# Psychology and Culture

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## *Beyond Cultural Universals and Particulars*

Edited by

Ulaş Başar Gezgin

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# CLINICAL PSYCHOLOGY AND CULTURE

# "WHOSE THERAPIST AM I?": CULTURAL EVOLUTION OF PSYCHOTHERAPY

YIĞIT UZUNOĞLU

## Abstract

Psychotherapy is a complex interdisciplinary practice that could not be explained as an invention of any person or a group. In this chapter, we would be using the theory of cumulative cultural evolution to examine the adaptations of psychotherapy to changing environment. We would start by examining culture and investigate how cultural scripts can change the meaning of disorder, which would show us the limitations of global mental health literacy. Then, we would make an etymological inquiry into the meaning of psyche and therapy and start their origins of inheritance with Heraclitus and Hippocrates. We will follow these cultural products of psyche and therapy and investigate modifications that were made to survive within the changing European culture of the post neoclassical era. We would then examine how their modifications in past centuries would culminate into a combination of psychotherapy as a healing practice. After this, we will look at its cultural transmission into different lineages by investigating occupations and theoretical orientations that practice psychotherapy. Afterwards, we will investigate the definition of psychotherapy that was accepted by the US and EU and examine modern psychotherapy components. Noting the difficulty to define psychotherapy, in the next part, we will investigate cultures of research and examine the debate over evidence-based therapies between proponents of common factors and specific factors. Then, we will examine the contextual model that is borne out of this debate and examine its distinctive qualities that make it separate from the medical therapy culture. This chapter concludes with a section that would draft an evolutionary picture on the whole cultural journey and examine psychotherapy's adaptations to survive through centuries. We end this chapter by reviewing current adaptations in psychotherapy and make an assessment on what the future may hold for psychotherapy.

**Keywords:** Psychotherapy, cumulative cultural evolution, history of psychotherapy, evidence-based therapy, contextual model

## Introduction

"I think you need some therapy" is a phrase with growing popularity these days. Which echoes societies recognition for their need for mental health care. To answer, The World Health Organization (2021) issued a call for an action that would expand Universal Health Care into Mental Health Care. Yet, many people around the world still have self-stigmatizing attitudes towards seeking psychological help, considering it a possible threat to their self-worth (Lannin & Bible, 2022). Even more alarmingly, even the people at the forefront of health care around the world, physicians, share these stigmatizing attitudes towards mental health care (Brower, 2021).

These issues would lead us to ask questions without easy answers, however, for the sake of prospective mental health consumers and esteemed colleagues, we will be trying to answer these questions in this chapter. What is this mysterious concept of (psycho)therapy? Where does it come from? Who are these people calling themselves psychotherapists?

Asking these questions within an enormous field such as psychotherapy would require us to look at it as a unique product of human culture. Considering that any cultural product as diverse as psychotherapy would not get invented by a singular individual or group, we would need to look at it as an evolutionary process of knowledge accumulation,

> "some individual or group of individuals first invented a primitive version of the artifact or practice, and then some later user or users made a modification, an "improvement," that others then adopted perhaps without change for many generations, at which point some other individual or group of individuals made another modification, which was then learned and used by others, and so on over historical time in what has sometimes been dubbed "the ratchet effect" (Tomasello et al.,1993, p.5).

However, as some cultural products do fail to endure the test time and stagnate, we would need to extend this definition. According to Mesoudi & Thornton (2018), any population who shows a cumulative cultural evolution must exhibit:

> "(i) a change in behaviour (or product of behaviour, such as an artefact), typically due to asocial learning (i.e., modified by solitary individual with trial and error), followed by (ii) the transfer via social learning of that novel

> or modified behavior to other individuals or groups, where (iii) the learned behaviour causes an improvement in performance, which is a proxy of genetic and/or cultural fitness, with (iv) the previous three steps repeated in a manner that generates sequential improvement over time." (p.2).

These criteria draw a noticeable parallel to classic genetic evolutionary terms as they imply: (i) variation; (ii) and (iv) inheritance; (iii) adaptation. Thus, we will be examining the populations that exhibit the behavioral or conceptual practice of psychotherapy and to do so we will be examining successfully inherited cultural products and their variable adaptations to their environment.

## Seeking Meaning in a Multi-Cultural World: Role of Culture in Mental Health

Before we even begin our journey into the enchanting world of psychotherapy, we need to understand the essential role culture plays in our collective information generation system. Matsumoto & Hwang (2022) defined human culture as: "Unique meaning and information systems, shared within groups and transmitted across generations, which allow groups to meet survival needs, pursue happiness and well-being, and derive meaning from life." (p.16). With this definition, culture would be distinguished from *society*, which refers to a structural system of relationships at individual or group level. Culture is also different from the *ethnicity*, which would be commonly defined as: "characterization of people based on having a shared culture (e.g., language, food, music, dress, values, and beliefs) related to common ancestry and shared history." (American Psychological Association, n.d.). However, according to Stein & Shneiderman (2022), in field of anthropology, *ethnicity* is generally perceived as a meaningful categorization for a political representation, which can be only earned through political action. Therefore, *ethnicity* represents active/inactive identification at a group level, while *culture* is an adaptive, information and meaning system.

In the context of mental health, a more specialized term such as cultural scripts is used to delineate meaning systems and behaviors in cultural context. Cultural scripts contain actions with observable behaviors; therefore, they have the capacity to transform the expectations and thoughts of others. Observable behaviors could also be inherited culturally, which will be used in determining "normal", and "abnormal" within that culture. When a person behaves abnormally it would be called "deviant". Furthermore, behaviors of deviancy also includes accepted expressions of behaviors,

where excessive expressions or insufficient expressions in cultural context could also lead to assumptions of deviancy (Ryder et al., 2011). Cultural scripts influence both the evaluation of deviancy and corresponding symptoms experienced by the culturally deviant individual (Chentsova-Dutton & Ryder, 2019). For example, a study conducted with psychoanalytic session records of patients who lived through separation of Western and Eastern Germany, had found differences in their descriptions of emotional suffering. Western German patients described their emotional suffering as feeling depressed and hopeless without drive to do anything; while Eastern German patients, described their emotional suffering with somatic symptoms and reported feeling nervous and tense (Singer et al., 2021), indicating that symptomatic representations of emotional deviancy (i.e., suffering) can be different even within cultures that share the same language and heritage; thus, allowing us to see the intricate nature of culture that is distinct from ethnic background. Another study conducted by Birtel & Mitchell (2023) on White British and South Asians living in U.K. has found that South Asians perceived depressed individuals on vignettes as more dangerous and stigmatized them more. Additionally, results would show that South Asians' most preferred explanations given as a cause for depression were supernatural (God's will) and moral (bad character). From these findings, we can assume that South Asian cultural scripts for depression could give explanations that are quite different from classical etiologies of disorders.

Cultural scripts are also supra-individual concepts at their essence. Thus, it also plays a crucial role in the creation of disordered loops of stigmatizing attitudes, which can lead individuals to give more attention to their deviant behaviors and gradually turn into pathologization of deviancy, which can increase the difficult emotions or behaviors that would lead to even more avoidant behaviors. Thus, we could call it a dysfunctional feedback loop, which can perpetuate the cycle of deviant problems. If a dysfunctional duration and stability extents long enough, it could be considered as a disorder (Chentsova-Dutton & Ryder, 2019). Within this context, we could say that feedback loops of deviancy have the potential to turn a minor deviancy into a full-blown mental disorder, highlighting the significant role cultural scripts have in the conception of psychological disorders. To conclude, we can assume cultural differences in understanding disorders would imply a limitation in defining disorders by using cultural standards of the West.

However, those who promote an increase in mental health literacy (MHL) around the world would be against this view. MHL is defined by Jorm et

al., (1997) as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention." (p.182). Movement of MHL aims to disseminate information about mental disorders (with special emphasis on psychiatric treatments), which would be used to mend the large gaps of misinformation that exists between mental health consumers and professionals. Jorm (2015) suggest that MHL movement had a positive impact on development and evaluation of interventions. Indeed, he may be right on that point, as the MHL movement helped a lot of people by underlining the gravity of mental disorders and importance of seeking professional intervention. However, studies comparing developed nations and developing nations have shown that while MHL is relatively useful to improve mental health information in developed countries, the situation is quite different in developing countries. Compared to developed countries, individuals in developing countries are more likely to seek out religious, supernatural or social deviancy factors that would serve as an explanation for mental health problems and they would be more likely to seek out non-traditional forms of healing such as indigenous healers (Furnham & Hamid, 2014; Furnham & Swami, 2018). In an attempt to find a solution to this gap, Na et al. (2016) have proposed a culturally responsive approach to mental health literacy and recommended to seek alternatives to Western understanding of mental health. To do so, they would recommend incorporating local customs of indigenous healing practices when appropriate. Aggarwal et al. (2014) expands on these healing strategies by studying mental health consumer preferences. Results showed that religious/spiritual practices, distracting activities and seeking support from family and friends would be popular among cultures that did not develop their own culturally appropriate psychotherapy methods. Hence, considering these findings, we could observe the role cultural scripts play in choosing viable pathways to healing.

As the cultural scripts have shown their cyclical nature in assessing and persisting the mental health problems that exists within a culture, it would also pose us with a unique conundrum: If every culture has these scripts of the psychological healing process, shouldn't the so-called developed countries' psychotherapists also have them? What is the culture of psychotherapists who have the power to determine mental health? Whose therapist, are they?

## To the Roots of the Words: What is the Meaning of Psycho and Therapy?

To begin pondering on these questions, we must first trace the roots to the linguistic origins of the word "Therapy". From an historical perspective, various traditions of healing have existed since time immemorial (Blom et al., 2015; Maneno, 2018; Qian et al., 2001; Wampold, 2001). All with rich traditions and understandings, playing crucial roles in their own cultural scripts for healing process. However, in this chapter, we would need to look at the history of psychotherapy and historian Marks (2017) gives us a good reason with her statement:

> "Any suggestion of equivalence between classical thought and practice and contemporary approaches raises obvious problems of anachronism, but it does hint at something of genuine significance, namely the active appropriation of classical motifs within the foundational texts of a number of modes of therapy." (p.6).

Thus, we can assume that modern practices of psychotherapy trace significant part of their heritage to Greek and Roman philosophical culture, leading us to start our cumulative cultural evolution journey by tracking psychotherapy culture to the antiquity.

Faccio et al. (2022) introduces the etymology of therapy as "therapy" and "therapeutic" terms are a derivation of the Ancient Greek word "*Therapeia*" with a verb form of "tharapeúō"; which means "serve", "cure" and "obey" (p.2). Meanings of *Therapeia* remains a subject of debate, as it leaves a certain amount of ambiguity due to various interpretations (Charen, 1963; Greenhalgh, 1982; Jost, 2014). However, some would explain the meaning of *Therapeia* with Greek word "therépon", which means "attendant" in Greek (Barnhart, 1995; Weekley, 1967). This bears a special significance as scholars trace the Western origins of rational-scientific model of medicine to the famous cult of Asclepius: The God of medicine and healing. The physician-priests who attended his temple found solutions to the health problems by giving an explanation to the problem and prescribing specific interventions such as: communion with Asclepius, dietary restrictions, specific exercises, herbal remedies, or surgeries to alleviate the suffering of their patients (Dargert, 2016; Limneos et al., 2020; Steger, 2018a). Cult of Asclepius carries a great significance in the history of western medicine as their most famous member was Hippocrates, the father of medicine (Retief & Cilliers, 2010). However, Hippocrates would go beyond the teachings of his cult and would modify the meaning of therapy to: Supporting a person

by attending to their problems and finding rational explanations for their symptoms and facilitating a treatment to find a cure at the end of a process. Furthermore, his definition would also include mental health problems by including the physical four humors model to explain mental illness (Tsagkaris & Kalachanis, 2020). From this definition, we can consider therapy practice as a practical and rational process. Consequently, this Hippocratic method of healing which relied on giving a rational physical cause for illness, will be cumulatively influencing the practice of medicine in the succeeding generations. However, we would need to separate this practice from other practices of healing at the time, thus, we would be using the term "rational therapy" to refer specifically to the therapy culture started from Hippocrates in this chapter.

The term *Psyche* on the other hand, is rooted in more abstract concepts. In an etymological sense, deriving meaning from the verb "psu̓khō ", which means "to cool, to blow" in Greek. This meaning implies a vitalizing breath of life and existence of a psyche relies on breath. Robb (1986) traces the meaning of psyche back to Homer's Iliad where it would be uttered mostly in situations of literal death. As the end of breath implied end of bodily functions and even though psyche would travel to the land of death, it would be without essential breath to revitalize psyche. This would imply a condemnation for a psyche, because without breath provided by body, psyche would lose all emotions and thinking faculties and spend eternity as a wraith in the afterlife (Antonakou & Triarhou, 2017). This, Homeric view of psyche implied a psyche's existential dependence on the body, since psyche's meaning and being would not exist without the essential functions provided by the body. This idea of a psyche being dependent on body would imply a nihilistic understanding of existence as it ends on death of body. An understanding that would eventually lead Aristo to question this concept and modify the meaning of psyche by combining body and psyche into one complete concept: the inseparable soul. According to Aristo, this meant psyche and body cannot exist without each other, therefore, existence of meaning does not depend entirely on the body (Katona, 2002).

While these interpretations would be cumulatively inherited by other cultures, these are not the *psyche* used today within the psychotherapy culture. As the psyche of today would also include a functional and rational mind. To find a meaning of psyche including mind, we would need to look for an alternative meaning that exists within Heraclitean's work. In his opinion, *psyche* is a multi-dimensional concept and contains a self-augmenting "*logos"* — a rational part of *psyche* that can describe, explain and reason with a proper philosophical prose (Stead, 1998). Exploration to

the depths of *psyche* would require an intellectual effort to comprehend the world by learning to properly listen and join the discourse of the philosophers. According to Heraclitean, without logos, a person would turn into a barbarous individual that cannot comprehend the information they receive and had to rely entirely on their senses. Heraclitean summarized his view with "Eyes and ears are bad witnesses to men having barbarian souls." (Harris, 1995, p. 7) as he held the view that "People do not learn what they should" and like a barbarian (i.e., non-Greek) they could hear the words of philosophers but could not understand their meaning (Graham, 2023). From the interpretation of Heraclitean, we can assume health of a psyche would depend on the functioning of a comprehending mind. Thus, we can consider his version of the *psyche* as the originating cultural product in this chapter. Additionally, the reason we choose his cultural understanding of psyche is due to his cumulative cultural evolution success. Because in future, whatever it stems from respect or enmity, the two of the most influential philosophers of that era, Plato and Aristo would be writing about the Heraclitean's logos and modify it according to their own philosophical culture (Zavko, 2002).

While philosophers had written about the concepts of *psyche*, there was still a need to approach the practical problems of the day. To understand these concepts in medical sense, we would need to investigate the culture of healing practiced by physicians in ancient Greece. For them, speech had a noticeable effect on health and mental suffering could be alleviated or exacerbated by use of words. Thus, physicians knowing this, could decide to speak rationally and ask questions to articulate the problems of their patients, however, they would put a special emphasis on the "corrective" verbal rhetoric and primarily aimed to restore the psyche of the patient (Thumiger, 2020). However, as time passed to Roman era, Hippocrates' physiological view of mental health would get popular and interventions that relied on speech would be relegated to the role of enhancing cooperation for the treatment. Direct interventions on psyche would be limited to supporting roles, as in only to be used to facilitate a better physiological based therapy to complement the medical model proposed by Hippocrates and his inheritor Galen (Mills, 2020; Thumiger, 2018). This is not to say, field of medicine was unaware of the influence of the mind has on the body, but, as Brown (2004) suggest, in neo-classical medicine, most of the causal explanations for mental health conditions (e.g., melancholia, hypochondria, hysteria) have been given under physiological terms. Although they appreciated the supportive roles of changing lifestyle habits or empathic communication with a melancholic patient, real treatment could only be on a physiological level.

In the end, *Psyche* and *Therapeia* separated from each other after the classical era. By the time of Roman Empire, physicians would inherit the rational therapy of Hippocrates, and used his successor Galen's modifications to rational therapy as a guidance to healing. With time, rational therapy culture would spread to other cultural spheres like wildfire and Galen's work would eventually be translated to Greek, Syriac, Arabic, Latin and Hebrew, to be read by the physicians of medieval and renaissance eras as a source of information akin to well spring of pure science. This trend continued until the early 1540's when the authority of Galen on both manners of *Therapeia* and *anatomy* had been challenged and brought down while Hippocrates remained something akin to a grand father figure of medicine that would be revered and respected (Nutton, 2023).

However, we need to keep in mind that contrary to most physicians who inherited Galen's work, Galen would describe himself as a philosopher too. Debru's (2002) work on Galen's rediscovered treatises would reveal that he considered explanations of soul (i.e., *psyche*) when an anatomical explanation for certain kinetic movements could not be explained by physical anatomy. In those cases, he explained the effects of imagination on physical movements which would not sound reasonable to his inheritors, thus, indicating future modifications to rational therapy by his inheritors. From a cumulative cultural evolutionary standpoint, his ideas have improved the practices of his inheritors by showing an evolutionary advantage to them. This advantage gets more obvious, when we consider that the practice of physicians at that era was considered a type of craftmanship (Pleket, 1995); and being a rational physician with an ability to explain the cause of disease would be a highly sought trait by a physician and allowed them to enter into a social circles of elites (Chang, 2007), thereby ensuring their genetic survival and improving their general quality of life. Thus, from these, we can conclude that in classical era and neo-classical eras, practices of rational therapy provided an effective method to improve chances of survival and would be imitated by the succeeding generations.

## Convergence of Psyche and Therapy: Evolution of Psychotherapy as a Rational Healing Method

After the fall of Roman Empire, Europe became fractured, and cultural systems began to change to adapt to the culture of Christianity. *Psyche* had gone through a modification as well, from animating breath of life, into an immortal divine spirit guided by God. Szasz (1998) vehemently argues that the rise of mono-theistic religions have widened the divide between psyche

and therapy even farther than before, as the domain of the spirit (i.e., psyche) would be entrusted to the clergy while domain of therapy would be given to physicians. However, divide between clergy and physicians were not clear cut – as we might expect – in Medieval era, as the inheritance of rational therapy would find a new home in 6th Century within the monasteries of Christian religion. Thereby, it would be culturally transmitted, and allowed the physicians to distinguish themselves from other healers who worked mostly on rural and urban masses without access to rational therapy. Consequently in 12th century the first use of term "doctor" physicians would originate from the universities of Christian culture. Finishing a university and gaining an official license to practice rational therapy would depend on the approval granted by the authority of Pope (Gelfand, 1993). This would create a unique situation for the cultures of medieval physicians, as the cultures of religious authority and rational therapy gets intertwined into their education. They would have to modify their practices to adapt. Blockmans (2020) explains this unique situation of allowing philosophy into Christian universities with "Autonomy guaranteed the universities' receptivity to older non-Christian scholarship, to which they showed an open mind justified by its evident superior development" (p.33) which shows the adaptive advantages of modifying rational therapy into their culture. However, they have granted the title of philosophy of law, philosophy of medicine, philosophy of theology to select few who can join their universities, which would result in a creation of an epistemic community of philosophy educated scholars (i.e., Ph.D.'s) who had to live under cultural norms of Christianity. As a result, they would need to keep the discussions of *psyche* within the boundaries defined by Christian theology (i.e., immortal spirit) and would be required to see *psyche* as a self-subsisting entity standing above everything else and had to keep it separated from the physical world (Lagerlund, 2007). In these eras, cultural products of *psyche* and *therapy* had different populations in control, one with the power of majority behind, would exert authority on the matters of spirit (i.e., *psyche*), while rational therapy had to preserve its culture within a closed epistemic community of scholars. Therefore, we would need to investigate cultural evolution within the community of philosophers.

The view of *psyche* as an immortal soul would continue until the time of the Renaissance, where zeitgeist of Europe would eventually change from handing the matters of spirit solely to ecclesiastical authorities representing God into a more human centered self-improvement ideal. Marsella's (1993) investigation into the scholars of the era, shows that their focus would gradually change from "life after death" and "welfare of the soul", implying *psyche's* modification to mean improvement of human life. This change

showed an example of the ratched effect, in which, they would be taking back the meaning from a past, where *psyche* was considered a center of comprehending mind rather than a spirit. Arguments within the realm of philosophy had reached its tipping point in 1637 with the famous sentence, “cogito ergo sum” or as we all know it today: ‘‘I am thinking, therefore I am.” (Descartes & Moriarty, 2008, p.27). According to Descartes, this meant that even if you question the existence of the soul with your thinking mind, it will continue to exist. Thus, neither body nor mind can affect the sanctity of soul, and soul’s existence relies solely on God’s will. As a result, this modification would separate body and mind from soul and give each of them a pure substance, therefore, opening a way for next generations to do research on both substances. However, this separation relied on an understanding of soul’s superiority, as mind and body would work together to inform the soul by sending information through pineal gland. Therefore, we could say, a devout Christian philosopher Descartes had found a culturally acceptable explanation within the powerful Catholic culture to conduct mechanistic empirical investigations into the mind and body. Although, Pickren & Rutherford (2010) suggests that even though soul would be separated from mind and body, components of psyche such as memory, perception, imagination, dreaming, and feelings would still be examined by naturalistic sciences as a property of body. Overall, this separation would make modifications to cultural products of both *psyche* and *therapy* and with the consequent technological advances coming to modify the culture of science, mind-body dualism would carve open a pathway for further generations to once more do research on the body and allowed them to look beyond the rational therapy knowledge left to them by Hippocrates and Galen.

By the turn of the 19th Century, rational therapy culture would already abandon old notions of neoclassical conceptions of rational therapy and would change its focus into the microbiological, cellular and organ anatomy (Brown, 2004). Speed of this change would further intensify with the Pasteur's (1881) phenomenal work “germ theory”, which would inspire the rational therapy culture by showing opportunities for finding latent causes behind unexplained illnesses. This change would eventually lead the rational therapists into developing medical specializations to find these underlying causes; with an unfortunate side effect of these fields attempting to explain every problem with their own specialty — a problem that would still continue even to present (Eronen, 2021; Satel & Lilienfeld, 2013). Thus, by the end of 19th century, studies on components of mind (i.e., *psyche*) and body (i.e., *soma*), would be focusing solely on the body. Hansen's (1999) study shows that Pasteur would get into headlines during

these times more often than others, thus it would mean that imitating Pasteur's success would provide lucrative opportunities to a physician, which would further incentivize research focused on body to find similar breakthrough. However, this also meant that research on *psyche* had to stay on fringe of popularity, as any explanations worth its salt would have to come with biological rationality. Thus, from an evolutionary perspective, rational therapy culture at that time favored those who choose the biological explanations. Therefore, this meant that psyche remained separated from practices of rational therapy as it did not lend itself to improvement of performance in practice.

According to various researchers, first attempt to coalesce these two terms under one definition would have been suggested by Daniel Hack Tuke in 1873 with the term: "Psycho-therapeutics" (Chaney, 2017; Haldipur, 1985; Shamdasani, 2005; Tuke, 1873). Tuke was the great-grandson of Moral Treatment Movement founder William Tuke (Borthwick et al., 2001). Thus, with his heritage of seeing positive effects on a moral care given to the psychiatric patients, he pondered extensively on the relationship between mind, body and soul and mind. Shamdasani (2005) suggest that he would be greatly influenced by the findings of French Royal Commission, as they were the ones who investigated the animal magnetism treatment of famous Parisian physician and father of hypnotism, Anton Mesmer. Royal Commission had conducted a hallmark experiment that defined the era, in which, they would investigate a treatment that was supposed to be based purely on a physical explanation. Treatment of Mesmer was based on the balance of a magnetic fluid that was distributed within the human body, accordingly, fluctuations in this magnetic fluid would cause diseases in some people that are particularly susceptible to it. The Royal Commission's report would show that animal magnetism treatment by using magnetic rods was actually "placebo" and required no actual magnetism at all. They have come to this conclusion because their experiment had shown that magnetic treatment has worked even with non-magnetic rods, as long as patients believed they were treated by magnetic rods. Thus, they concluded the treatment was coming from the "imagination" of the patients (Franklin, 1837). Inspired by this report, Tuke reasoned that imagination might have a role beyond healing and can be the cause for mental illness (Chaney, 2017). However, his novel idea of "psycho-therapeutics" did not get popular and he would only manage to influence select number of his peers who worked with him in his mental asylum. Thus, we can say, he would not manage to make modifications to the cultural product directly, however his term would be used and go through modifications by others.

Bondi (2009) proclaims the rise of the prominence for psychotherapy would start with Sigmund Freud's first inclusion of the term into his books. Freud was a neurologist and protégé of famous Austrian neurologist Josef Breuer and Jean-Martin Charcot (founder of the hypnotic condition as an explanation for hysteria). He was greatly influenced by Josef Beuer's case of Anna O, in which, a neurological problem (i.e., *Hysteria*) with symptoms of paralysis, loss of sensation and speech, and a state of confusion (i.e., hypnotic condition), had been treated by asking her to recount her lucid melancholic fantasies during a hypnotic trance state (Freud, 1977). This procedure would later be described by Anna O. as "talking cure", which symbolizes its uniqueness from other methods of rational therapy. After this event, Freud would work on to modify these cultures and create psychoanalysis in future, which would demonstrate to his peers and public that an alternative and effective method for conducting rational therapy is possible (Gosling, 1985). However, contrary to the claims of Freud on the effectiveness of Beuer's "talking cure", evidence would resurface with time to disprove claims of the longevity and efficacy of this cure. The case notes of Beuer would show that the hysteria of Anna O. only went to remission and she would relapse soon after completing the therapy process (Ellenberger, 1972; Reeves, 1982). Yet even with that, the concept of "talking cure" had made an impression on the public and made an important modification to the field of rational therapy.

However, Freud was not the only one popularizing psychotherapy in Europe. During the height of popularity and eventual fall to the notoriety for the hypnotic movement, there would be a need to separate the concept of psychotherapy from hypnosis (Maehle, 2017). Thus, Shamdasani (2005) credits Hippolyte Bernheim for carrying the mantle of Tuke, and distinguishing psychotherapy from hypnosis in 1891. His work would be the first one to use psychotherapy distinctively from hypnosis and he would make lots of modifications through his books. Moreover, Freud would be inheriting the term from Bernheim, as he translated his work *Hypnotism, Suggestion, Psychotherapy: New Studies* 3 years before his first usage of psychotherapy in his writings (Bernheim, 2015). Which might be the reason for Freud's decision to use the term psychoanalysis in future, as it might have helped him to distinguish his cultural modification from the other psychotherapies growing at the time.

While rational therapy practices in Europe was slowly transitioning to accept *psyche* as an efficient method into their culture, the situation in the United States was widely different. In the other side of the continent, physicians preaching for scientific methods of rational therapy would have

a clash with a religious organization called Emmanuel Church, who tried to provide an unscientific method of “talking cure” to the masses who had started complaining about unempathetic practices of rational therapy. Caplan's (1998) work would put the start of movement as 1906, in which, they started with formation of an unusual coalition between Boston Physicians and Episcopalian Christian Ministers. The side of ministers were led by Prof. Elwood Worcaster, who had a degree in psychology under the founder of experimental psychology, Wilhelm Wundt; and Prof. Samuel McComb who was a professor of ecclesiastical history. Their education showed a direct inheritance from epistemic communities of scientists and improved their credibility in both public and professional circles. The primary goal of the Emmanuel movement was to provide psychological treatment –based on religious faith and up-to date scientific knowledge– to help alleviate the suffering of patients by using Christian morality. To achieve this, they opened a clinic inside their church and devised a special system of care. Inside this clinic, Physicians would examine the patient and treat them with biological methods, while ministers would provide spiritual treatment. Additionally, social service workers trained by the Church would provide additional support to patients by visiting their homes, procuring employment and housing if necessary, and provide a group environment for recreational activities (Greene, 1934). Emmanuel movement faced substantial amount of criticism for their employment of ministers and lay people without any formal education at all. These criticisms would force them to issue a statement and declare statutory rules for their treatment process, which would put the professional opinion of physician as a mandatory requirement to start the treatment, as only under their recommendation patients would be referred to see a minister or social worker for a moral treatment (Goldthwait et al., 1909). As the movement grew, it attracted a considerable number of critics and supporters, thus, the concept of psychotherapy had gained a sudden attention in US, eventually forcing the rational therapists who were in stark opposition to psychotherapy to find a way to adapt it into their own practice. These developments would lead to the end of Emmanuel movement in 1910, as they had already lost their momentum and would be prohibited from practicing psychotherapy when the right to practice would be authorized solely to the psychiatrists. Coincidentally to these events, Freud’s visit to US in 1909 would also result in US culture embracing psychoanalysis rapidly, therefore leading to a sudden increase in psychoanalysis schools in a short time (Benjamin, 2005). We can consider this sudden popularity as a response to the rapid rise in demand for a psychotherapy given by rational therapist, which might have led them into adapting a culture of effective psychotherapy –produced by a

physician– thus ensuring a cultural inheritance of psychoanalysis in US physicians.

As the demand for psychotherapy increased in the US and Europe, other professional fields started to modify their treatment methods to satisfy this demand efficiently. By the turn of 20th century, specialized fields in medicine was becoming common, however these new specializations may face a strong opposition from their traditional peers when they draw the attention of public and became popular (Weisz, 2003). This opposition was also seen in Emmanuel movement, as their attempts to treat people with ministers and unprofessional social workers were met with serious opposition. To rectify this issue, schools from diverse range of disciplines found ways to adapt scientific versions of psychotherapy into their curricula; establishing a culture of psychotherapy to educate professionals that can properly execute this groundbreaking method (Abraham, 2018; Farreras, 2016; Leahy et al., 2015).

Thus, we can say, be it by the influence of Tuke, Freud, Bernheim or Emmanuel Movement –or many more unsung contributors to the accumulation of cultural evolution– psychotherapy would have joined the vocabulary by the start of the 20th century. However, many people in public were still thinking of it as a "talking cure", which would compel the next generations into making modifications to escape from this narrow definition of psychotherapy.

## Century of Psychotherapy: Models of Psychotherapy

Since its first inception in 1973 to its latest iteration in 2019, monumental work had been done by Wedding & Corsini (2019) to keep up with "Current psychotherapies". Their opening statement summarizes the rapid pace of cultural evolution in the 20th century:

> "It's evident that theories have an increasingly short half-life. Entire schools of psychotherapy have undergone dramatic change, some more rapidly than others—and some have virtually disappeared (e.g., transactional analysis). New and increasingly integrative approaches to mental health have been presented. Although built on strong historical foundations, these recent modalities would strike even psychotherapists of the 1960s and 1970s as novel if not strange..." (p.2).

Prochaska & Norcross (2014) have estimated that over 500 distinct psychotherapy systems exists –for now– and would fittingly describe the psychotherapy marketplace as a "jungle place". A description that would

also remind us of an old evolutionary expression, “survival of the fittest”. We could see that psychotherapy in the 20th century would be modified constantly to create niche cultural products, a model of psychotherapies.

Enumerating these models and detailing their evolutionary trajectories would sadly be beyond the scope of this chapter, however, we can refer to Fleuridas's & Krafcik's (2019) identification of 6 powerful forces. They have defined these forces by tracing the evolutionary progress of psychotherapy by identifying the efficient psychotherapy cultures among those that survived natural selection. These are: (1) Psychoanalytic; (2) Behavioral (includes Cognitive); (3) Humanistic–Existential; (4) Transpersonal Psychology – Family Systems – Feminist Psychology – Multicultural Psychology – Ecopsychology – Social Constructivism – Postmodernism; (5) Social Justice – Advocacy; (6) Holistic Integrative Conceptualization of Psychotherapy. This was a century filled with constant modifications, although, even with the recent additions increasing popularity within the field, first three forces would continue to remain as the most preferred psychotherapy cultures for psychotherapists around the world (Draguns, 2013; Liu et al., 2013; Norcross et al., 2023; Orlinsky et al., 2024; Poznanski & McLennan, 1998).

Historically, these psychotherapy cultures have been founded by charismatic leaders who rebelled against the previous generations cultures and modified psychotherapy in solitude to give supplementary training to improve efficiency of psychotherapists from different backgrounds (Sollod, 1978; Poppen, 2001; Rosner, 2014). Thus, from a cultural evolution perspective, these cultures of psychotherapy have gone through all the necessary steps needed to transmit their cultural products to the next generations. Not only that, but they also accepted students from a wide range of occupations and diversified their cultural lineage. This diversification can be seen in a worldwide study done by Orlinsky et al. (2024) in collaboration with 90 psychotherapy programs (including universities and private institutions) in 16 countries. Results show that criteria for acceptance can be met with degrees of psychology (%64), medicine (%49), psychiatry (%38), social work (%37), education (%32), nursing (%31), clergy or chaplaincy (%30) and counselling (%12). In addition to this, %30 of programs did not expect any previous occupational education from the prospective applicants, which implies that, as a cultural product, psychotherapy is not exclusive to a specific occupation, but rather it is open to other occupations that brings their own cultures with them. This plurality would be advantageous in ensuring evolutionary success, but on the other hand, it would make it difficult to understand psychotherapist as a profession.

Tenuous nature of psychotherapy would be depicted by Klein et al. (2010):

> "Anyone seeking psychotherapy quickly realizes that various types of "therapy" are practiced by mental health professionals as well as others who do not necessarily have a background in the social and natural sciences. Many of these "psychotherapists" are not subject to state licensure requirements, nor are they necessarily part of any national professional regulatory organization." (p.13)

This statement would illustrate the lack of legislation on professional psychotherapy. We could see that there are different laws in different countries which would limit the practice of private practice (Eby et al., 2011; Draguns, 2013; Pomerantz & Murphy, 2016), however, in most cases these laws are limited to only allowing the rights to certain occupational degrees. A worldwide study conducted by Kim et al. (2022) shows that out of 55 countries participating in the study, only 16 regulate the profession of psychotherapist by law. Thus, we could say that legislative limits do not define the culture of psychotherapists and even though global requests for more strict legislation to conduct psychotherapy are increasing, it has also met with criticism, who would say that legislation carries the risk of turning psychotherapy into a conformist enterprise under a hierarchical power structure and would not be a guarantee for actual competency of psychotherapists (Danish & Smyer, 1981; Shaw & Tudor, 2022; Smith, 2011). From these findings, we could make an argument that psychotherapy would not be defined by any occupational culture and legislative challenges highlight the difficulty of giving a unitary definition to psychotherapy.

## Defining the mysterious "Talking Cure": Psychotherapy of the West

Giving a concrete definition to psychotherapy would remain a mereological challenge for all the aspiring researchers in the field. With all these modified cultures coming to the field of psychotherapy, should we see them as the next step in evolution and start calling psychotherapist as cognitive therapist, psychodynamic therapist, humanistic-existential therapist, or any other name for a therapist? Or should psychotherapists be known primarily by their prestigious occupational specifications and understood as a psychologist, psychiatrist, social worker, counselor and such? Question we begin with repeats itself again: Whose therapists, are they? Which culture do they belong to?

This question remains a challenge as the culture has already diversified its lineages with many theories and occupations educating those who can conduct psychotherapy. However, to encapsulate the concept of psychotherapy and follow the evolution of rational therapy started within the European culture, we could look at their descendants' understanding of psychotherapy. Official definition adopted by the American Psychological Association (Campbell et al., 2013) and European Federation of Psychologist Associations (EFPA, 2017) is:

> "Psychotherapy is the informed and intentional application of clinical methods and interpersonal stances derived from established psychological principles for the purpose of assisting people to modify their behaviors, cognitions, emotions, and/or other personal characteristics in directions that the participants deem desirable" (Norcross,1990, p. 218).

This definition would give us the essential ingredients characterizing the modern version of rational psychotherapy. It would do so by denoting its goals (change in direction both participants find desirable); intentional planned nature (rationality of therapy); application methods (including both technical and interpersonal methods); targets (cognitive-emotional-behavioral and others). As a cultural product, it would show us an elegant attempt to integrate various inheriting cultures that exist within psychotherapy. It would also give us an expansive list of change targets while preserving the rational part of therapy, which is probably the main reason why it's accepted by psychotherapists from a variety of cultural backgrounds in EU and US. Additionally, it would not include any occupation in its definition, hence separating it from any profession's culture. However, even with all these important points, Campbell et al. (2013) remarks that "All psychologists have an opinion about psychotherapy. Yes, even those psychologists who said they had not studied, practiced, or researched psychotherapy approached us with revisions to the resolution draft" (p.100). We could take this statement as an indication for conflict of opinions, that would be trying to define the field in the future.

## War of Evidence: Controversial Rise of Empirically Supported Treatments

*Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* had been a treasured guidance for generations of psychotherapy researchers since its first edition in 1970. In the 50$^{th}$ anniversary, Lutz et al. (2021) have categorized past generations' research themes on outcomes as:

> "Justification in 1950s – 1970s (Is it effective?); Specificity in 1960 – 1980 (Which psychotherapy is more effective); Efficacy & cost effectiveness in 1970 – 1990s (How can it be more cost effective); Effectiveness and clinical significance in 1980s – 2000s (How can we improve effectiveness); Evidence-Based Practice in 1990s – 2010s (How can we improve the delivery of treatment); Practice-Based Evidence in 2000s – 2020s (How can we improve the treatment outcome)." (p.5).

They would also add to it by defining the current generation's research theme as precision mental health (Tailoring the treatment to an individual). However, we could see that something strange had happened during this generational change, which is, the sudden reversal of priority on order for these generations where they changed from "Evidence-Based Practice" to "Practice-Based Evidence". This change would be the result of an era defined by a great schism between cultures of psychotherapy who had a great debate at the turn of 21st century.

First use of the word "evidence" in the context of rational therapy would see its start within the field of medicine, where proponents of Evidence-Based Medicine (EBM) detected a serious disconnection between evidence gathered in research and actual clinical practice of physicians. They would have found that rather than reading up on the recent advances in medicine, most of the physicians would have relied on their intuition and go back to the knowledge they learned during their medical education. To solve this gap between science and practice, they would advise for a ease of access for evidence, which would be done by preparing guidelines for the medical evidence and would also give recommendation on how to applying it to the actual practice (Sackett & Rosenberg, 1995). Influenced by this, American Psychological Association (2006) would also define Evidence Based Practice in Psychology (EBPP) as "Integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273). Guidelines of EBPP had advised psychotherapists to inform themselves on the best possible research evidence and use their clinical expertise to match evidence to the patient's idiosyncratic qualities. Hoping to foster a productive system for psychotherapists to manage their clinical plans, EPPP would give guidance on how to assess research taken from multiple research models and hoped that therapists would integrate them into actual practice. However, even though they had explicitly stated "EBPP articulates a decision-making process for integrating multiple streams of research evidence—including but not limited to RCTs—into the intervention process" (p.273), Evidence Based Practice's meaning is often conflated with Empirically Supported Treatment (EST) movement.

EST movement started with a benevolent statement, "APA needs to continue its efforts to educate third party payers and the public about the health benefits and cost effectiveness of psychotherapy" (Chambless, 1995, p.14). Focusing on the efficiency of psychotherapy, they would determine a categorization for "Well-Established Treatments" which includes treatments that have demonstrated a clear benefit compared to a placebo conditions (i.e., alternative treatment or no treatment). Additionally, they also include a requirement for specificity, which required treatments to prove its core mechanism of action, by elimination of all the confounding variables such as expectation of change and contact with a supportive empathic professional (Chambless et al., 1996). To achieve this well-established status, researchers would need to use the same method pharmacological companies use to validate psychiatric drugs: Randomized Controlled Trial (RCT). The use of RCT was deemed to be necessary, which would prove that psychotherapy can be a valid alternative to psychiatric drugs. The reason for it can be seen within EST statement:

> "We believe that, if the public is to benefit from the availability of effective psychotherapies, and if clinical psychology is to survive in this heyday of biological psychiatry, APA must act to emphasize the strength of what we have to offer a variety of psychotherapies of proven efficacy." (Chambless, 1995, p.3).

Based on this statement, we could assume that the alternative motivation for the research would be to compare psychotherapy with biological psychiatry and survive natural selection — in the most cost-effective way possible.

Even though it would start with the intention of finding a cheaper and effective alternative to pharmacological treatments, EST research models would quickly turn research culture into a gladiatorial colosseum of competition for psychotherapy models fighting to prove their efficacy. It encouraged psychotherapy researchers to conduct expensive RCT in laboratories with bare-bones treatment protocols to earn the highly coveted "Well-Established Treatment" seal and prove their therapy models' success in curing a specific mental "disorder". In addition to this, even though they have intended these tests to be open to all psychotherapy cultures, criteria for approval would favor short term symptom-focused therapies (behavioral therapy culture) and would not be suited to longer psychotherapies that focus on improvement over a long time, which would be not in favor of psychodynamic therapy culture (O'Donohue et al., 2000). These factors have naturally resulted in a major success for behavioral therapies as they would gain approval of community as an empirically evaluated, scientific therapies. However, in the long run, revisions to the criteria would show a

success for psychodynamic therapies in empirical research too (Leichsenring et al., 2023; Tolin et al., 2015; Tolin, 2020). Eventually, lots of criticisms would be pointed at the EST movement for their attempts to integrate the psychotherapy process into medical research culture, whom, even after long centuries and specializations in *psyche*, would continue to value biological explanations for an illness over alternative psychological explanations.

During this cultural warfare over evidence, pursuit of finding latest and most comprehensive evidence (i.e., meta-reviews) for psychotherapies would start to be seen as an indicator of scientific inequality. As the economic disparities between countries that can conduct rigorous methodological research and those who cannot afford it would become more obvious, which would force the developing nations to follow studies conducted in rich developed nations (Kirmayer, 2012; Koç & Kafa, 2019). Moreover, even though they would try to follow the evidence, majority of data would still be coming from a Western, Educated, Industrialized, Rich and Democratic (WEIRD) societies, and this posed a problem as reliability of these findings would be limited in different cultures (Henrich et al., 2010; Ruggeri et al., 2019). To find a solution to this problem, EBPP model would recommend adapting the evidence selectively and being sensitive to cultural context (Morales & Norcross, 2010). This important distinction would also accentuate the importance of picking the correct evidence for the patient.

However, even with the amount of evidence on psychotherapy increase, actual usage of the evidence would remain as a problem. Even if a psychotherapist collects evidence from different sources, it may remain inconclusive for practice amidst all the details actively influencing the context of a patient (EBPP model). On the other hand, if they only rely on concrete evidence given by RCT's, it may carry a risk of being too specific and possibly lead the psychotherapist into convincing the patient into a specific template for treatment (EST). Which would leading to a dilemma accurately described by Littell (2010) as "therapy requires action and faith in the process, whereas science demands observation and skepticism" (p.167). In the unknown context of multiple possibilities, psychotherapists would rely on evidence to guide their practice and give help to their patients in finding their way out of their psychological suffering. Thus, we could say that relying on evidence-based practices would be helpful to both practitioner and patient to achieve success in psychotherapy. However, even though preference for ESTs with strong evidence base is shown to be high among U.S. mental health consumers (Kirk et al., 2016); strong evidences would not be seen as a priority for individuals in other cultures (Adewuya & Makanjuola, 2009; Cutrer-Parraga et al., 2022; Kirmayer et al., 2007),

which would suggest certain difficulties in basing entire psychotherapy practice on one source of evidence when working in different cultural scripts.

In addition to this, studies in the US would have shown that while scientific characteristics of psychotherapy were deemed as an important quality, it would still be overshadowed by the relational characteristics of psychotherapy. Although, in anxiety disorders this difference would be less obvious (Farrell & Deacon, 2016). Furthermore, another study would also show relational characteristics such as warmth, empathic relationship and positive working relationship would be valued over scientific characteristics (Swift & Callahan, 2010). These relational factors are just one facet of a more expansive common factors research culture, in which, researchers would seek to understand shared components among all psychotherapy cultures, thus according to them, finding the commonality –rather specificity– should be the aim of psychotherapy research. Contemporary researchers of this culture would trace their inheritance to the model of Jerome Frank (1961), who had an avid interest in understanding not only the rational therapy cultures but also the religious healing cultures (Wampold, 2010). His interest would also remind us of the Emmanuel movement, a culture of religious psychotherapy that would be cumulatively modified through different heirs to survive the test of time (Hickey, 2019).

Comprehensive categorization for these common factors could be found in Frank & Frank's (1993) book, *Persuasion and Healing: A comparative study of psychotherapy*, in which, they identified shared factors between all psychotherapies as (a) emotional relationship that provide space to confidently share experiences to the healer; (b) setting that ensures privacy and professional roles as a healer; (c) cogent explanation/myth providing a rationale for the problems and procedure/ritual prescribed by healer as a solution to problems; (d) active participation to the procedure/ritual by both sides and shared belief on the healing capacity of this activity. This would be an attempt to integrate healing factors not only within the psychotherapy community, but also within all the psychotherapy communities. Thus, we could say common factors were not limited to psychotherapy for them.

While the common factors culture had taken root in one part of the research community, specificity focused models continued to be developed for better and more cost-efficient care in laboratory settings. However, cultural scripts for psychotherapy researchers would come to conflict over the famous Dodo Bird Verdict, which had its name coined by a famous story from Alice in Wonderland, where a track race without a course or a finish line is initiated

and at the end dodo bird called out to the contestants: "At last the Dodo said, 'Everybody has won, and all must have prizes'." (Carroll, 2004, p.34). Saul Rosenzweig (1936) would take this story as an inspiration and would argue that something may be working beyond the specific treatment claims of psychotherapy models and even if they don't openly acknowledge it, they already share the very same common factors required to win the race of psychotherapy outcome.

Inheritors of Dodo verdict would carry the torch and form a serious opposition to the EST's expectation of conducting RCTs for a proof of treatment establishment. They would argue against their recommendation of controlling placebo and would consider it an attempt to disregard common factors by turning psychotherapy into a bare bone, treatment ingredient only application. Moreover, they would see the recommendation of controlling placebo by blinding the participants or psychotherapists as an unrealistic wish for a causality in a process complex as psychotherapy. Scriven (2008) for example, would suggest that the RCT's requirement to eliminate placebo would always be limited by the very nature of psychotherapists interacting with a participant who can quickly figure out if they are in an actual therapy or a placebo therapy. Not only that, psychotherapists would also have their own perspective regarding the effectiveness of their treatment and would naturally find it difficult to engage when they know they are in an ineffective control treatment group (Wampold et al., 2005). These objections would naturally lead the generation to a giant war of evidence, which would be fought with flurry of meta-analyses. While one side would argue against problematic nature of bona-fide placebo controlled treatment research and its ineffectiveness at proving specific factors success (Baskin et al., 2003; Benish et al., 2008; Luborsky et al., 2002; Spielmans et al., 2013; Wampold et al., 2011, 1997), other side would argue that specific factors provided by the treatment packages do make noticeable difference on the psychotherapy outcomes (Bell et al., 2013; Butler et al., 2006; Ehlers et al., 2010; Honyashiki et al., 2014). Both sides would raise valid points during this time and argued with an intense passion to decide once and for all which factor is crucial to effectiveness of psychotherapy: Specific factors of the Medical Treatment Model or Common Factors of Dodo Bird Verdict.