

Psychotherapy and psychotherapy research: Quo Vadis?

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It is a great honor to comment on Tullio Carrere-Comes's paper, as it addresses some of the key issues of the future of psychotherapy integration and psychotherapy as such. Carrere-Comes's concerns regarding the future of our profession are widely shared by researchers and clinicians alike – perhaps more widely than he wants to believe. It is therefore neither appropriate nor productive to speak of a “holy war” in the psychotherapy domain, as Carrere-Comes does. Of course, there are those who believe that scientific findings can and should be used in a prescriptive way in the field of psychotherapy, and that psychotherapy should be nothing more than the application of specific procedures, techniques, and interventions. While it cannot be denied that their ideas have been somewhat influential in recent years, all this has been more a result of power dynamics than of the innovative or convincing nature of their ideas.

Unfortunately, orthodoxy and authoritarianism can be found in all walks of life. But there is no point in creating antagonism and conflict by calling a disagreement in approach and opinion a holy war. Disagreements are an essential component of scientific progress, we should embrace them, and we should not forget that there is still a big difference between the holy wars that have raged on the world scene in the past – and continue to do so today – and the current psychotherapy debate. More importantly, there are clear signs that the pendulum has already started to swing in the other direction: there is now widespread dissatisfaction with current categorically based diagnostic systems such as the DSM as the basis for the development of effective treatments, and major new dimensional approaches rooted in multivariate (Caspi et al., 2014; Costa & McCrae, 2010; Krueger, Skodol, Livesley, ShROUT, & Huang, 2007), personality-based (Luyten & Blatt, 2011), and neurobiological (Insel et al., 2010) theories have emerged. In the domain of psychotherapy specifically, there is a growing consensus concerning the importance of common factors in all *bona fide* treatments (Laska, Gurman, & Wampold, 2014),

and there is a strong movement away from narrow, diagnosis-focused interventions toward spectrum-based, integrative treatments (Bateman, 2012; Weisz et al., 2012; Wilamowska et al., 2010). This has also led to a move away from simple lists of so-called evidence-based treatments to more complex treatment guidelines that consider the importance of empirical support, patient preference, and clinical judgment. This is typical of good science: it has a self-correcting tendency, putting us back on track whenever our ideas take us off course. These are important developments that are already casting doubt on Carrere-Comes's analysis of the psychotherapy debate. But there is more.

In my commentary I will discuss two key issues raised by Carrere-Comes. First, whether there indeed is a “prescriptive movement” driven by naive scientism, as Carrere-Comes argues. Second, whether the dialogic–dialectical model he then proposes offers a viable alternative. My comments are offered in a spirit of openness and the fostering of dialogue. I strongly believe that what our profession needs now is a thorough but balanced reflection on where we want the field of psychotherapy, and psychotherapy research, to move to in the future. This reflective exercise needs to be informed by both scientific findings and clinical wisdom. In fact, in contrast to Carrere-Comes, and like many others, I do not see the two as distinct, but rather as part of a broader critical and reflective attitude that characterizes any scientific enterprise. In this sense the times are changing as well, as more and more researchers and clinicians share this view. I believe it is highly unfortunate that some continue to depict research and clinical practice as separate endeavors, thereby perpetuating an unhelpful distinction between them. Most of the leading scientists in this domain are simultaneously involved in theory building, clinical practice, and research. They are far from the naive scientists Carrere-Comes desperately wants us to believe they are, that is, researchers who feel superior and who look down from their ivory tower upon

mere clinicians (because they themselves are clinicians in the first place and are also involved in the development and dissemination of their treatments). I will argue that this is why both proponents of scientism in the domain of psychotherapy, as those who hold the view that scientific findings are of little or no relevance for psychotherapists – like Carrere-Comes– are mistaken. Their views both originate in the false and increasingly obsolete dichotomy between science and clinical practice.

Is there really a prescriptive model of psychotherapy?

One of the central assumptions made by Carrere-Comes is that there is a prescriptive model of psychotherapy that instructs therapists “what to do” on the basis of scientific findings. But do such prescriptive models of psychotherapy really exist? Are there researchers or clinicians who hold such views?

It is perhaps very telling that Carrere-Comes does not give a single example of such prescriptive models or approaches. If they are so widespread, why not start by giving a series of examples? I would be very curious to see a discussion of such examples by the author. In all honesty, in preparing this commentary I had a very hard time locating examples of such “prescriptive” approaches. The nearest I came were some (but definitely not all) cognitive-behavioral approaches for the treatment of discrete and isolated symptoms and complaints such as phobias. Some of these manuals indeed “tell” the clinician what to do in detail, although they still leave considerable room for flexibility and clinical judgment – an issue to which I will return in more detail below. Further, as Westen, Novotny, and Thompson-Brenner (2004) pointed out quite some time ago, these interventions are often very effective when used for the treatment of problems they were developed for, as meta-analyses suggest. But there is still more. Recent

findings concerning self-help and internet-based interventions suggest that even the simple application of interventions without the presence of a therapist can be quite effective in a considerable subgroup of patients (Andersson et al., 2012; Johansson et al., 2012). These findings in themselves cast doubt on the universality of the psychotherapy model that Carrere-Comes is proposing. If anything, they should urge him to rethink his central argument that “If the common factors do not depend on the theory and technique of the therapist, they cannot depend on anything else than the inner logic of the therapeutic relationship”, as there is no therapeutic relationship in most of these interventions – at least, definitely not the kind of therapeutic relationship that Carrere-Comes deems necessary for any type of psychotherapy to be effective. And what about the other key argument that he proposes for effective therapy: “If the therapist starts acting in their usual way ... before the client has had the experience of being really listened to and understood, the chance that the therapy will not work very well is significant (you don’t have to put to empirical test such statement)”? Well, this statement has been put to the test, and as we just saw disproving Carrere-Comes’s central claim, once more demonstrating the great importance of scientific research for checking our cherished beliefs.

This also leaves us with the question what *could* explain the effects of psychotherapy – whether with or without a therapist being present – a question Carrere-Comes never answers. He focuses only on what does not seem to be effective, wrongly concluding from findings concerning the Dodo bird verdict (that the outcomes of all *bona fide* treatments are roughly equal) that specific techniques, interventions, and theories do not matter. Granted, this error is made repeatedly in the psychotherapy literature (see Fonagy, Allison, & Luyten, in press for an overview and a different perspective). But, even in brief, focused treatments, regardless of their theoretical orientation, there is ample attention for nonspecific factors such as empathy, the

importance of a shared illness theory, providing hope, etc., as well as patient preference and clinical decision-making as I will discuss in greater detail below. These notions are a central part of the guidelines of the American Psychological Association (2013), so can hardly be depicted as the view of a (clinical) minority.

The more one moves toward the treatment of more complex problems, the more the importance of these factors is emphasized in research and treatment manuals. Compare, for instance, the manuals for dialectical behavior therapy (DBT; Linehan, 1993), mentalization-based treatment (MBT; Bateman & Fonagy, 2006) and schema therapy (Young, Klosko, & Weishaar, 2003) with regard to their focus on the importance of validation, empathy, offering structure, the flexibility of the clinician to deal with crises, etc. The same can be said with regard to treatments for depression, for instance (Luyten, Blatt, & Fonagy, 2013). This does not mean that theory is unimportant. By contrast, there is great variability in the empirical validation of different theories concerning the nature of psychopathology, and thus it is not the case that “anything goes”. In fact, the importance of offering a theoretically coherent, consistent, and continuous treatment is currently considered to be the main factor explaining the efficacy of current evidence-based treatments, particularly treatments aimed at severe psychopathology (Bateman & Fonagy, 2009; Clarkin, Fonagy, & Gabbard, 2010).

Further, research has amply demonstrated the importance of the integration of clinical experience, theoretical thinking, and scientific research as part of a cycle, and not as separate endeavors as Carrere-Comes wants us to believe. Everyone who is familiar with the psychotherapy literature knows of the many examples where outcome (and process–outcome) research has led to a rethinking of theoretical conceptualizations and then the development of

new clinical interventions, which then have been empirically evaluated, starting the cycle all over again.

In fact, there are clear indications – again based on research findings (!) – that because of this learning process involving the development and systematic evaluation of new treatments, therapists across the board are offering less iatrogenic treatments than in the past, particularly to more seriously ill patients (Fonagy & Bateman, 2006). A pessimistic interpretation of this body of research suggests that we might perhaps have not so much improved in terms of developing more effective interventions as such, but that our interventions generally have become more effective because they have become less iatrogenic. This also seems to have resulted in the increasing efficacy of routine clinical treatments, as is shown in increasing effect sizes of so-called treatment-as-usual conditions in more recent trials compared to earlier trials (Luyten, 2014; Luyten, Blatt, & Mayes, 2012). However, this may also reflect an increase in the placebo effect (a non-specific factor), as there is a widespread growing belief in the treatability of mental disorders (Walsh, Seidman, Sysko, & Gould, 2002).

This also questions another key assumption of Carrere-Comes, namely that “Clinicians make very little use of empirical research, and mostly don’t even read it, because they don’t find it very useful for their practice the study of factors isolated from the context”. First, Carrere-Comes vastly underestimates the direct (let alone implicit) influence of research findings on clinical practice. Even a quick perusal of the reading list of clinical and psychotherapy training programs demonstrates the vast influence of both basic and outcome research findings on the training of future psychotherapists. With the exception perhaps of the most orthodox training programs, it is very hard to imagine a training program in cognitive-behavioral therapy (CBT) that does not include a module on DBT or mindfulness, models that have been amply

investigated in both naturalistic and controlled trials. Similarly, psychoanalytic training programs without a module on current evidence-based treatments are increasingly difficult to find, and training programs in humanistic psychotherapy have always included a focus on detailed process research. And then there is the vast implicit influence of both scientific and societal developments on psychotherapy (Luyten, 2015; Safran, 2009). For instance, Carrere-Comes himself emphasizes the importance of the mirroring of patients' needs, wishes, and concerns, particularly in the early stages of treatment, in combination with validation and a general empathic stance. I personally wholeheartedly agree with this emphasis, but this is something one does not find in the standard psychoanalytic textbook of technique (except perhaps in more recent handbooks that have been influenced by research findings concerning the importance of these factors). Instead, it is something that has emerged first and foremost from the humanistic tradition, forerunner in the domain of detailed process–outcome research, and also from DBT and MBT, two treatments that have arisen from the confluence between theory, technique, and research, which are both strongly rooted in developmental research that demonstrates the key role of validation in human development. A case of cryptomnesia, Carrere-Comes's emphasis on mirroring, validation and empathy?

Replacing a straw man prescriptive model with a tacit prescriptive approach

The above discussion brings us to the second key issue in Carrere-Comes's paper: that the field should adopt a position that “supports the freedom of each therapist to work in the way that best fits their personality” and to do “what feels right at the time” in treatment. This approach is once more juxtaposed with a purportedly science-based prescriptive model that tells the therapist what to do at each time: “The researchers prescribe to clinicians, the clinicians prescribe to patients,”

argues Carrere-Comes. Again, perhaps with some deplorable exceptions, this is not the way that scientific findings have influenced psychotherapy – or, for that matter, are influencing psychotherapy today. Science-driven psychotherapy research, as we have seen, is not prescriptive in the sense that it “tells the therapist what to do or not to do with whom.” This, clearly, is setting up a straw man to then knock it down.

There may also be an important bias at play here. Throughout his paper, Carrere-Comes uses a cryptically described longer-term variant of psychoanalytic treatment as the prototype of what “good” psychotherapy practice should entail. I find myself in agreement with many of the elements in this cryptic description, which, in my humble opinion, is much influenced by new theoretical, empirical, and clinical developments in psychoanalytic treatment as well as by research on common factors. But it cannot be a universal model of psychotherapy, as outlined earlier; nor does it explain how psychotherapy may be effective or how we could increase its efficacy (and/or decrease the number of iatrogenic components). Not everyone needs, wants, or has the means to enter into such a long-term treatment. Nor has this model been shown to be superior to other treatments that often start from very different basic assumptions (remember the Dodo bird verdict!).

This aside, the model that is described is prescriptive as well. It is the clinician prescribing to other clinicians and researchers what good psychotherapy should look like! Pay attention to the language used: “other therapists know better [sic]: they don’t take this experience (of being understood) for granted and introduce into their work some practice of mirroring, which consists in paraphrasing what the client has just said, being careful to avoid any judgment, confrontation, suggestion or interpretation, asking for feed-back, going on until the result is good enough”. Carrere-Comes could be right here, as there are many research reviews supporting such

an attitude, which, again, differs dramatically from the standard psychoanalytic textbook's emphasis on neutrality. Note again that the concept and the potential importance of mirroring emerged out of infant research and mentalization-based approaches specifically, both of which are strongly dedicated to the empirical study of dyadic processes. Carrere-Comes then goes on: "Next, it is the practice of genuine dialogue that logically requires and experientially proves the possibility and necessity of self-forgetfulness." But we have seen that, at least for a sizeable group of patients, treatments that do entail such a dialogue can be very effective. Again, my point is not that the proposed theoretical approach does not make sense from a clinical perspective or that it would be completely at odds with empirical findings. Rather, my point here is that it cannot be a *universal* model of psychotherapy, and that it is equally as prescriptive as the disavowed, purportedly prescriptive, approach rooted in science. Carrere-Comes may deny this, but of course it can be denied only if one believes in the straw man version that there is a scientific approach that prescribes every step in the therapeutic process. We simply need some kind of prescription; without one, there would be total chaos. And here we stumble upon the major problem with Carrere-Comes's approach: what if we disagree about the proposed approach? If systematic empirical research is not relevant, how then can we ever know that what we are doing is effective, or simply superstitious behavior that is perpetuated because we believe it is associated with improvement (Fonagy, 2010), or even iatrogenic? And what then does explain the effects of psychotherapy if it is not the therapeutic relationship or dialogue (Fonagy, Luyten, & Allison, in press)?

This brings us back to the confluence of clinical wisdom, theory, and research findings. It is wrong to suggest that even the most empirically supported psychotherapies are prescriptive in the sense that Carrere-Comes suggests, and that each and every aspect of them is rooted in

scientific findings. Rather, most treatment manuals are not cookbooks that prescribe every single step in detail, but rather provide general principles, techniques, and interventions that clinicians can rely on in the various stages of treatment. My personal experience, and that of many of the therapists I have trained with – and trained – is actually exactly the opposite of what Carrere-Comes suggests: manualized treatments are not felt by therapists as a harness that hinders their being flexible in treatment as Carrere-Comes suggests, nor do they promote one theory to the level of absolute truth. Again, research findings contradict Carrere-Comes's assumptions. To mention just a few examples related to my own personal experiences. Clinicians trained in Dynamic Interpersonal Therapy and MBT typically report that training in these manualized treatments has increased their capacity to respond flexibly to unexpected situations in treatment (Bateman & Fonagy, 2009; Gelman, McKay, & Marks, 2010).

Another good example in this context is the Improving Access to Psychological Therapies (IAPT) initiative in the UK, which has identified specific competences that therapists trained in a particular theoretical approach (e.g., CBT, psychodynamic or humanistic) should possess, based on a detailed study of treatment *manuals* of therapies with demonstrated efficacy (the kind of manualized treatments that Carrere-Comes depicts as “prescriptive” and in contrast to a dialogical-dialectic approach). The IAPT initiative also led to the identification in these manuals of a set of meta-competences that all therapists, regardless of their theoretical orientation, should have. These meta-competences include the capacity to apply the theoretical model “flexibly in response to the client’s individual needs and context,” and an “ability to foster and maintain a good therapeutic alliance, and to grasp the client’s perspective and ‘world view’” (Lemma, Target, & Fonagy, 2010). This comes eerily close to Carrere-Comes’s emphasis on the need for flexibility, the bracketing of theory, and establishing a therapeutic relationship

that fosters validation and understanding, does it not? But it is not merely based on “clinical wisdom”, but on treatments that have emerged out of a dialogue between theory, clinical practice, and research. And perhaps most importantly: treatments with demonstrated efficacy. And what about this conclusion based on a review of relevant empirical research: “rigid adherence to the application of psychotherapy techniques can be a potentially harmful therapist behavior that necessitates careful training on the nature and flexible use of interventions” (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010, p. 34). Indeed, if research has taught us anything, it is that clinicians who lack these meta-competences do not do well with most of their patients (Ackerman & Hilsenroth, 2001; Blatt, Zuroff, Hawley, & Auerbach, 2010; Grant & Sandell, 2004). Where is the contrast with the “dialectic-dialogical” model?

Which brings me to a final, but important, point: there is great variability between therapists in their effectiveness (Castonguay et al.; Crits-Christoph & Gallop, 2006; Zuroff, Kelly, Leybman, Blatt, & Wampold, 2010). Perhaps Carrere-Comes is one of those gifted master clinicians who intuitively knows what is effective and what is not with each patient (Goldfried, Raue, & Castonguay, 1998). But most of us aren't, and need all the support we can get, as, I'm sorry, both clinical experience and research again clearly demonstrates. We cannot therefore leave everything up to the individual clinician to do “what feels right at the time” in treatment. Studies of videotaped sessions – in the context of either research or training and supervision – show us how much each of us still can learn, and how much room there is for improvement of therapist skills. Therefore, prescriptive models are needed, but not, as I have hoped to demonstrate, models of the nature Carrere-Comes depicts. Rather, prescriptive models support us and offer us ways to improve what we do in our daily clinical practice. At the very least, they may prevent us from doing harm to our patients.

Conclusions

My main argument is that good psychotherapy is not a matter of either science or clinical wisdom, but of the combination of theory-driven research and clinical practice. I do not consider these to be distinct enterprises, but rather, as do most current researchers and a growing number of practitioners, as part of a broader critical and reflective attitude. With the growing emphasis on the integration of science and clinical practice in research, clinical training, and treatment guidelines, the future generation of therapists is likely to have very different attitudes toward debates such as the current one. Historically, many clinicians have had little exposure to treatment research and have been trained in clinical models that were passed down from generation to generation, without any felt need to systematically evaluate what was passed down from generation to generation. It shouldn't surprise us that this led to hundreds of different therapeutic models, and battles over who developed the most effective model. With the systematic evaluation of different treatments came the growing realization that there are probably only a very limited number of mechanisms of change, that we need to identify these mechanisms, and that clinicians thus need to be aware of this growing body of knowledge.

But we are not there yet. I therefore sincerely believe that the cause that Carrere-Comes stands for is a noble and a just one: he seems genuinely concerned with the future of psychotherapy and the welfare of patients. There are undeniably forces that threaten the future of good psychotherapy. I have been involved in research and academics for too long to be blind to the potential destructive influence of naive scientism, however well-intended it may often be. It is therefore important to take this debate seriously, as it still influences the hearts and minds of some. Given that a new generation of therapists has a far better grasp of the possibilities and

difficulties to integrate science and clinical practice, as I have tried to demonstrate, however, we would do better to join the many who believe that psychotherapy is more than the mere application of scientific findings, but also more than an art. We have a major responsibility in this regard. Rather than splitting the field, which might have been an appropriate response to naive and simplistic views in the past, we should be open to new developments and knowledge and what they can teach us about the workings of the human mind.

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