Humanism as a Common Factor in Psychotherapy

Bruce E. Wampold
University of Wisconsin—Madison and Research Institute, Modum Bad Psychiatric Center, Vikersund, Norway

There are many forms of psychotherapies, each distinctive in its own way. From the origins of psychotherapy, it has been suggested that psychotherapy is effective through factors that are common to all therapies. In this article, I suggest that the commonalities that are at the core of psychotherapy are related to evolved human characteristics, which include (a) making sense of the world, (b) influencing through social means, and (c) connectedness, expectation, and mastery. In this way, all psychotherapies are humanistic.

Keywords: psychotherapy, common factors, humanism

Over the years, many common factors of psychotherapy have been proposed, including relationship, alliance, expectation, myth and ritual, corrective experience, and insight (Frank & Frank, 1991; Grencavage & Norcross, 1990; Imel & Wampold, 2008; Tracey, Lichtenberg, Goodyear, Claiborn, & Wampold, 2003; Wampold, 2001b). There have been many attempts to classify the common factors, each based on a different conceptual scheme. In this article, I make the case that the factors that make all therapies effective (i.e., the common factors) are ones that are uniquely human (Wampold, 2007). That is to say, all psychotherapies are humanistic. Actually, humans evolved to respond to psychotherapy—or better put, psychotherapy evolved as a culturally imbedded healing practice because of human traits.

The Humanistic Components of Psychotherapy

The idea that psychotherapy is a culturally imbedded healing practice has been discussed, almost from the beginning of psychotherapy (Caplan, 1998; Fancher, 1995; Langman, 1997; Morris, 1998; Painter, 1913; Taylor, 1999; Wampold, 2001a). Indeed, it seems that healing practices are uniquely human and exist in every society, historically and currently (Frank & Frank, 1991; Wilson, 1978), and is one of the defining feature of humans (Wilson, 1978). There is something intimate between being human and using healing practices—the connection is made through the vector of sociality. Although the evolution of social groups in primates, and particular humans, is not completely understood, it is clear that humans' survival is intricately linked to the ability to form social groups for survival (Dunbar & Shultz, 2007; Shultz, Opie, & Atkinson, 2011). There is a hypothesis that fitness of humans depended, in part, in being able to heal through social means (Benedetti, 2011; Papakostas & Daras, 2001; Williams, 2002). There is good evidence that human facial expression of pain is a means to elicit assistance of others—in time of need, the assistance of others in the social network is particularly important.

Correspondence concerning this article should be addressed to Bruce E. Wampold, Department of Counseling Psychology, University of Wisconsin, 335 Education Building, 1000 Bascom Mall, Madison, WI 53706. E-mail: bwampold@wisc.edu

So, clearly, humans are social, survival depends on others in the social network, healing practices are ubiquitous, and healing through the social means is critical. In this article, I will discuss several critical aspects of humans that render psychotherapy effective.

Making Sense of the World

Humans have a propensity to make interpretations about the world—that is to say, they are curious about events, their antecedents, and their consequences. The interpretations may be metaphysical (e.g., religion) or scientific, two very different explanatory systems, to say the least. Of course, this propensity to make interpretations is used to explain illness, mental and physical, and is one of the reasons that healing practices originated, according to Shapiro and Shapiro (1997). Of course, competing explanatory systems for the same phenomenon exist—for example, some prefer evolution to creationism, and some not. When applied to the human mind, the explanation of mental events, those of one's own and of others, is called *theory of the mind, folk psychology*, or *mentalization.* Basically, all humans make inferences about the internal states of one self and of others, particularly goals, desires, motivations, and beliefs (Boyer & Barrett, 2005; Hutto, 2004; Stich & Ravenscroft, 1994; Thomas, 2001). This human ability is adaptive because it allows humans to develop a "coalitional alliance, based on a computation of other agents' commitments to a particular purpose . . . as well as the development of friendship as an insurance policy against variance in resources" (Boyer & Barrett, 2005, p. 109).

Unfortunately, not everyone's folk psychology is adaptive. There are times when one's explanations, particularly around psychological problems, are not adaptive, as the explanation alienates the person from family, work setting, or community, prevents finding solutions to problems, or creates internal distress. It is critical to be aware that what is important here is not whether the person's folk psychological explanations are scientific, but whether they are adaptive. As Boyer and Barrett (2005) put it, the "human brain's intuitive ontology is *philosophically incorrect"* (p. 99). Indeed, by the standards of scientific psychology currently, people in previous generations and most people today have beliefs about human behavior broadly conceived that are scientifically

incorrect. But the purpose of the folk beliefs is to regulate social relations and internal states in order to survive, not to be scientifically correct. Indeed, theories of mind have cultural variations (Cohen, Nisbett, Bowdle, & Schwarz, 1996; Lillard, 1998; Thomas, 2001), with the variations often serving various purposes (see, e.g., Cohen et al., 1996). As well, certain nonscientific beliefs, such as religion, may serve a psychological function, such as to ease existential angst and manage the anxiety related to the awareness of one's mortality (Vail et al., 2010).

One of features of the various forms of psychotherapy is that each gives a particularly compelling story for the client's complaints. Jerome Frank (Frank & Frank, 1991) referred to the healing *myth*, not to disparage healing practices, but to refer to the fact that all healing practices provide the person an *explanation* for their complaints and that the *scientific basis* of the explanation is not what is important. More explicitly, the scientific basis of the explanation is irrelevant (Wampold, 2007; Wampold & Budge, in press; Wampold, Imel, Bhati, & Johnson Jennings, 2006); what is important is that the explanation is accepted and that it is adaptive. This is well understood by therapists from a range of perspectives, including cognitive–behavioral therapy:

> As part of the therapy rationale, the therapist conceptualized each client's anxiety in terms of Schacter's model of emotional arousal (Schacter, 1996) . . . . After laying this groundwork, the therapist noted that the client's fear seemed to fit Schacter's theory that an emotional state such as fear is in large part determined by the thoughts in which the client engages when physically aroused . . . . Although the theory and research upon which it is based have been criticized . . . the theory has an aura of plausibility that the clients tend to accept. The logic of the treatment plan is clear to clients in light of this conceptualization (Meichenbaum, 1986, p. 370).

The process of transmitting the explanation to the client occurs in the social interaction between therapist and client.

Social Influence

Humans evolved to be influenced by others and to influence others (see, e.g., Zimbardo & Leippe, 1991). This influence is linguistic, nonverbal, and contextual. Tightly woven into the notion of social influence is the phenomenon of social contagion, defined as "the spread of affect, attitude, or behavior from Person A (the "initiator") to Person B (the "recipient"), where the recipient does not perceive an intentional influence attempt on the part of the initiator" (Levy & Nail, 1993, p. 266). Interestingly, mental and behavioral health statuses are transmitted through this means. For example, people with friends who smoke are more likely to smoke, after controlling for the fact that smokers tend to associate with other smokers. Similarly, obesity, loneliness, and depression propagate through social networks (Cacioppo, Fowler, & Christakis, 2009; Christakis & Fowler, 2007, 2008; Fowler & Christakis, 2009, 2010; Rosenquist, Fowler, & Christakis, 2011). That is to say, people are likely to modify their behavior based on their relationship with trusted others. Indeed, we are evolved to make quick decisions about trust—humans, based on visual appraisal of faces, make trust determinations within 100 to 500 ms (Benedetti, 2011).

Of course, clients come to therapy primed to be socially influenced, generally speaking. First, they are seeking help because

they are distressed, they are using psychotherapy presumably because they believe it will be helpful, and they have chosen this particular therapist because he or she will be helpful. The empathic stance of the therapist facilitates the emotional connection and increases the likelihood of influence (Benedetti, 2011; de Waal, 2008).

In all therapies, the therapist uses social influence, through the verbal transactions of the therapy, to induce acceptance of the explanation provided by the treatment method (Imel & Wampold, 2008; Wampold & Budge, in press; Wampold et al., 2006). However, the skilled therapist will provide an explanation that is likely to be accepted—there are several considerations that improve the likelihood of acceptance. The first consideration is that recipients of a healing practice expect the explanation to be congruent with the philosophical bases of the practice—for example, patients in Western medicine expect biological explanations for their disorders. Similarly, clients of psychotherapy expect psychological explanations. Second, the explanation should not be too discrepant from the folk beliefs of the client. In this regard, cultural beliefs and attitudes are critically important, as there are differences in folk psychology across cultures (Lillard, 1998). It seems to be the case that culturally adapted treatments are more effective than nonadapted treatments, particularly if the adaptation is around the construction of the explanation (Benish, Quintana, & Wampold, 2011). Third, treatments that match certain personality characteristics have been found to be more effective; for example, clients with characterological resistance do better in nonstructured treatments while the opposite is true for less resistant clients (Beutler, Harwood, Michelson, Song, & Holman, 2011).

We now have several pieces of the psychotherapy puzzle. People seek explanations for internal and external events in their lives, and thus are predisposed to create such explanations for mental distress. Put in the context of sociality, this gives rise to healing practices, in which the healer has a particular influence over the recipient of the practice. Endemic to the practice is the provision of an explanation, which is accepted and is adaptive. To this point, the meaning of the term *adaptive* has been a bit unclear, but leads us to the final piece of the puzzle—how these characteristics of healing practices in general, and psychotherapy in particular, lead to change.

Connectedness, Expectation, and Mastery

Psychotherapy creates change through connectedness, expectation, and mastery. It is well established that belongingness is an evolved characteristic of humans and is essential for survival (Baumeister, 2005). Attached individuals are more mentally and physically fit than unattached individuals. Indeed, the evidence "suggests that individuals in higher quality relations benefit from greater regulatory effects on the neural system involved in negative emotions, for example, the affective components of pain" (Benedetti, 2011, p. 149). In all psychotherapies, there is a real relationship between the therapist and the client (Gelso, 2011). This bond is unique—the therapist is expected to remain in this relationship, empathic and caring, despite what the client might divulge (with some exceptions of course, e.g., danger to self or others). This real relationship, which brings to the client belongingness, is in and of itself therapeutic—human connections are essential to well-being. This is particularly the case for clients with

poor attachment histories and impoverished social support networks.

The second process essential to psychotherapy is the creation of expectations. Although clients seek explanations, as they are expected in healing practices, the power of the explanation is the creation of expectations. The client's explanation (i.e., the folk psychology) for the disorder affords no possible way to change (or they would have changed already); in its place, the therapist provides a cogent explanation, based on psychological principles, that provides opportunities to change, provided the patient follows the treatment protocol (Wampold & Budge, in press). In Jerome Frank's term, therapy is remoralizing (Frank & Frank, 1991).

The power of expectations should not be underestimated. The effects of placebo medications are quite remarkable, often accounting for most (and sometimes all) of the effect of many medical procedures (Benedetti, 2009, 2011; Kirsch, 2002; Price, Finniss, & Benedetti, 2008; Wampold, Minami, Tierney, Baskin, & Bhati, 2005). The effects extend well beyond subjective reports, including documented neural changes, and occurs for many disorders not thought to be amenable to placebo, such as diabetes, Parkinson's disorder, and cardiac conditions (Benedetti, 2009, 2011; Simpson et al., 2006). Placebo effects most likely occur when the person is motivated to have the placebo work (e.g., is in pain, or experiencing distress) and the expectation that the placebo will work is induced (Price et al., 2008). Not surprising given that the discussion about healing through social means, the expectations are typically (and powerfully) created through the interaction of the administrator and the placebo recipient. However, the recipient is not passively provided a "placebo" and an explanation that it will work—the explanation itself must be convincing. That is, the patient actively processes the explanation to determine if it makes sense, within his or her frame, and assesses the implications. The implications of an adaptive explanation are positive—that is, the explanation foreshadows a solution, and hence provides hope and positive expectations (Moerman & Jones, 2002).

Each type of psychotherapy elaborately provides the explanation, delivered by a culturally sanctioned and trusted healer (i.e., the therapist), to a client seeking help, who will be attempting to make sense of therapy in relation to their problems. Is psychotherapy simply then a placebo? This is not a useful question, in my mind. The mechanisms of placebos have much to tell us about change and provide insight into how psychotherapy works (for a discussion of this issue see Kirsch, 2005).

But there is more. As Frank and Frank (1991) have discussed, to the "myth" must be added *ritual*—therapeutic actions. All forms of psychotherapy have treatment actions, loosely or not so loosely defined. The explanation is not sufficient: Explanation X suggests that if the client enacts Y, he or she will feel better. The treatment induces the patient to do something that is healthy—think about the world more adaptively, expand social networks, reinterpret past events in a constructive way, take another person's perspective, express repressed affect, and so forth. Healthy behavior is a strong predictor of well-being, something that is often ignored (Walsh, 2011). But performing the therapeutic actions goes a step further: As the client copes with problems, a sense of mastery is created (Liberman, 1978). That is, the client has a belief that he or she has control over events, particularly internal events, such as anxiety and depression—Kirsch discusses how psychotherapy (and placebos) creates a change in response expectancies (Kirsch,

1985), and Bandura discusses a change in self-efficacy (Bandura, 1999). Again, however, the client is not a passive recipient, but rather it is the *belief* that one's own efforts are responsible for the control over one's problems that are critical. If a client is led to believe that their symptomatic relief is due to an external source rather than their own actions, then they are likely to relapse (Liberman, 1978; Powers, Smits, Whitley, Bystritsky, & Telch, 2008).

Conclusions

In this article, the characteristics of humans that "make" psychotherapy work have been discussed. To me, that implies that psychotherapy is a "humanistic" activity, at its very essence. However, does that beg the question about whether all forms of psychotherapy are essentially humanistic? Schneider and Langle (this issue) noted, "In psychotherapy, humanism places special emphasis on the personal, interpersonal, and contextual dimensions of therapy and on clients' reflections on their relationship with self, others, and the larger psychosocial world." I would make the claim that this description of humanistic approaches to psychotherapy is exactly the essence of all psychotherapies, as I have discussed. Psychotherapy clients are not passive recipients of treatment—even in the most structured therapies imaginable, the client is actively processing the meaning of the explanation and its acceptability and gauging the effects of therapeutic actions, all the time, making attributions about the situation and his or her role in that situation.

The fact that all forms of psychotherapy are—at least in my opinion—humanistic should not be interpreted as a victory for humanism, as a school of psychotherapy. The goal is not to privilege one approach over another, but rather to understand how psychotherapy works, to improve the quality of the care we provide, and to train therapists to be effective. However, it is clear that a humanistic stance is at the very core of all psychotherapies. The therapist, whether one is a humanistic, psychodynamic, interpersonal, or cognitive–behavioral therapist, needs to appreciate that psychotherapy is a deeply humanistic experience— two humans in a room, in an intense interpersonal interaction.

References

Bandura, A. (1999). Self-efficacy: Toward a unifying theory of behavioral change. In R. F. Baumeister (Ed.), *The self in social psychology* (pp. 285–298). New York: Psychology Press.

Baumeister, R. F. (2005). *The cultural animal: Human nature, meaning, and social life.* New York: Oxford University Press.

Benedetti, F. (2009). *Placebo effects: Understanding the mechanisms in health and disease.* New York: Oxford University Press.

Benedetti, F. (2011). *The patient's brain: The neuroscience behind the doctor-patient relationship.* New York: Oxford University Press.

Benish, S. G., Quintana, S., & Wampold, B. E. (2011). Culturally adapted psychotherapy and the legitimacy of myth: A direct-comparison meta-analysis. *Journal of Counseling Psychology, 58,* 279–289. doi:10.1037/a0023626

Beutler, L. E., Harwood, T. M., Michelson, A., Song, X., & Holman, J. (2011). Resistance/reactance level. *Journal of Clinical Psychology, 67,* 133–142. doi:10.1002/jclp.20753

Boyer, P., & Barrett, H. C. (2005). Domain specificity and intuitive

ontologies. In D. M. Buss (Ed.), *The handbook of evolutionary psychology.* Hoboken, NJ: Wiley.

Cacioppo, J. T., Fowler, J. H., & Christakis, N. A. (2009). Alone in the crowd: The structure and spread of loneliness in a large social network. *Journal of Personality and Social Psychology, 97,* 977–991. doi:10.1037/a0016076

Caplan, E. (1998). *Mind games: American culture and the birth of psychotherapy.* Berkeley, CA: University of California Press.

Christakis, N. A., & Fowler, J. H. (2007). The spread of obesity in a large social network over 32 years. *The New England Journal of Medicine, 357,* 370–379. doi:10.1056/NEJMsa066082

Christakis, N. A., & Fowler, J. H. (2008). The collective dynamics of smoking in a large social network. *The New England Journal of Medicine, 358,* 2249–2258. doi:10.1056/NEJMsa0706154

Cohen, D., Nisbett, R. E., Bowdle, B. F., & Schwarz, N. (1996). Insult, aggression, and the southern culture of honor: An "experimental ethnography." *Journal of Personality and Social Psychology, 70,* 945–960. doi:10.1037/0022-3514.70.5.945

de Waal, F. B. (2008). Putting the altruism back into altruism: The evolution of empathy. *Annual Review of Psychology, 59,* 279–300. doi:10.1146/annurev.psych.59.103006.093625

Dunbar, R. I., & Shultz, S. (2007). Evolution in the social brain. *Science, 317,* 1344–1347. doi:10.1126/science.1145463

Fancher, R. T. (1995). *Cultures of healing: Correcting the image of American mental health care.* New York: Freeman.

Fowler, J. H., & Christakis, N. A. (2009). Dynamic spread of happiness in a large social network: Longitudinal analysis over 20 years in the Framingham Heart Study. *British Medical Journal: British Medical Journal, 338,* 1–13. doi:10.1136/bmj.b1

Fowler, J. H., & Christakis, N. A. (2010). Cooperative behavior cascades in human social networks. *PNAS Proceedings of the National Academy of Sciences, USA of the United States of America, 107,* 5334–5338. doi:10.1073/pnas.0913149107

Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: Johns Hopkins University Press.

Gelso, C. J. (2011). *The real relationship in psychotherapy: The hidden foundation of change.* Washington, DC: American Psychological Association. doi:10.1037/12349-000

Grencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice, 21,* 372–378. doi:10.1037/0735-7028.21.5.372

Hutto, D. D. (2004). The limits of spectatorial folk psychology. *Mind & Language, 19,* 548–573. doi:10.1111/j.0268-1064.2004.00272.x

Imel, Z. E., & Wampold, B. E. (2008). The common factors of psychotherapy. In S. D. Brown & R. W. Lent (Eds.), *Handbook of counseling psychology* (4th ed.). New York: Wiley.

Kirsch, I. (1985). Response expectancy as a determinant of experience and behavior. *American Psychologist, 40,* 1189–1202. doi:10.1037/0003-066X.40.11.1189

Kirsch, I. (2002). Yes, there is a placebo effect, but is there a powerful antidepressant drug effect? *Prevention & Treatment, 5.*

Kirsch, I. (2005). Placebo psychotherapy: Synonym or oxymoron? *Journal of Clinical Psychology, 61,* 791–803. doi:10.1002/jclp.20126

Langman, P. F. (1997). White culture, Jewish culture, and the origins of psychotherapy. *Psychotherapy, 34,* 207–218. doi:10.1037/h0087640

Levy, D. A., & Nail, P. R. (1993). Contagion: A theoretical and empirical review and reconceptualization. *Genetic, Social, and General Psychology Monographs, 119,* 233–284.

Liberman, B. L. (1978). The role of mastery in psychotherapy: Maintenance of improvement and prescriptive change. In J. D. Frank, R. Hoehn-Saric, S. D. Imber, B. L. Liberman & A. R. Stone (Eds.), *Effective ingredients of successful psychotherapy* (pp. 35–72). Baltimore, MD: Johns Hopkins University Press.

Lillard, A. (1998). Ethnopsychologies: Cultural variations in theories of mind. *Psychological Bulletin, 123,* 3–32. doi:10.1037/0033-2909.123.1.3

Meichenbaum, D. (1986). Cognitive-behavior modification. In F. H. Kanfer & A. P. Goldstein (Eds.), *Helping people change: A textbook of methods* (3rd ed., pp. 346–380). New York: Pergamon Press.

Moerman, D. E., & Jones, W. B. (2002). Deconstructing the placebo effect and finding the meaning response. *Annals of Internal Medicine, 136,* 471–476.

Morris, D. B. (1998). *Illness and culture in the postmodern age.* Berkeley, CA: University of California Press.

Painter, C. F. (1913). The evolution of healing. *The Boston Medical and Surgical Journal, 169,* 605–611. doi:10.1056/NEJM191310231691703

Papakostas, Y. G., & Daras, M. D. (2001). Placebos, placebo effect, and the response to the healing situation: The evolution of a concept. *Epilepsia, 42,* 1614–1625. doi:10.1046/j.1528-1157.2001.41601.x

Powers, M. B., Smits, J. A., Whitley, D., Bystritsky, A., & Telch, M. J. (2008). The effect of attributional processes concerning medication taking on return of fear. *Journal of Consulting and Clinical Psychology, 76,* 478–490. doi:10.1037/0022-006X.76.3.478

Price, D. P., Finniss, D. G., & Benedetti, F. (2008). A comprehensive review of the placebo effect: Recent advances and current thought. *Annual Review of Psychology, 59,* 565–590. doi:10.1146/annurev.psych.59.113006.095941

Rosenquist, J. N., Fowler, J. H., & Christakis, N. A. (2011). Social network determinants of depression. *Molecular Psychiatry, 16,* 273–281. doi:10.1038/mp.2010.13

Shapiro, A. K., & Shapiro, E. S. (1997). *The powerful placebo: From ancient priest to modern medicine.* Baltimore, MD: Johns Hopkins University Press.

Shultz, S., Opie, C., & Atkinson, Q. D. (2011). Stepwise evolution of stable sociality in primates. *Nature, 479,* 219–222. doi:10.1038/nature10601

Simpson, S. H., Eurich, D. T., Majumdar, S. R., Padwal, R. S., Tsuyuki, S. T., Varney, J., & Johnson, J. A. (2006). A meta-analysis of the association between adherence to drug therapy and mortality. *British Medical Journal, 333,* 15. doi:10.1136/bmj.38875.675486.55

Stich, S., & Ravenscroft, I. (1994). What is folk psychology? *Cognition, 50,* 447–468. doi:10.1016/0010-0277(94)90040-X

Taylor, E. (1999). *Shadow culture: Psychology and spirituality in America.* Washington, DC: Counterpoint.

Thomas, R. M. (2001). *Folk psychologies across cultures.* Thousand Oaks, CA: Sage.

Tracey, T. J., Lichtenberg, J. W., Goodyear, R. K., Claiborn, C. D., & Wampold, B. E. (2003). Concept mapping of therapeutic common factors. *Journal of Counseling Psychology, 13,* 401–413.

Vail, K. E., III, Rothschild, Z. K., Weise, D. R., Solomon, S., Pyszczynski, T., & Greenberg, J. (2010). A terror management analysis of the psychological functions of religion. *Personality and Social Psychology Review, 14,* 84–94. doi:10.1177/1088868309351165

Walsh, R. (2011). Lifestyle and mental health. *American Psychologist, 66,* 579–592. doi:10.1037/a0021769

Wampold, B. E., & Budge, S. L. (In press). The relationship—And it's relationship to the common and specific factors of psychotherapy. *The Counseling Psychologist.*

Wampold, B. E., Imel, Z. E., Bhati, K. S., & Johnson Jennings, M. D. (2006). Insight as a common factor. In L. G. Castonguay & C. E. Hill (Eds.), *Insight in psychotherapy.* Washington, DC: American Psychological Association.

Wampold, B. E., Minami, T., Tierney, S. C., Baskin, T. W., & Bhati, K. S. (2005). The placebo is powerful: Estimating placebo effects in medicine and psychotherapy from clinical trials. *Journal of Clinical Psychology, 61,* 835–854. doi:10.1002/jclp.20129

Wampold, B. E. (2001a). Contextualizing psychotherapy as a healing

practice: Culture, history, and methods. *Applied and Preventive Psychology, 10,* 69–86.

Wampold, B. E. (2001b). *The great psychotherapy debate: Model, methods, and findings.* Mahwah, NJ: Erlbaum.

Wampold, B. E. (2007). Psychotherapy: The humanistic (and effective) treatment. *American Psychologist, 62,* 857–873. doi:10.1037/0003-066X.62.8.857

Williams, A. C. (2002). Facial expression of pain: An evolutionary account. *Behavioral and Brain Sciences, 25,* 439–488. doi:10.1017/s0140525x02000080

Wilson, E. O. (1978). *On human nature.* Cambridge, MA: Harvard University Press.

Zimbardo, P. G., & Leippe, M. R. (1991). Psychology of attitude change and social influence. New York: McGraw-Hill.