that patients' health, relationships and work lives are put under strain. It can encourage patients to become excessively inward looking, self-absorbed and overly self-conscious; and to dwell on painful feelings and memories with the risk of reinforcing them. This may be particularly true of those with Spleen *qi* deficiency who are inclined to excessive thinking and obsessiveness. In such cases CM or CBT may be a more appropriate choice of therapy.

Therapies in general have their domains of competency and individual therapists their strengths and weaknesses. An essential part of the skill sets of therapists is knowing not only how to help patients but when they cannot help them and when they may be better served by another form of therapy or care.

Locating the problem: mind or body?

Psychotherapists usually look for explanations and resolutions on the psychosocial plane, locating problems in the minds of patients and their intimate associates whereas CM locates problems, from the Western dualistic viewpoint, jointly in the mind and the body, seeing them as manifesting simultaneously on both levels. Thus, in CM, anxiety may be due to the Blood or the *yin* failing to 'root' or 'anchor' the etheric soul; depression to stagnation of *qi*; psychosis to Phlegm-Heat; and dwelling on grief and loss to Lung *qi* deficiency. This represents the relative lack of duality in Chinese thought, with the mind, instead of being split from the body, being intimately and mutually related to it. When *qi* stagnates or Heat is generated on one level it transposes to the other. The syndrome of Liver Fire, for instance, manifests with psychological symptoms such as anger and irritability and physical ones such as headaches and dizziness, with its causes such as pent-up emotion or excessive alcohol intake occurring on one or both of these levels. A deficiency such as Spleen *qi*, characterised by excessive thinking and weak digestion, usually sets up a bidirectional chain of causation or vicious circle leading to mental and physical aspects reinforcing each other.

Psychotherapy has emphasised – and arguably overstated – the capacity of the mind to cause physical illness. The origin of psychoanalysis lay partly in Freud's study of hysteria and his view – the evidence base for which was highly questionable – that mental traumas could be 'converted' into physical symptoms.(13) Since then psychotherapists have been some of the foremost standard bearers of the psychosomatic thesis: that psychological factors play a major part in the development, expression and resolution of physically manifesting illness.

This view, largely the preserve of psychoanalysis and alternative therapies till the 1970s, has become widely accepted. IBS, fibromyalgia and chronic fatigue syndrome (CFS), for instance, have been assumed by much of the medical establishment to be largely caused by mental factors with the last two routinely treated with CBT and low-dose antidepressants. There may however be a growing awareness that the pendulum may have swung too far in favour of the psychosomatic thesis with the discovery of more physiological bases for IBS, and – partly as a result of 'ME' pressure groups vigorously lobbying to liberate it from the grasp of psychiatry and psychological therapies – CFS being increasingly seen as a chronic inflammatory condition due to a dysfunctional immune response rather than being diagnosed as a depressive disorder and thus delegitimised as 'all in the mind' and 'not a real illness'. It is interesting that in China any bias has been in the opposite direction: towards somatising psychological problems as opposed to psychologising physical ones.

When no physiological cause can be discovered for a physical illness, there has been a tendency among some clinicians and medical theorists to hypothesise a psychological one, which often readily presents itself, given that patients are often understandably anxious or depressed about their condition. The 'psychosomatic' or 'somatisation' category may thus be used as a catch-all discard box or diagnostic classification of last resort (similar to that of IBS) for those symptoms for which no organic cause can be readily identified. This tendency by no means represents the consensus view of orthodox medicine. In a review study of research into medically unexplained physical symptoms (MUPS) in primary care, Burton, for example, challenges this questionable approach, concluding that empirical evidence does not support the view that somatised mental distress or alternatively somatoform disorders, based on symptom counts (where symptoms are assumed to derive solely from mental factors), account for most patients seen with 'MUPS'. Instead, he says that patients with MUPS are best regarded as having 'complex adaptive systems in which cognitive and physiological processes interact with each other and the environment', one example of this being the tendency of sufferers to manifest heightened body sensitivity.(14)

There are dangers in being predisposed to too readily assuming that patients' physical symptoms derive from emotional causes such as 'stress' or depression (as psychotherapists might be inclined to do, should they overreach themselves in attempting to treat patients with physically manifesting illnesses). Potential physiological causes, possibly sinister ones, may be disregarded or not explored, resulting in conditions being treated inappropriately or not at all.

The tendency to solely locate the problem on the psychological plane and intervene on the same level is not true of all forms of psychotherapy. 'Bioenergetics', based on the ideas of Wilhelm Reich, locates the subconscious partly in the body with chronic muscle tension – 'body armour' – a part of the individual's emotional defences that repress painful feelings and memories and block (or 'resist') their being consciously experienced and expressed.(15) Repressed psychic content is supposedly forced or coaxed to surface into consciousness by releasing muscle tension (and thus blocked energy) through

massage or specially designed exercises and stress positions as well as by using more conventional psychotherapeutic techniques. The Reichian model is similar to the CM one of *qi* flow and stagnation with life force energy or 'bioenergy' building up in the form of emotional or sexual charge and then, unless blocked, being released through self-expression or orgasm. The bodywork techniques used to unblock and then harmonise pent-up emotional energy are paralleled in CM by acupuncture, *tui na* and *qi gong*.

Gerda Boyesen developed a form of Reichian body psychotherapy called 'biodynamic psychology'. As in CM, the digestion is seen as linked not only to the assimilation of food but also ideas and feelings. Boyesen thought that repressed emotions and memories can partly be released 'vegetatively' through peristalsis (which she called 'psycho-peristalsis') and used 'biodynamic massage' to induce and encourage this. Her technique involved the use of a stethoscope on the abdomen – a form of biofeedback – to listen out for particular peristaltic noises such as loud, creaky door or 'watery' ones that might indicate the release of deep-seated emotional tension. She also believed that this massage can disperse the excess fluid in the tissues that tends to build up in states of emotional tension.(16) In CM, of course, such distention is seen as a manifestation of stagnant Liver *qi.* For Boyesen, a major aim of therapy was to foster the capacity to achieve a sense of 'body sweetness' which provides the somatic basis for an independent sense of wellbeing.

Psychiatry, lacking a concept like *qi* or 'bioenergy' to bridge the Western gulf between mind and body, tends to have a highly polarised view of the mind-body dichotomy and a very divided response to it, predominantly diagnosing and categorising mental illness using psychological constructs such as anxiety disorder, but relying mainly on a medication-based biomedical approach to treat or contain it.

The question of whether an illness is caused psychologically or physiologically can be seen, particularly from a Chinese perspective, as a false dilemma, since illnesses are liable to be underpinned by elements of both, the more so when they become chronic. More crucially, in CM, the same pathogenic factors and disease mechanisms, such as *qi* or Blood disharmonies, are seen as operating simultaneously on both levels.

The therapeutic relationship and the 'placebo effect'

Like psychotherapists, Western CM practitioners may achieve much of their therapeutic effect from rapport, empathy, caring attitude and counselling (which, in effect, constitute an institutionalised form of love). Counselling might only touch tangentially on emotional issues, with advice limited to suggesting practical, mundane changes such as taking more exercise, eating breakfast, getting a hobby or going to bed earlier, all of which can promote emotional wellbeing. Some of the most valuable things practitioners offer are insights about lifestyle and attitude to living drawn from the principles of CM and the philosophy behind it. In particular, the emphasis on balance, moderation and harmony provides a much-needed antidote to the contemporary way of living, characterised by excesses and extremes. Simply being offered the opportunity to view and approach life from this different moderating and grounding perspective can have tremendous therapeutic benefits. Many of these guidelines – for instance, those governing the timing and manner of eating which also form part of Western traditional folk wisdom – have often been lost sight of or are dismissed as old fashioned and baseless, but may gain a renewed authority by being recycled as examples of Eastern erudition.

The concept of 'therapeutic relationship' (or 'therapeutic alliance'), that originated in psychoanalysis, is used to refer to the means whereby healthcare professionals can constructively engage with their patients to bring about beneficial changes in them. Many studies have shown a positive correlation between the quality of this relationship and treatment outcomes.(17) The effect size tends to be relatively small but statistically significant. One meta-analysis of 79 studies concerning psychotherapy, for instance, showed a 'moderate' correlation which was fairly consistent across a wide range of psychotherapy settings. (18) Both psychotherapists and Western CM practitioners place a comparatively strong emphasis on the therapeutic relationship, usually being able to devote more time and energy to developing this than most healthcare workers.

One important benefit of this relationship is that it can enable what could be called 'problem parking'. The understandable tendencies to worry and feel frustrated, angry or despairing about emotional and physical problems tends to aggravate them and disrupt or block homeostatic healing mechanisms that might help to resolve them, as is the case with IBS where these emotions feed into the vicious circle that sustains it. Such aggravation also occurs when emotions feed on themselves, as when the stressed get even more stressed about being stressed and anxiety

levels in anxiety sufferers are augmented by the fear – likely to become self-fulfilling – that they may have an panic attack in public. Both CM practitioners and psychotherapists can help patients to suspend these exacerbating emotional reactions by providing an opportunity to temporarily 'park' their problems with them. The therapist is effectively giving a reassurance – to some extent illusory and a projection of patients – that their problems are being dealt with by a wiser, more gifted being – an expert equipped with an effective, seemingly magical set of healing techniques – such that they do not have to worry about them. This allows homeostatic healing mechanisms to kick in unhindered.

Therapists thus function like sorcerers or faith healers in some respects. Kaptchuk, a founding father of Western CM, sees parallels between the spiritually charged healing rituals and symbols involved in Navajo ceremonial chanting and those he attributes to biomedicine and acupuncture, claiming they all function in a similar way by creating 'a receptive person suggestible to the influences of authoritative, culturally sanctioned "powers"' (or in the case of acupuncture, 'opening to cosmic' ones), with even physicians retaining, for the patient, 'some of the numinous power of a priestly profession'.(19)

These potential therapeutic benefits – ones that do not derive directly from the application of techniques such as acupuncture but from the hope, caring, understanding and insights offered through the therapeutic relationship – are often viewed, rather dismissively, by the scientific establishment as aspects of the placebo response. The notion of the placebo effect recognises the tendency for patients to report improvements in symptoms that may be solely due to the perception of being treated and cared for, as opposed to the effectiveness of the technique or drug being tested. Unfortunately this notion devalues or fails to acknowledge any actual real therapeutic gains that might stem from the therapeutic relationship. In fact, the orthodox randomised, placebo-controlled trial (RCT) with its double-blind protocol (where the therapeutic intervention is compared to that of a placebo, and ideally neither the subjects nor therapists administering them know which is which) is designed to control for and factor out the possibility that the relationship between the subject and the therapist might affect the outcome. The short-term and strictly controlled experimental setting is, in any case, not conducive to its development, at least not to the point it achieves its full therapeutic potential. This means that in assessing the effectiveness of therapies RCTs tend to be particularly unfair to those such as psychotherapy and to a lesser extent acupuncture where the therapeutic relationship is an integral part of treatment, inseparable from it and often crucial to its success.

In psychotherapy, the therapeutic relationship itself is often the means of healing, especially in those forms which are non-directional and thus virtually technique free, unless listening with the odd verbal prompt can be described as a technique. Therapists may achieve a therapeutic effect simply by embodying the qualities they hope to inspire in their patients. Where there are distinctive techniques whose effectiveness can be tested, it is difficult to analytically separate these from the input of the therapist who, given the highly interactive nature of process and the consequent need to continually adapt them to match the varying responses of patients, plays a crucial part in determining how and when they are applied. Success depends largely on the particular personal qualities of the therapist; his or her idiosyncratic style, experience, sensitivity and intuitive abilities; and whether or not he or she is able establish rapport and inspire confidence, factors that cannot be readily standardised in controlled trials.(20) A study by Najavit et al (1994), for instance, showed that psychotherapists rated as having more 'positive' qualities such as being 'warm', 'less attacking' and more self-critical generated beneficial, statistically significant differences in therapeutic outcomes.(21) To a large extent, 'it's the singer, not the song' that is crucial to the success of the therapy.

This applies to acupuncture but to a more limited extent as this does have distinctive physical techniques that are more amenable to testing in the RCT format. (It is easier to standardise treatments in the form of point prescriptions, and the use of sham acupuncture is supposed to create a convincing, comparable and inert, and therefore valid, placebo.) However, the effectiveness of particular acupuncture interventions depends to some extent on the strength and depth of the therapeutic relationship which affects receptivity to treatment and the sensitivity of the therapist. Needling is not a purely technical activity that can be successfully performed mechanically – as if acupuncture, any more than portrait painting, can be done by numbers – but involves an intimate energetic exchange similar to that involved in massage and laying-on-of-hands healing. An intrinsic feature of CM is that acupuncture and herbal treatments are tailored to the particular requirements of the patient such that point and herbal prescriptions vary within the same disease category. This means that the skill,

experience and perceptiveness of the practitioner play a crucial role in ensuring the effectiveness of a technique. This factor cannot readily be standardised and thus controlled for in RCTs, and consequently uniform prescriptions are normally used, reducing any chances of success.

According to MacDonald, RCTs were designed to measure a single variable, such as a specific medication, 'while attempting to control for all others... but are problematic... for assessing complex skill-based therapies including acupuncture, psychotherapy and surgery'. In the case of acupuncture, the use of sham acupuncture protocols as placebos is questionable since evidence shows these are not inert but have effects, some of which acupuncture does not have. MacDonald claims this results in the underestimation of the effect size of real acupuncture.(22)

All these considerations mean that double-blind, random placebo-controlled trials, although considered to be the 'gold standard' of research designs, are not appropriate for assessing CM and psychotherapy. A more feasible and fairer way of assessing their effectiveness is to use 'pragmatic trials' that compare their outcomes with those of other therapies or 'standard' or 'usual care' in real-world settings rather than artificial experimental ones. These allow therapists to use their clinical judgement to tailor their treatments to meet patients' individual needs and avoid ethical concerns about using placebos which inevitably involve deception and some patients missing out on treatment.(23, 24) They not only give much more opportunity for the therapeutic relationship to develop but, more pertinently, ensure that any potential real therapeutic gains from this are not factored out by the research design – tantamount to throwing out the baby with the bathwater – but allowed to make a valid contribution to the measured effect size of the therapy. It does not however meet the objection that it fails to control for differences between therapies in the sizes of the placebo effect. These vary considerably with those for physical placebo interventions, such as sham acupuncture found to be significantly greater than those for non-physical ones.(25)

Kaptchuk turns this issue on its head, believing that the healing power of the placebo response can and should be consciously utilised as a valid therapeutic tool and that it is possible to successfully use 'placebos without deception', thereby overcoming ethical problems. This latter, highly controversial claim is made in relation to a study of placebo medication for IBS led by him in which placebo pills were found to produce improvements in symptoms that were significantly greater than those in the 'no-treatment' control group.(26) This claim has been strongly contested on the grounds that the way the placebo pills were presented to subjects – as 'placebo pills made of an inert substance, like sugar pills, that have been shown in clinical studies to produce significant improvement in IBS symptoms through body-mind self-healing processes' – was deceptively misleading in that this used the power of suggestion.(27) By taking this iconoclastic approach, Kaptchuk does, however, underscore a very salient point: that the potentially powerful healing mechanisms that underlie what are often dismissed as 'placebo responses' need to be explored more fully with a view to using them more effectively, rather than being 'ideologically devalued' and treated merely as potential pitfalls along the path towards scientific truth.

Any research design, whether RCT or 'pragmatic', needs to acknowledge and allow for the fact that the effectiveness of a therapy depends not only on its techniques and theory but also on the individual qualities of the therapists themselves. Thus, CM was at a relative disadvantage when first introduced in the West since early practitioners lacked knowledge and experience (if not passion and flair) compared to those in China.

To acknowledge this, a research design needs not only to decide on how to validly select the recipients of treatment but also therapists who administer it. In one psychotherapy study, for instance, comparing the effectiveness of 'exposure therapy' (a form of CBT) with 'psychodynamic therapy' for PTSD in adolescents, the odds were stacked against the latter because it was provided by graduate students who had only a few days training given by other students.(28)

Successful therapy also depends on the extent to which patients commit to and actively engage in the therapeutic relationship and the healing process in general. Individual therapists, especially if the ethos of their therapy is conducive, can play a large part in engendering this, although patients' levels of engagement may vary considerably between and within social and cultural groupings as a result of other factors. The findings of a study of psychotherapy for depressed patients, for instance, suggests that those who expect treatment to be successful are not only more likely to experience symptom reduction but also to engage more actively in the 'therapeutic alliance', which further contributes to reduction.(29)

Psychotherapy East and West

Alan Watts, Zen Buddhist teacher, philosopher and countercultural icon who rose to fame in the 1960s 'flower power' era, adds another dimension in his seminal thesis, *Psychotherapy East and West*. Building on the ideas of psychoanalyst Carl Jung among others, he claims that Eastern spiritual traditions such as Daoism, Buddhism, their synthesis, Zen, Yoga and Vedanta offer 'ways of liberation' and as such have much in common with psychotherapy. Both are 'concerned with bringing about changes of consciousness, changes in our ways of feeling our own existence and our relation to human society and the natural world.'(30)

A major aim of these Eastern spiritual traditions is to liberate individuals from the constraints of socially conditioned existence. This includes freeing them from the oppressive and onerous expectations to be 'respectable', 'happy', 'attractive', 'normal', 'successful', etc., and from pressure to force and even distort their selves and their worlds to conform to these supposed ideals – so they may discover, accept and be what they spontaneously and essentially are rather than striving to become what they think or are told they should be. Those psychotherapists who genuinely wish to help their clients – as opposed to those who see their role as 'adjusting the individual and coaxing their "unconscious drives" into social respectability' – will also seek to help them to liberate themselves from the self-negating aspects of social conditioning and to be their authentic selves.

Liberation essentially involves seeing through the illusory and potentially harmful ways in which we are conditioned to see the self and the world. One of these, particularly prevalent in the West, is that of the 'skin encapsulated ego'. Here the self is identified with an ego usually pictured as being located in the head 'from which centre the rest of us dangles.... It is as if there sat beneath the dome of the skull a controlling officer who wears earphones wired to the ears, and watches a television screen wired to the eyes. Before him stands a great panel of dials and switches connected with all other parts of the body that yield conscious information or respond to the officer's will.'(31) An illusion is created of an ego separate from the individual's thoughts and experiences, and also cut off from others and the world, enclosed in an isolating bag of skin. This dualistic, egocentric perspective predisposes individuals to see the world, including other human beings and even their own feelings and bodies, as things to be controlled and, if possible, dominated rather than becoming at one with. Trying to control the self and the world is an ultimately futile and self-defeating strategy: 'The more we struggle for life (as pleasure), the more we are actually destroying what we love... trying not to feel pain is pain...'(32) Instead, Watts advocates accepting and living with uncertainty and even celebrates, what he calls in one book title, the *Wisdom of Insecurity.*

Trying versus spontaneity: the therapeutic implications

Watts brings these insights to bear on his concept of forced spontaneity, one which is highly pertinent when applied to the realm of illness and healing. The above perception of the self, caricatured by Watts as a miniaturised 'controlling officer' determining feelings and bodily functions, does not acknowledge the reality that these are largely or sometimes completely beyond direct conscious control. Any attempt to control emotional states and many of these functions, by an act of will, can result in the absurd contradiction of trying to be spontaneous in the sense of trying to achieve desired states that can only come about spontaneously, 'of themselves'. Watts talks about contradictory social pressure to conform and yet do it freely, giving the example of the 'double-bind' of being expected to be loving, sincere or natural but in a way that is genuine rather than forced or feigned. Watts even questions 'spiritual practices' such as meditation and yoga since their practice is often characterised by striving and competitiveness rather than total acceptance. 'For when practiced in order to "get" some kind of spiritual illumination or awakening, they strengthen the fallacy that the ego can toss itself away by a tug at its own bootstraps.'(33)

It is not possible to try to relax or go to sleep; to 'stop feeling self-conscious'; to feel love, joy and sexual desire to order; to wish away unpleasant feelings; to force an urge to defecate or a feeling of hunger; or indeed to effectively and reliably control, through willpower and effort, any response or function governed by the autonomous nervous system. Attempts to do so often produce the opposite effect, a phenomenon known as paradoxical intention as when stutterers try not to stutter and males try to achieve (or suppress) erections. Just as psychotherapists and spiritual masters often encounter this in their patients or students, so do CM practitioners. Once sleep, for instance, has become an issue for whatever reason then it is compounded by the counterproductive process of trying by conscious effort to get to sleep – spurred on by growing frustration, anxiety about being unable to adequately function the following day and an unnerving sense of impotence and thwarted

expectation – which is in total opposition to the optimum state of relaxation, trust and surrender. Here it is tempting, even for seasoned therapists, to utter the oxymoronic injunction 'try to relax'.

Buddha saw expectation and desire as the basic cause of frustration, worry and suffering generally. The answer to insomnia is to suspend or transcend the expectation to sleep and instead accept and surrender to sleeplessness. This involves having the grace and equanimity to accept what cannot be changed by conscious effort, a spiritual quality closely associated with Christianity (and its concept of faith) as well as Eastern spiritual traditions. In the West, the religious vacuum caused by the decline of Christianity has been filled partly by these traditions and also by psychotherapists, said to be the modern, secular equivalents of priests, who have substituted the couch (or armchair) for the confession box, seeking out repressed emotions and memories in the place of sin.

The spiritual aspect of religion – as opposed to its moral, potentially repressive one – can induce surrender to a higher transforming force which, though it is referred to as divine or godly, can be seen as the healing power of Nature in the form of homeostatic biological and psychological processes. Psychotherapy can also be seen as representing a surrender: a letting go of outdated inhibiting and self-negating patterns; a lowering of defences and opening up to new experience and relationships with others; and accepting rather than repressing or disowning painful or socially proscribed emotions, thoughts, subpersonalities and memories. Both the spiritual and the psychotherapeutic paths are attempts to accept and come to terms with what is – pain, loss, 'sin', warts and all – rather than denying it or hankering after what should be or should have been; and to become a 'bigger person', both in terms of being able to tolerate and contain hitherto uncomfortable thoughts and feelings within the psyche and to reach out to and care for others.

Watts's highly distilled characterisations of psychotherapy and Eastern spiritual traditions are over-simplified and idealised, as he himself acknowledged. When Daoism and Buddhism, for instance, function more like conventional religious institutions, embracing dogmatic beliefs and enforcing adherence to restrictive, guilt-generating moral codes, they can be the opposite of liberating. Equally, there are forms of psychotherapy such as hypnotherapy, CBT and neuro-linguistic programming that – though not intrinsically repressive – utilise techniques such as positive affirmation, guided imagery and 'cognitive restructuring' which, in stark contrast to Watts's non-controlling, 'don't push the river – it flows by itself' approach, are designed to manipulate and 'reprogramme' the mind. He is effectively being more prescriptive than descriptive, picking out and affirming an ideal form rather than making valid empirical generalisations. Watts has been highly instrumental in popularising Eastern philosophies and healing practices in the West by reinterpreting them in ways that resonate with Western concerns and perspectives, thus helping to erect one of the key pillars of 'New Age' consciousness.

Daoism and Confucianism: spontaneity versus structure

CM is engaged in a different, usually more mundane enterprise than that concerned with personal or spiritual transformation but it is worth being mindful of the insights that derive from psychotherapy and traditions such as Daoism and Buddhism (which have helped to shape Chinese culture and medicine). This is particularly pertinent in the case of Daoism, a philosophical cornerstone of CM, which celebrates *wu wei*, meaning effortless, intention-free, spontaneous action – 'not doing' or 'going with the flow' – and seeks perfection through following the 'Dao' or the 'Way', becoming one with the rhythms of Nature and the Universe. However, when counselling patients this perspective may need to be counterbalanced by the opposing but complementary philosophy of Confucianism which stresses the importance of a structure in the form of rules, rituals, hierarchical relationships and social order. CM is informed by both these philosophies. It recognises that individuals need freedom from excessive constraint to thrive but their lives need some degree of externally imposed regulation, predictability and purpose.

This seeming contradiction between Daoism and Confucianism, between spontaneity and structure, is evident in the ambivalent demands of the Liver. For Liver *qi* to flow, it needs freedom from constraint but the Liver provides hope, a sense of direction in life and a capacity to make plans, all of which imply structure. However, if the Liver *qi* is severely constrained by an oppressive structure, hope is crushed giving way to despair or bitterness and consuming anger. Paradoxically Liver *qi* flows most freely when someone leads an ordered, structured life such that Liver Blood is nourished by the digestion, replenished by sufficient rest and sleep and not depleted by Heat from stress and emotional turbulence.

CONCLUSION

This article has tried to refrain from being prescriptive in terms of saying what the roles of Western CM practitioners and psychotherapists should be, except to point out possible problems when they go beyond the limits of their expertise. Attempts to make universal generalisations about differences in their roles in practice are confounded by the wide diversity in the styles and approaches within both psychotherapy and CM. Bioenergetics, for instance, uses bodywork techniques and an explicitly energetic and somatic model of the emotions that parallel those of CM; and CBT avoids the deep delving into childhood experiences characteristic of the psychodynamic therapies and instead adopts a more superficial and pragmatic counselling approach. Equally schools and styles of CM vary considerably between those such as Five Element Acupuncture which have focused strongly on the emotions and the spiritual realm and those that are much more body-centred. Roles are also hard to delineate because of the overlap in the problems CM practitioners and psychotherapists treat and the fact they often share similar techniques such as counselling and similar aims and orientations. However, it is possible to identify for either discipline a distinctive, more circumscribed area of expertise or domain of competency representing the exclusive preserve of its therapists, ones who have the requisite training and competence to anticipate and deal with the particular problems liable to arise in that context, especially ones that, if faced by the uninitiated, might have potentially harmful consequences.

The generally pronounced psychological orientation of Western practitioners, often reciprocated by their patients, inclines many of them towards focusing on emotional problems either as the causes and symptoms of physical conditions or because they constitute the problem to be treated. However, in the course of this, they may be drawn into becoming amateur psychotherapists and attempt to go more deeply into the nature and roots of unbalanced psychological states when they are not qualified to do so, with the risk that patients may become destabilised or denied more appropriate treatment. In so far that many psychotherapists tend to be overly predisposed to the psychosomatic view of illness, they may also overreach themselves by attempting to treat conditions that are or may be predominantly caused by physiological factors, possibly overlooking, for instance, 'red flags' that CM practitioners are trained to recognise.

Though they usually approach patients' emotional problems from different ends, with psychotherapists focusing on the psychological bases of emotional disharmony and CM practitioners devoting considerable although not exclusive attention to the somatic ones, their approaches can readily complement each other. At a more fundamental level, they have much in common. Both usually take a more holistic view than orthodox medicine and share similar views on the nature of healing such as a focus on harnessing homeostatic mechanisms and a tendency to discourage pharmaceutical interventions to suppress pain and other symptoms.
Both stress the importance of developing the therapeutic relationship. CM is linked to the spiritual traditions of Daoism and Buddhism which function in some ways like psychotherapy and many Western practitioners have been drawn to CM via these. Psychotherapists are often well versed in these traditions with Carl Jung and Eric Fromm having been particularly influenced by them, and Eastern practices such as mindfulness meditation are also used in psychotherapy. This means the two disciplines can in the appropriate setting work well together.

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