

The Emerging Paradigm

Introduction

Our current approach to mental health issues such as anxiety and depression appears to be constantly improving and evolving. Sophisticated research is providing more and more data about diagnosis and treatment. Psychotherapists grow increasingly eclectic, moving away from any shared core belief system that once formed the crux of our therapeutic understanding. A large variety of practice styles exists with distinctly different perspectives and solutions. Psychopharmacology grows increasingly sophisticated and complex, with new options elaborated yearly. Yet, people continue to suffer and struggle. The practitioner listens to the client; the doctor and patient sit down together. In some ways, nothing has changed for a long, long time

Psychotherapy

Each year, new psychotherapeutic approaches and theories unfold—each driven by a passionate belief in its deeper understanding of the human psyche. These new ideas continue to excite practitioners, who are eager to learn new breakthrough techniques. We now have close to five hundred psychotherapeutic approaches by some counts, all of which appear to work for some individuals and not for others. Research in psychotherapy has given us some answers, but

many questions remain. The complexity of human relationships makes this research extremely difficult. Few evaluate generalizations pass without significant controversy. No quality outcome studies exist for a large number of clinical problems. Most forms of psychotherapy have had no systematic evaluation at all and very little research has been done on long-term intensive treatments, even though they figure prominently in clinical practice. We do know, however, that certain types of psychotherapy are effective for a few types of clinical patterns. Much like the humans that psychotherapy addresses, we have more variables, questions, and complexities than definite answers.

In an attempt to find more answers, research has explored the common or central factors responsible for the creation of positive change by psychotherapy. The results seem to focus on the nonspecific factors—that is, on the intangibles that exist in the relationship and the interpersonal connection with a client—more than on the specific technique employed by a practitioner. Technique seems to matter less than the quality of the relationship.

Jerome Frank, MD, wrote about much of this in his seminal 1961 work, Persuasion and Healing. He examined the process of healing all over the planet in different settings and cultures. In his view, the therapeutic process distills down to a few factors common to all healing encounters, whether it occurs on Fifth Avenue in New York City or the jungles of Borneo. These common factors include the generation of hope, a shared belief system, and an emotionally charged, confiding relationship.

Psychopharmacology

Even psychiatry, which has moved further and further down the path of purely biological psychopharmacology, meets Frank's criterion (1961). The impact of belief on medication trials is quite profound. For example, a challenging aspect of experimental design for psychiatric drug trials involves separating the pharmacological impact from the effect of the placebo response, which can account for at least 30 percent, and up to as much as 75 percent of the total response observed (Benson, 1996). In fact, this is why trials are placebo-controlled in psychosomatic research. If this is true in very controlled research, why could it not be even more of a variable in the uncontrolled reality of day-to-day practice? Even schizophrenia, which most view as a very biologically mediated problem, exhibits placebo response rates of up to 50 percent (Manschreck, 2001).

Andrew Weil, MD, and Herbert Benson, MD, two physicians coming from very different perspectives, have thoughtfully explored the impact of placebos and belief in the practice of medicine (Benson, 1996; Manschreck, 2001; Weil, 1995). Dr. Benson (1996) sees three components to the placebo response (or, as he terms it, remembered wellness):

- “Belief and expectancy on the part of the patient.”
- “Belief and expectancy on the part of the caregiver.”
- Belief and expectancy generated by the relationship between the patient and caregiver.”

Dr. Weil (1995) urges us to accept and amplify the placebo response, not avoid and criticize it. The power of our mind to heal us or keep us ill cannot be ignored even from the most biochemical of perspectives.

The power of this biochemistry cannot be ignored either. Psychiatric science holds powerful tools of increasing precision and safety. Medications continue to evolve that can document proven statistical success for many psychiatric disorders. We now have numerous effective antidepressants that are not lethal in overdose. As our understanding of postsynaptic receptors and neurotransmitter systems in the human brain evolves, so does the pharmacology to induce change at this level. All of this biomolecular technology has brought psychiatry to near parity in the medical model.

However, Psychiatry still lacks the precise anatomical model that makes a field like surgery so clear and concrete. We have a variety of conflicting and confusing models for depression (the serotonin theory, the norepinephrine theory, the monoamine theory, etc.) Our understanding of the fundamental basis for schizophrenia remains clouded in spite of enormous research and data. Even though Obsessive Compulsive Disorder (OCD) looks to be, quite biologically mediated, the most severe and genetically mediated forms (juvenile onset) typically respond only partially to Selective Serotonin Reuptake Inhibitors (SSRIs) intervention (Thomsen, 2000). In addition, behavioral approaches in OCD such as exposure and response prevention (ERP) appear to have the same response rate as initial pharmacotherapy (Koran & Sexena, 2000). Even more confusing for this extremely biologically mediated problem—up to 20 percent to 30 percent of children with severe OCD spontaneously and completely recover (Leonard, 1993). How do we integrate all of this into a strictly neurological understanding of OCD? A strictly biological/neurological model does not fit exactly with the data and knowledge base in psychiatry.

Individual response to any specific agent remains quite unpredictable in spite of broad statistical predictability. Even the best responses to pharmacological interventions often fade over time. We have many powerful tools for use on a system (the human brain) that we only partially understand. This is both the blessing and the curse of psychiatry.

Both the psychotherapeutic model and the psychopharmacological model exhibit a number of factors in common. Practitioners in both fields recognize the importance and validity of the other. In fact, some psychologists are now actively fighting for the legal right to prescribe psychiatric medications. Frequently, psychiatrists find themselves fighting with insurance companies for fair reimbursement of their psychotherapeutic skills, not just the use of medications. Obviously, both fields address many of the same issues and attempt to treat the same problems, often in the same people. The fields overlap; yet, at times they are in conflict.

A Meta-Model

Well, which model is correct, which represents the truth? Most current research points toward a synergy of these two models. For example, chronically depressed patients who receive both therapy and medication seem to do significantly better in the end. This view was recently reiterated in a recent major study published in the New England Journal of Medicine (Keller, M. B., et al., 2000, May). Are we not like the five blind men who examined a different part of the elephant, each with an accurate but quite divergent description of the elephant? If both models are correct and relevant, then we need a Meta-model that can put both the psychopharmacological and the psychotherapeutic models into proper context.

As we step back and try to gain perspective, some thoughts come to mind. What seems clear is that neither current model has a monopoly on success. I frequently evaluate individuals who have failed to respond to the intelligent and creative use of pharmacology, even after years of effort, only to find genuine relief in a psychological or even spiritual approach. Likewise, I often encounter people who continue to suffer after years of varied and effortful therapy, but then respond remarkably well to a simple biochemical intervention. How do we make sense of this?

We can add to this insight if we recognize that people continually find healing of mental/emotional disorders from outside either of these models. For example, research documents that the effective treatment of depression has been found in herbs (Cass, Chapter 20), acupuncture (Motl, Chapter 22), light therapy (Terman, 1999; Shafii, 1990), exercise (Blumenthal, 2000; Matinsen, 1985), negative IONS (Finley, 1995), meditation, and nutritional compounds (Settle, Chapter 7). These treatments fall outside our current models and, in fact, challenge them. If we recognize and accept the limitations of our current research style (more on this later) and the lack of broader questioning on this topic, then we can see that mental/emotional issues are impacted by a much wider range of influences than either of our two current models allow. For example, I continually observe individuals who find healing of mental/emotional disorders from factors that lie well outside the psychotherapeutic or psychopharmacological models. Whether it is a new pet, a supportive friendship, an exciting romance, a pleasurable hobby, a spiritual deepening, some selfless service, a life-threatening illness, or an inexplicable personal epiphany, people come upon healing via a multitude of paths and methods. In addition, if we step outside our own narrow cultural view, we can also see that cross-cultural approaches to healing offer relief to many and have for eons.

Some of these methods step outside the box that Jerome Frank (1961) outlined for us forty years ago. The examples listed above do not involve healers; there is no placebo response or suggestion involved. In some ways, this challenges our profession, perhaps creating defensiveness or resistance: a puffed-up, “they can’t heal without me” response might be elicited. Yet, when we look honestly at our lives and our experience, professional healing stands as just one path of many to healing and growth.

Simply put, people are much more complex than any current model of healing fully allows. Technically, neither the psychotherapeutic nor the psychopharmacological model explains the impact of the other. In some ways, they are even mutually exclusive. However, if we can see that people function simultaneously on many different, interconnected levels (physical/biological, mental/emotional, and spiritual, for example), we can begin to grasp a solution to this modern dilemma. Neither model is wrong. They are merely reasonable models for an isolated, fragmentary view of human nature.

Our physical/biochemical nature is real and can be impacted by medication. Our mental/emotional self exists and it can be impacted by therapy. Beyond this, we have a spiritual existence (honored by every major historical culture on earth) that can also impact change and illness. Significant documentation from Freud onward honors the ability of the mind to impact physical health and/or create symptoms. An ever-increasing number of studies give solid evidence that spiritual belief (Matthews, 1998) and even social connectedness (Ornish, 1998) can improve physical health. A new paradigm or model that allows for the existence of our body-mind-spirit and their inherent interconnectedness opens us to a broader vision of human nature.

This also fits better with our existing data. This text seeks to elaborate on this new model and to share how a wide array of modalities, both ancient and modern, can impact mental health issues.

Knowledge and Wisdom

Before we can examine this new model clearly, we need to step back and look at the tools that we can employ to sort out validity. Knowledge involves the accumulation of data. We have a clear scientific process in place that isolates variables and collects data. This process tends to emphasize the magnification of details and the loss of context. The scientific process has brought clarity of detail and enormous amounts of knowledge. Knowledge is a linear approach that applies the left hemisphere style of cognition, which we often call logic.

Wisdom involves a non-linear process in which we apply context to our knowledge. It involves the big picture, while de-emphasizing small details. Knowledge tells us which chemotherapeutic agent is most effective against a specific cancer. Wisdom tells us when to stop treatment. Knowledge tells us which DSM-IV diagnosis an individual has. Wisdom tells us when to wait in silence during a conversation with a client. Wisdom comes from a more intuitive style of information processing that mirrors the mode of the right hemisphere.

A strong emphasis on the application of logic has created the trend toward reductionism and fragmentation that modern science has taken. This three- or four-hundred-year trend towards extreme reductionism and fragmentation has given us much in the way of science and technology. The gifts are all around us: cell phones with web access, the human genome, satellite navigational systems, evolving personal palm computers, etc. With it comes a mountain of knowledge, which grows overwhelming and doubles every three years.

We all can appreciate these gifts, but do we comprehend the real cost to us price that we pay for all of this? First, we have lost a sense of perspective and balance about our world and our self in proportion to how immersed we are in this mound of knowledge. Wisdom is a polar opposite of knowledge. The two complement and balance each other. Much of our current crisis in the world of healthcare flows out of the extreme imbalance that we now experience. We have given up wisdom for knowledge. The price is a loss of connection, a loss of context, and the vacuum of real guiding wisdom.

This loss of wisdom particularly impacts those issues that are least amenable to the dissection, isolation, reductionism, and fragmentation of modern science. As we move from chemistry to biology to psychology to social health to theology/spirituality, we follow a steady progression from the reducible to the irreducible. The importance of wisdom in each field grows as we move along this path. How do we find balance and context for the wise application of our current substantial knowledge regarding mental health issues?

The Emerging Paradigm

Our current scientific view of human nature does not allow for body-mind-spirit. The existing view is the Cartesian principle of body-mind and body-spirit separation. A significant amount of data continues to accumulate which challenges this aging perspective. What will the new view look like? Where are we in this process of change? Obviously, we know that knowledge and data can change belief systems. This comes as no surprise. The surprise, however, comes when we discover that this change occurs slowly, no matter how solid and credible the information.

Clearly, this is true in traditional psychotherapy where emotional issues can create an inertia that insight must overcome in order for the process of change to occur. People cling to beliefs for both comfort and safety. Often, change occurs for an individual much more slowly than seems reasonable from an independent perspective.

Science mirrors this same process. Clearly, new data alters specific scientific theories. What happens when this is not merely an isolated theory but the much broader conceptual perspective from which all the individual theories flow? When the data or information falls outside the broader belief system, opening to a new insight can begin to create change, but clinging to the old perspective can actually slow down the process of scientific change.

This larger or systemic belief can be called a paradigm. It is the broadest worldview of science from which we operate. Like the personal beliefs we explore in psychotherapy, our scientific paradigm is often unspoken, typically unrecognized, and usually unchallenged. In science, our paradigm governs not only which theories we create and test, but also and more importantly, which ones we don't challenge. These broad assumptions channel our view of the world and how we search for and categorize the information that we find as well as the data that we dismiss or ignore. For example, the normal process of science often suppresses fundamental novelties, because they undermine its basic intent and seem irrelevant (Kuhn, 1962).

If our scientific theories and the data we collect operated like a computer-based program, change would be much more fluid. However, profound scientific change is a slow, episodic and human process. Thomas Kuhn, the philosopher of science, wrote of this in his 1962 book, The Structure of Scientific Revolutions. In this book, he documents that in spite of revolutionary discoveries or concepts, the change in the larger belief system takes generational time. Scientific

understanding and our belief systems become quite institutionalized. Change threatens the status quo and the established hierarchy. The institutions resist change; the older generation doubts the new concepts and the validity of the data. The process of a true scientific revolution takes a number of generations to fully unfold (Kuhn, 1962). “That professionalism leads...to an immense restriction of the scientists’ vision and to a considerable resistance to paradigm change. The science has become increasingly rigid” (p. 64).

A paradigm changes slowly over time. Einstein’s new concepts of relativity were espoused at the turn of the last century. Evidence for his ideas continued to build for many years. Now, a century later, they are well accepted in the physics community, but this was not the case in the early part of the twentieth century. However, the broader ramifications of his new paradigm continue to percolate through science. Most of us still instinctively clutch to a more Newtonian view of the world. Einstein’s view of the world does not negate Newton’s view. It merely expands upon it to explain other things.

In a similar manner, most new paradigms do not invalidate the older paradigm; they merely supercede it with a broader, more inclusive, explanation. When a new paradigm completely invalidates the old one, extreme emotions often erupt, as Galileo discovered when he rebutted the Copernican view of the world—that the earth was the center of the solar system. The reaction of scientists when their paradigm is challenged mimics an emotional and spiritual affront. This becomes a paradigm crisis that precedes a paradigm shift.

The New Paradigm

Three concepts, shared early in the last century, form the roots of our current paradigm shift.

- Albert Einstein explained that energy and matter are merely different forms of the same thing.
- Sigmund Freud noted that the mind can influence the body and, at times, can lie completely outside our conscious awareness.
- C. G. Jung documented the spiritual core that exists in our psyche and strives to find meaning and balance in our life.

Over time, these three concepts percolated through the scientific communities and then penetrated the awareness of the general public. By the 1960s, these three concepts came together with other new concepts to create a consciousness revolution—a dramatic rejection of the old cultural perspective. In some manner, most of the older generation initially resisted these ideas. Many of the core principles of the emerging paradigm were voiced clearly during the consciousness revolution of the 1960s.

- We have many levels of awareness. It is important to explore and validate each of them.
- The physical body is composed of energy. It is capable of and includes much more than we now know.
- We must follow our unique inner spiritual path, not just a traditional religious institution, to find meaning in our lives.
- The body has the power to heal itself—and simpler, more natural methods of healing may be better.

- Our individual beliefs are valuable and can be powerful tools for creating personal change.
- The mind is incredibly powerful. We can use it to impact our body, our health, and our well being.
- We all exist in a vast matrix of interconnections, a web of life, which encompasses our entire environment.
- Each of us is **unique** and must be respected as an individual in our full autonomy.

The areas that were most impacted by this new paradigm were those which dealt most broadly with the higher dimensions of human functioning, in particular, mental healthcare and spirituality. Psychotherapy in particular saw a large influx of new ideas based on this emerging worldview. This was called the human potential movement. These changes have continued to evolve as the young people of the '60s have aged.

The decision makers are now baby-boomers who have grown up. In the last ten years or so, we are witnessing an interesting phenomenon: the general public is starting to transform healthcare from the outside. In 1993 David Eisenberg, MD, of Harvard, documented in the New England Journal of Medicine that almost one-third of Americans were using complementary/alternative medicine (CAM) and spending nearly \$13 billion dollars in out-of-pocket expenses (Eisenberg, Kessler, and Foster., 1993). Over the last few years, this trend has continued unabated. Eisenberg shared that by 1998 these figures had grown to 42 percent in utilization and \$30 billion in expenditures. CAM visits and spending are accelerating at a phenomenal pace. Visits to CAM practitioners now exceed the visits to primary care physicians by almost 40% (Eisenberg, Davis, and Ettner, et al., 1998).

This consumer-driven trend has started to transform healthcare. Noticing this level of consumer interest, most major hospital systems, which are fighting for market share and survival, are addressing this demand. Now, nearly every major healthcare system, including the National Institute of Health (NIH), has a center for complementary medicine or some project in development. The leaders in this trend come from the top echelon of our healthcare institutions: Harvard, Columbia, Duke, and Stanford. The University of Arizona, College of Medicine, under the leadership of Andrew Weil, MD, now has an Integrative Medicine Fellowship Program. The graduates of this program are mainly seeding other innovative academic models which address the exploding public demand and utilization for this type of healthcare. Holistic Medicine established Board Certification in the year 2000, signaling further integration into mainstream medicine. Consumers have driven this trend. Why? People choose CAM services because they have begun to embrace the perspectives of the new paradigm.

In 1998, John Astin of Stanford published an article in the Journal of the American Medical Association in which he explored why people are turning to complementary medicine (Astin, 1998). His survey illustrates that this trend is not a reaction to the cost or danger of modern medicine, nor is it a push for more personal autonomy. Rather, it is a self-directed movement toward an approach to healthcare that matches our changing internal belief system. People choose CAM services because it mirrors their own philosophy of health. The people using CAM are typically well-educated and affluent, harbingers that the rest of America will soon follow.

We have an aging scientific paradigm increasingly questioned by well-educated consumers and dissatisfied practitioners. This old paradigm is an extension of the movement

toward scientific reductionism and fragmentation that has been evident over the last three hundred years. Most of the profound new data regarding the power of the mind and spirit to alter well being has been relatively ignored by modern medicine, because the old paradigm has no place for it. Following is a list of biases inherent in our established model of healthcare that reflects the old paradigm.

- The body is a physical biochemical machine and can be treated in isolation from emotional, mental, social, and spiritual issues.
- The practitioner has more knowledge and directs treatment for the patient.
- Lifestyle issues and stressors are a minor factor in the development of illness.
- We understand illness much better than health, so this becomes our costly focus of technology, especially at the end of life.
- Invasive treatments have significant risk, but this is outweighed by their statistical value at reducing symptoms.
- We can find a specific biochemical agent to reduce every type of symptom or symptom pattern.
- Non-medical and non-surgical approaches have limited value and validity. They are often marginalized.
- Cost is secondary; technology is king. The practitioners who use the most technology receive the most remuneration.
- The more specialized and narrow the practice, the more status and reimbursement to the practitioner.

The status quo that is held in psychology, social work, and counseling is less obvious. In effect, although the wide variety of theories and techniques has served to present many options, it also creates a lack of clarity and cohesion. In turn, this has made it easier for the current healthcare paradigm to marginalize mental, emotional, and social treatments. Mostly, they are fragmented from the traditional healthcare delivery system. Non-psychiatric mental health holds a peculiar role. It stands in a transition between one paradigm and another.

Non-Local Mind

Larry Dossey, MD, in his work Reinventing Medicine (1999), describes three eras of healthcare. Era I started with the elaboration of basic medical science in the late 1800s. He calls it the Era of Mechanical Medicine. In this model, mental, emotional, and spiritual concerns are dismissed. The second era Dossey calls Mind-Body Medicine. In this era (which begins in the post World War II time frame), mind increasingly becomes a factor in treatments such as counseling, relaxation, biofeedback, and alternative therapies. He sees us now entering the third era—Non-local Medicine. Mind becomes a factor not just in healing with the single person but between people. Healing moves beyond the individual to a larger context.

Dossey sees the documented value of prayer (1993) and other spiritual healing techniques as generated by the power of the mind to have distant effect on the health of others. He elaborates how the physics of quantum mechanics makes this possible (1982). Certainly, nothing in our current paradigm of healthcare allows this non-local healing to be a possibility. However, many of the modalities elaborated in this text come from ancient traditions that have long held

this view. With the concepts of non-local mind, the intention, attitude, and openness of the practitioner become critical elements.

Not surprisingly, these elements were also recognized by Jerome Frank in his previously mentioned study of healing, Persuasion and Healing (1961). He saw the same pattern but attributed the positive impact to suggestion, which was the closest answer available to him. Current research points away from pure suggestion and towards a non-local effect (Dossey, 1993). Non-local effects are well documented in modern physics with the spin of electrons separated at a distance (Zukav, 1979). The concept of non-local mind brings together modern physics and current clinical research into a new vision of human potential.

Era III medicine embraces the concepts of modern physics and the most ancient of healing traditions on our planet. It fully accepts the models of spiritual healing and medical intuition outlined in this book. The term spirit, used as one foundation of holistic medicine, could also be defined as non-local mind. This model challenges us conceptually by limiting our ability to cling to a Newtonian view of reality. It does not invalidate our current healthcare system; it merely places it in a larger context. In my view, Era II Healthcare, Mind-Body Medicine, forms a description of the overlap between the old and the new paradigms. It is this period of emergence and transition that we now occupy. We are confronted with the conceptual extremes of advanced psychopharmacology on one hand and therapeutic touch on the other. Can we embrace both behavior modification and Hakomi?

Research and Validity

The solution to this enormous challenge grows from a model of inclusion not exclusion. How can we sort through these models rationally and even-handedly to find a core of validity? The scientific method comes to us as a gift from the old paradigm. Our newest challenge is to apply this wonderful tool in a manner in which it doesn't reflect the limitations and inherent biases of the old paradigm. Obviously, we need to sort out what is valid, but what is the best approach to do this as we grow in our understanding of a broader view of our nature and of healing? How does research into the effectiveness of healing change with the concept of non-local mind?

The broader our view of human nature, the wider must be our scope of inquiry. For example, in vitro biochemical medical research reflects the biases of the old paradigm. We need a research model that honors our holism and our vast interconnections. How do we cast such a large net? We know clearly how difficult it is to do sophisticated research on psychotherapy variables. In the new paradigm view, the variables are much harder to isolate and assess. Health outcome studies (which employ a more naturalistic format) represent a mode of inquiry and one possible solution to this dilemma. We must also be aware that this new paradigm challenges the conceptual framework that we use to evaluate what is real and valid. For example, can we really isolate human variables in a being that is so complex and interconnected? The questions that we have not asked and the data that we have not examined also must speak more loudly. This topic is reconsidered in the concluding chapter, Synthesis.

Data and Risk

Clearly, we need cogent research and documentation of effectiveness for all of our healthcare techniques—old and new. Integrative Medicine respects this need. The studies are growing. Some of the modalities elaborated in this text have a very solid and growing research data bank (Meditation, Biofeedback, Acupuncture, Homeopathy, and Herbal Medicine), and some more narrow areas have strong preliminary data (EMDR, QiGong, Omega 3 Oils, and Prayer). Many of the areas are difficult to scrutinize by the placebo-controlled, double blind mindset of our current paradigm (Music, Creative Arts, The Environment, Medical Intuition, Process Work, and Hakomi). As expected, in the field of complementary and alternative medicine, the data for mental health issues lacks the great sophistication of the purely medical issues (given the aforementioned complexities). As the prevailing perspective opens to a new conceptual base, we will adapt and find new methods to evaluate these more complex and less divisible models of human healing.

One issue that our current model does not acknowledge or address well is the issue of risk. When a discussion of herbal medicine arises in a medical setting, the inevitable skeptic often raises the issue of safety. Herbal medicines and supplements do have a risk. The American public generally has no primary care physician guidance on this topic in spite of huge demand and utilization (Eisenberg, 1993, 1998). Partially because of this, extreme overuse or inappropriate application can and does occur. In addition, we are beginning to realize that herb-drug interactions (Ginkgo and Coumadin, for example) can be significant. A few herbs are outright dangerous for human use. Overall, herbs harm some people, and a few (less than ten) even die per year. Herbs and nutritional supplements possess some inherent risk, especially when used without the supervision of a healthcare professional.

In addition, physicians often raise a concern about the patient using CAM modalities to the exclusion of medical care. However, numerous studies indicate that people who use CAM were more likely than the general population to seek medical care. In Eisenberg's study, not one person was using CAM for the treatment cancer without the simultaneous involvement of the conventional medical community (Eisenberg, 1993). This is why the term "complementary" evolved from "alternative." The data simply does not support the concern that appropriate medical care is sacrificed by CAM utilization.

To keep these concerns about CAM utilization in proper context, however, we must compare and contrast this with the risk of prescription medications. According to a recent report in the Journal of the American Medical Association by Dr. Barbra Starfield of Johns Hopkins Medical School (July, 2000), adverse drug reactions to correctly prescribed medications kill approximately 106,000 people annually in this country. Medication errors kill another 7,000. Unnecessary surgery results in the death of about 12,000 people per year. Errors in hospital care causes about 27,000 deaths each year. Dr. Starfield's study documents that there are at least 225,000 deaths each year from iatrogenic causes (physician-based). This makes medication reactions the sixth leading cause of death in this country, and iatrogenic causes the third leading cause of death, after heart disease and cancer. This is in spite of the fact that Americans made one and one-half times as many visits to CAM practitioners as they did to their primary care physicians in 1997 (Eisenberg, 1998). Where did we lose sight of "primum non nocere, Hippocrates' admonition, to first of all, do no harm?"

All of the modalities included in this book combined cause less than 10 untoward deaths each year, as best we can document. Does mainstream medicine really want to debate this issue?

These modalities are safe, gentle, and possess statistically less potential for harm than an airplane flight or even climbing a ladder. Risk to the consumer using CAM modalities appears to be a much less significant issue than the risk in conventional medical care.

Rick and Effectiveness

A more pressing issue would be how we begin to factor in risk/adverse effects into our research and documentation of effectiveness. Clearly, we know that prescription drugs and surgery represent powerful tools for impacting illness. With power comes risk. Should not our research document total positive potential by some compilation of positive benefits and adverse events? How do we factor in all those people who drop out of a drug study because they cannot tolerate the treatment? How do we factor in the side effects of prescription medicines that people just live with? What is the impact to quality of life that is created by drug induced lethargy or impotence? If you stand a very small chance, say 1/100,000, of risk of dying from a prescription medication, how do you factor this into the benefit you personally derive? How does that one person who dies factor in? If we moved to research tools that factored both positive and negative events (weighted in some manner), the documented therapeutic differential between prescription medications and CAM approaches would narrow rather considerably. Risk and total negative effect should be weighed in any consideration of therapeutic benefit.

Make no mistake, I prescribe conventional medications, when indicated, nearly every day and would be hard pressed to give up this valuable therapeutic tool. My point is that we need to be more circumspect about the dangerousness of our tools and continue our search for other safer options that expand our healthcare palette.

Summary

The emerging new paradigm does not reject the old one; it merely seeks to expand upon it. As we hold a broader vision of humanity and human wellness, our current healthcare approaches can be placed into proper context. In this way, we can use a broader wisdom to guide us in the current knowledge that we hold. Wisdom guides knowledge. Without sound knowledge, wisdom is empty, just as knowledge can be misdirected without guiding wisdom.

Currently, we are witnessing the process of integration as the holistic paradigm begins to shift healthcare. The terms we use to describe this new style of healthcare have gone through a curious evolution. In the early 1970s, it was termed Holistic Health. In the late '70s and early '80s, it was called Alternative Medicine. By the late 1980s, the British term Complementary Medicine was coming to the forefront. By the early 1990s, another term, Integrative Medicine became popularized by Andrew Weil, MD. Three of these terms (complementary, alternative, integrative) represent the progressive relationship of this new paradigm to the current health system. Only one term is actually descriptive of the new model: holistic (and its root holism). Holism becomes our topic of consideration in Chapter 2.

References

Asin, J. A. (1998). Why patients use alternative medicine: Results of a national study.

Journal of the American Medical Association, 279:1548-1553

Benson, H. (1996). Timeless healing. New York: Simon and Shuster.

Blumenthal, J. A. (2,000, Oct). Exercise as a treatment for depression.

Psychosomatic Medicine

Dossey, L. (1982). Space, time, and medicine, Los Angeles, CA: Tarcher.

Dossey, L. (1993). Healing words. New York: Harper Collins.

Dossey, L. (1999). Reinventing medicine.

Eisenberg, D. M., Kessler, R. C., and Foster C. (1993). Unconventional medicine in the United States. New England Journal of Medicine, 328, 246-252.

Eisenberg, D. M., Davis, R. B., Ettner, S. L., et al. (1998). Trends in alternative medicine use in the United States, 1990-1997: Results of a follow-up survey. Journal of the American Medical Association, 280, 1569-1575.

Finley, J. (1995, Jan.) Treatment of SAD with negative IONS. Journal of Alternative and Complementary Medicine, 97-92.

Frank, J. (1961). Persuasion and healing.

Keller, M. B., et al. (2000, May 18). A comparison of Nefazadone and cognitive behavioral psychotherapy and their combination for the treatment of chronic depression. New England Journal of Medicine, 342(20), 1462-1470.

Koran, L., and Sexena, S. (2000, June). Issues and Strategies in Treating Refractory OCD. CNS Spectrums, 5, 6(4), 24-31.

Kuhn, T. (1962). The structure of scientific revolutions. Chicago, IL: University of Chicago Press.

Leonard, H. C., et al. (1993). A two to seven year follow-up study of 54 OCD Children. Arch. Gen. Psychiatry, 50, 429-439.

Manschfeck, T. (2001, February). Placebo studies: Lessons from psychiatric research. Psychiatric Annals, 31(2), 130-136.

Matinsen, E. W., et al. (1985). Effects of aerobic exercise on depression. British

Medical Journal, 291, 6488-6509.

Matthews, D. (1998). The faith factor. New York: Penguin Books.

Ornish, D. (1998). Love and Survival. New York: Harper Collins.

Shafii, M. (1990). Biological Rhythms, Mood Disorders, and Light therapy.

Washington, D.C.: American Psychiatric Press.

Terman, M. (1999). Bright light therapy. Journal of Clinical Psychiatry, 60(11), 799-808.

Thomsen, P., and Keckman, J. (2000). Obsessive compulsive disorder and anxiety spectrum in children. CNS Spectrums, 5, 6(4), 18-23.

Weil, A. (1995). Spontaneous Healing. New York: Alfred Knopf.

Zukav, 1979. The Dancing Wu Li Masters