STRUGGLING WITH PSYCHOLOGICAL TREATMENTS COMPARISON: LOOKING FOR PRACTITIONER'S SURVIVAL

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Los intensos debates sobre la eficacia diferencial de las psicoterapias nos sitúan en un impasse que analizamos desde dos perspectivas: a) el debate académico, marcado por el contraste entre una propuesta dominante (tratamientos basados en la evidencia) y una serie de alternativas (movimiento de factores comunes, énfasis en las relaciones terapéuticas, desarrollo de la excelencia profesional); y b) el impacto emocional en los profesionales, abrumados ante el gran número de propuestas, la poca aplicabilidad de algunas de ellas en los contextos habituales de trabajo, o las decepciones que conlleva la lealtad a algunas terapias que se revelan fallidas. Con objeto de superar fructíferamente este estancamiento sugerimos adoptar una actitud diferente, que implica aplicar cierta irreverencia, aceptar algunos límites epistemológicos, valorar la sabiduría práctica, tolerar cierta ingenuidad, y cultivar como profesionales algunas actitudes de las que recomendamos a nuestros pacientes.
Palabras clave: Psicoterapia, Tratamientos psicológicos, Terapias basadas en la evidencia, Factores comunes.

Hot debates about the comparative effectiveness of psychological treatments have led us to an impasse. This is analyzed from two perspectives: a) an academic debate, where the most acknowledged proposal (evidence-based treatments) is compared with a number of alternative ones (common factors models, psychotherapy relationships, expertise in psychotherapy); b) the emotional impact on practitioners, who can feel overwhelmed by the huge number of models, the mismatch between them and the typical work environments, and disappointments after committing allegiance to therapies that turn out to be fallible. In order to overcome this stalemate in a fruitful way, a new approach is suggested, which involves applying a certain amount of irreverence, accepting epistemological limitations, valuing practical wisdom, tolerating a certain ingenuity, and developing some of the attitudes we recommend to our patients.
Key words: Psychotherapy, Psychological treatments, Evidence-based treatments, Common factors.

DEBATE AND AN IMPASSE

A We are currently witnessing an interesting debate (which is no stranger to this journal) about the differential effectiveness of psychotherapeutic interventions, where academic issues, professional definition and healthcare organization come into play. However, the academic aspects are the most referenced, within a conflict marked by a succession of studies on the similarities-differences and advantages-disadvantages of different psychotherapeutic proposals. These conflicts, despite the enormous effort deployed in them, are as yet incapable of producing victors, which suggests the convenience of adopting alternative approaches that will take us out of the current impasse. The aim of this article is to offer an analysis and some reflections that will guide us towards an enriching exit for our profession.

AN ACADEMIC HISTORY

The first psychotherapeutic proposals were raised by the different psychological models (psychoanalytic, behavioral, humanistic, cognitive, systemic, etc.) as they developed. This occurred in a climate marked by conflict among the schools, and by the need to differentiate one from the other, such that each model defended its identity and the supremacy of its proposal. Later, especially from the 1950s onwards, demand began for treatments that defend their efficacy through empirical studies (Lambert, 2013). Some of the theoretical frameworks were more willing than others to take this step; the cognitive-behavioral proposals assumed the leadership, while other schools alleged obstacles of different kinds when testing their therapeutic efficacy (for example, the essentially "ungraspable" character of a therapeutic process characterized by fluency and privacy) .

Those who advocated testing the models benefited from a movement that emerged from another clinical setting, that of evidence-based medicine. Taking this as a model, many psychotherapeutic proposals were submitted to

studies to compare their performance (efficacy, effectiveness, efficiency, etc.) with that of other models, psychological or others. Talk began of "treatments with empirical support", "evidence-based therapies" and other similar expressions. Randomized clinical trials became the "gold standard" methodology, and two ideas were adopted from medicine: every treatment contains specific ingredients and is designed for an equally specific psychopathological condition. Thus, academics and institutions developed guidelines with psychotherapeutic proposals that had undergone these processes, and thanks to this they received a certain seal of validity (Pérez, Fernández, Fernández, & Amigo, 2003). But moreover, it seemed to be a path that had to be traveled in order to lose innocence, to cease to assume the validity of these treatments, and to prove it to society as a whole (Pérez, 2013).

Although this proposal has become the dominant one, it has not been exempt from questioning (Lambert, 2013). First of all, we highlight the surprise (and frustration) of not finding therapeutic proposals that are clearly differentiated from the others in terms of efficacy. Even models that were expected to be excluded joined this trend and passed the tests, such as the psychoanalytic model (Fonagy, 2015). Where it was expected to find decisive verdicts, instead uncertainty and arguments arose. The proposals for overcoming this impasse (meta-analysis and later meta-meta-analysis) have given rise to arguments and counter-arguments that do not enable us to get out of the impasse (González-Blanch & Carral-Fernández, 2017). But basic principles of this proposal are also questioned, such as:

a) it being based on nosological categories of dubious validity, so the very concept of mental disorder that is at the base of the model of evidence-based practices is questioned, habitual classifications are rejected or alternative proposals such as transdiagnostics are presented (Marchette & Weisz, 2017; Sandín, Chorot, & Valiente, 2012). Also criticized is the idea (very established in the medical world) of a specific cause that gives rise to an equally concrete problem, from which an also specific therapeutic intervention derives. The result criterion is also questioned, up to now very much based on the reduction of symptoms. Therefore, the question arises: What if the whole of that ambitious building of evidence-based therapies had been built on a weak foundation?

b) it being based on a methodology (randomized clinical trials) which, although very useful, does not exhaust the possible approaches to this field. Considering the prestige of this research model, and that one of the objectives of the first efficacy studies of psychotherapy was to compare it with psychopharmacological interventions, it was not strange to resort to it. But limiting the research to what fits this study instrument would imply a reductionism and impoverishment of the concept of science (Beutler, 2014).

While this bitter debate was developing, appeals were increasingly made to an old Rosenzweig proposal (1936), inspired by a passage from "Alice in Wonderland", where the Dodo bird considers that all participants in a competition have won and they should have a prize. Thus arose the well-known "Dodo bird verdict". According to this, perhaps all the psychotherapeutic proposals (by this we mean the serious ones) would be more or less equally effective. More than just an inspiration, this idea gave rise to fruitful studies about what have been called "common factors" to all psychotherapies, such as the expectations of being cured, the instillation of hope, or the therapeutic alliance (Wampold, 2015). The verdict of the Dodo bird has also generated fierce debates. In this sense, it is curious to review the titles of some articles, where they talk about caging him (González-Blanch & Carral-Fernández, 2017) or killing him (Hoffman & Lohr, 2010), or he is considered an "urban legend" (Hunsley & Di Giulio, 2002).

This journey that we have reviewed briefly has resulted in a bitter and unresolved confrontation. On one side is the proposal, perhaps dominant, that defends the specificity of the therapeutic models (own and differential effects, aimed at specific mental disorders). On the other, a series of alternative proposals that diverge from this. Among them we could point out three that are illustrative to the understanding of the general field of this dispute:

a) The common factors movement, in which it is stated that psychotherapy contains a number of elements that are necessary and sufficient for change: an emotionally charged therapist-patient bond, a healing context of trust in which the therapy takes place, a therapist who provides a (culturally adjusted) psychological explanation regarding the emotional distress, and a series of procedures or rituals (Laska, Gurman, & Wampold, 2014). Based on this approach, it is

understood that all therapies containing these ingredients will be effective. In addition, relationship factors such as empathy, spirit of collaboration, or the therapeutic alliance will predict the outcome of the psychotherapy. In this approach we would include the proposals that try to delimit the variables linked to psychotherapy, and the complex relationships that are established between them (Beutler, 2014; Beutler, Forrester, Holt, & Stein, 2013).

b) Proposals that emphasize aspects of the therapeutic relationship. As opposed to evidence-based *therapies*, evidence-based *therapeutic relationships* would be sought. The basic idea is that therapeutic relationships make substantial contributions to psychotherapy, regardless of the specific type of treatment, and in fact, they influence at least as much as the treatment itself (Norcross & Lambert, 2014). In recent years, this proposal seems to have adopted the same spirit of searching for evidence and meta-analysis as its inspiration (evidence-based therapies), which has led it to collect relational elements that influence the therapeutic process positively or negatively. For illustrative purposes we can highlight the conclusions of the second task force promoted by the American Psychological Association. The systematic collection of research data on the elements that make up the therapeutic relationship allowed this group to determine the ones that have been proven to be effective: alliance in individual psychotherapy, alliance in child and youth psychotherapy, alliance in family therapy, cohesion in the group therapy, empathy, and collecting feedback from the client (Norcross & Wampold, 2011). In the climate of confrontation that presides over these debates, there seems to have been a dispute between the defenders of the models (which refer to the classic procedures of testing evidence, and are usually based on specific diagnoses) and the defenders of the therapeutic relationship (who emphasize the importance of the latter, regardless of the model and the diagnosis). In a simplified way, we find ourselves between the defenders of the relationship and the technique, between those who emphasize the *what* (the technique) and those who focus on the *how* (the relationship). This has generated what could be a false and unproductive dichotomy (Norcross & Lambert, 2011).

c) Proposals focused on the practitioner. From the idea that what is most important is not what treatment is provided, but who is conducting it, interesting contributions are being made; see for example the 2017 monograph of The Counseling Psychologist on "Therapist Expertise" (Volume 45, number 1), or closer to us, the review by Prado-Abril, Sánchez-Reales, & Inchausti (2017). Nevertheless, and guided by the illustrative eagerness that we indicated at the beginning, we are going to choose a specific proposal; it is the "Supershrink" project (which can be translated into Spanish as "superloquero"), led by the International Center for Clinical Excellence (www.centerforclinicalexcellence.com) (Miller, Hubble, & Duncan, 2007). It is again a rejection of the medical perspective of mental health and the orientation based on therapeutic models. The proposed alternative is to direct attention to the process by which a practitioner develops their professional expertise in order to (if they do it effectively) become an expert, a "supershrink". If we have talked about evidence-based *therapies*, and evidence-based therapeutic *relationships*, we could now move on to discuss evidence-based *therapists* (Miller, Hubble, Chow, & Seidel, 2013). Thus, the search has begun for the elements that allow a practitioner to distinguish themselves from their colleagues due to their success in patient care. The great inspiration for this search has been K. Anders Ericsson, considered the "expert of the experts", for his work on excellence. The study of this in very different areas of practice has led him to propose, as a key element, the "deliberate practice" (Ericsson, Krampe, & Tesch-Romer, 1993). This implies, among other things, working hard and doing so just beyond the level of expertise (and comfort) that one has already reached. To be a "supershrink" one would not have to adjust to specific treatment protocols, nor develop one's diagnostic skills, but rather to add to the chosen therapeutic model a series of concrete practices that would generate a "cycle of excellence": determine your base line of effectiveness, commit yourself to a deliberate practice and get feedback (Miller, Hubble, Chow, & Seidel, 2013).

One thing these proposals have in common is their attempt to stay away from specific psychotherapeutic theories or models, and even diagnoses. Therefore, they are easily applicable to very different models. The idea is

that the psychotherapy is not done by the models, but by the psychotherapists and the relationship they generate; and that although supported by models and techniques, the psychotherapists and relationships are the central element. This does not necessarily mean an abandonment of the therapeutic models (Truscott, 2010), but they would not contain the key therapeutic element, rather it would be the relationship context in which these other factors (the common ones, the therapeutic relationship, the factors of change, the generators of professional excellence, etc.) exert their influence.

This journey that we have briefly described, so loaded with debates and conflicts, offers us an image of our profession that highlights the richness of the contributions, and the ultimate confusion this causes. These confrontations have forced us to scrutinize, investigate and reflect on what we do. This has led us to try to delineate clearly what our therapeutic practice consists of, and it has motivated us to make it more transparent to our colleagues. But it has also thrown us into a state of doubt and confusion, not only among the academics who carry out investigations and debates, but also among the bewildered and sometimes lost practitioners of the profession, and the patients they are trying to help.

OVERWHELMED PRACTITIONERS

How are these debates experienced in the process of becoming and practicing as a psychotherapist? The practitioners are the protagonists of these disputes and must position themselves; at the least, they will have to choose from among the numerous therapeutic practices in the field. And in this situation exasperating experiences could arise that may be disregarded. The profession of the psychotherapist is full of myths, taboos and uncomfortable topics that tend to be ignored in public forums, and that usually lead us to uncomfortable professional situations, and to emotions that embarrass us (Pope, Sonne, & Greene, 2006). The ones we are going to talk about are not usually the objective of academic studies, nor do they appear in impact journals, but they do occupy a certain space in professional meetings, especially when dealing with small and informal groups. Given that psychotherapy tends to be studied more than the psychotherapist (Orlinsky & Rønnestad, 2005), some problems and experiences are not made public.

At these times it is easy to feel overwhelmed by the enormous number of therapeutic proposals available. In addition to the main traditional models, there are numerous well-developed specific therapies. Likewise, the breadth of our field and the consequent specialization has given rise to proposals for very specific areas of intervention (borderline personality disorder, intervention in trauma, parent-child relationships in disadvantaged contexts, etc.). This panorama means the practitioner is confronted with their inability to encompass such wide and diverse fields of knowledge. As well as the intellectual limitations, there are logistic and financial ones. There are models that establish very formalized training and accreditation procedures, and this implies an significant effort in time, work and money. For practitioners working in generalist contexts, these appeals from so many places (sometimes very different) can be very demanding and even overwhelming. We do not even have the old resource of sectarianism (the firm adherence to a school of belonging), which provided the security of unconditionally defending the model in which one has been trained: from an honest stance, the most we can aspire to is to think that our model solves certain things a little better.

Undoubtedly, at this moment there is pressure on the practitioners aimed at the application of treatments based on evidence, that is, properly structured and manualized, with defined objectives and standardized procedures. For this, the ethical and intellectual obligation is called upon to make use of scientifically validated knowledge (Tortella-Feliu et al, 2016). Indeed, some of these proposals not only underscore their technical superiority, but even the ethical imperative of choosing it over other procedures; thus, there is a fertilized field for the feeling of guilt.

The knowledge of these proposals, well formalized and studied in research contexts, can lead the practitioner to a sense of incompleteness or incompetence. Compared with the more aseptic contexts or those with more research experience, the standard practitioner will find him or herself in more complex and precarious situations. This can lead to a constant struggle to adjust patients or the work environment to impossible standards set by the model. Practitioners (especially in public contexts) encounter poorly defined clinical conditions, with vague demands, weak commitments, and high comorbidity. Many of these manualized proposals begin with formal therapeutic work with the patient; but in the applied contexts the first major concern of the practitioner is an

earlier one, because the great challenge in the first interview is to make the patient want to come back: to return to formalize a diagnosis, to create a minimum therapeutic alliance, to set a commitment... and then to begin "the therapy". Even with the patient already delimited and committed, the intervention will face practical limitations, both in the patients (economic availability, accessibility, support of the environment) and in the practitioners (little time to attend to the patient, absence of spaces to reflect on the case, scant external support, etc.).

Indeed, it is common for the practitioner to attend to patients with vague demands and, due to particular organizations of personality, they put the aspects of the therapeutic relationship in the foreground, forcing the postponement (or waiver) of complete formulations of the case; and it is precisely these that usually start standardized treatments. Possibly this is one of the reasons why evidence-based treatments are so difficult to extend in the care units (Fonagy & Allison, 2017; Marchette & Weisz, 2017). It may turn out that the therapeutic procedures with empirical evidence really are valuable but constitute a small, very selective package of psychological interventions, insofar as they would be aimed at selected patients and equally selected resources (or practitioners).

One last experience leads us to disappointments. There have been many therapeutic procedures that appeared to be dazzling proposals, attracted the interest of practitioners, and then deflated. What happens to the practitioner who was excited about them, made a great effort to assume them and was finally disappointed? This has happened with proposals as established as cognitive therapy. For example, cognitive-behavioral therapy for depression has recently been the subject of several meta-analyses that call into question the efficacy that it has always demonstrated; among these we highlight that of Johnsen and Friborg (2015) published in the Psychological Bulletin of the APA. As to be expected, this study has given rise to a series of replications (for example, Ljótsson, Hedman, Mattsson, & Andersson, 2017) and counter-replications (Friborg & Johnsen, 2017), that leave us in uncertainty. And if this happens in already veteran formats with reliability evidence, what can we expect in other more recent and trendy proposals? A very illustrative example is found in EMDR, which generated great debate from the first moment: it

presented an all-encompassing proposal to work with traumatic conditions, but at the same time it gave rise to many criticisms, due to technical issues and the training system (controlled and expensive) (Davidson & Parker, 2001), even being compared with mesmerism (McNally, 1999). And if after such a long journey, it is confirmed not to be so effective, what happens to the practitioner who got excited, bought the product and sold it to his patients?

After this journey marked by skepticism, it seems necessary to re-emphasize the richness of all of the contributions that have been made; and this is not an obstacle to directing a careful look at all of these very human elements that support the practitioner's view; if we do not pay attention to the practitioner, we could continue to invest great effort in generating procedures that are not used, and then become indignant about it.

PROPOSALS FOR SURVIVAL

We are, therefore, in the middle of great debates that are as yet unresolved. Evidence-based *therapies* or *techniques*? Formalized *procedures* versus interventions based on the *relationship*. Emphasis on *techniques* and *procedures*, or on the *practitioners*? And so it goes on. Philosophical thinking has familiarized us with the idea that the dispute between two opposing arguments (thesis and antithesis) can be overcome when we succeed in creating a new vision that surpasses this one, either through an integrating synthesis, or through a paradigm shift. This seems to be especially necessary when the complete defeat of the rival idea is not possible. How does one build a vision of the problem that allows us to generate new perspectives and approaches? Let us note down some ideas that may help us in that search.

Irreverence

When three great figures of family therapy improvised a taskforce to analyze difficult cases, the proposed concept to favor the therapist's survival was "irreverence" (Cecchin, Lane, & Ray, 2002); difficult cases require the therapist to show irreverence with respect to the knowledge given, be it the theory and techniques of his training, or the vision that patients, their families or colleagues present to him. Proposals such as these generate suspicion because they seem to invite unsystematic practices, and involve discarding the valuable contributions that so many practitioners have

formalized. But these therapists posed a precondition: this type of irreverence can only develop with respect to knowledge that has been well acquired and dominated. In other words, it is necessary to have been trained in a model and know it well, in order to be irreverent with it. It is a valuable idea because it allows us an exit from a false dichotomy: individual spontaneity versus manualized models. It is necessary to master a model, a technique, or a practice in order to have the freedom to skip ahead, make adaptations and be creative.

Epistemological limits

Perhaps it would help us to understand this impasse if we recognize that we are in the midst of an epistemological crisis. From many fields of knowledge (philosophy, biology, sociology, physics, economics, etc.), there have emerged epistemological approaches that converge in a questioning of the traditional premises of positivism, both at a conceptual and methodological level. This implies moving on to constructivist and constructionist visions, from which there is no reality independent of the observer; the linear logic that has facilitated the progress of science so much, gives way to other types of logic (circular, complex, confusing, etc.). It is the paradigm of complexity, which has also knocked at the doors of psychology (Munné, 2004). All of this fits with a different way of seeing and positioning oneself in the world, postmodernity, from which the world of psychotherapy has not remained detached (Feixas & Villegas, 2000). However, modern approaches persist, so the psychologist of the beginning of the 21st century is situated between modernity and postmodernity, and the field of psychotherapy is also experiencing this confusion. Postmodern thought is invading us progressively, and bringing us back to complexity. It shows us the futility of looking for simple and linear explanations, and the inappropriateness of aspiring to great models that explain everything, leading us instead to constructivist approaches or to chaos theory, with its dynamic, complex or non-linear systems.

But despite this cultural context and post-modern professional practices, the most widespread research methodology is still modern. The t, ANOVAS and the bulk of the study procedures in which we have been trained and which are still a basic criterion of our research, are typical of a modern, linear, empiricist mind... Thus, we could be evaluating our professional practice with tools that do not

fit the complexity with which we wish to understand psychotherapy, a process so complex and difficult to grasp with simple and linear logic. We have noticed the complexity of our object of interest (psychotherapy) but we have not yet developed instruments of study at the level of this complexity. It is easy to consider that our intervention with the patient creates a non-linear dynamic system, the type of system that the new sciences of complexity approach, which provides us with concepts such as "attractor ", "deterministic chaos" or "emergence" (Coderch, 2013). But possibly they are still insufficiently developed, at least in their application to our discipline; and even if their development is forthcoming, their level of complexity could involve such a level of intellectual challenge that the majority of practitioners will be forced to continue with more simple and "imperfect" visions. In that case we would continue to be postmodern minds with modern tools...

The value of the leap

Patients turn to psychotherapy in relation to some distress or discomfort for which they seek help. We practitioners have approached these difficulties using psychopathological models, which involve a specific way of understanding and classifying psychological problems. Undoubtedly the perspective that has been dominant is indebted to the psychiatric, and therefore medical, vision of mental disorders. This model has enabled great advances to occur in psychotherapy, but nowadays critics warn of the restrictive effects of this perspective, and underline the maturity that clinical psychology already has to propose models more established in our own discipline (González & Pérez, 2007; López & Costa, 2013). Some of these proposals move from understanding mental disorders as "natural entities" to conceiving them as behaviors that should be defined as such, that is, as behaviors within a context. Adopting this model means taking a risky leap, insofar as it deprives us of the security of well-established models over decades of clinical psychology, and deprives us of the (desired by some) closeness to medicine; but it is precisely these risks that spur the desire of other practitioners to build a perspective of psychological dysfunctions that is fully based on the psychological and proud of it. Exiting the current impasse could make it advisable to thoroughly explore this paradigm shift in the way we understand the discomfort or distress for which patients come to us.

Practical wisdom

It could be useful to revive the Aristotelian distinction between three types of knowledge: episteme or theoretical knowledge, techne or technical knowledge, and phronesis or practical knowledge (Rodríguez Sutil, 2013). Although in Greek thought phronesis referred above all to moral questions, we can extend it to any area of human experience. It is the wisdom provided by the combination of experience and prudence, but not of just any experience (one that comes from simple repetition or the mere passage of time repeating the same thing), but the experience that allows us to become authentic experts, which opposes both incompetence and hubris or disproportion; and involves turning a critical eye towards one's own performance. We all know that in the areas of phronesis (whether as a carpenter or as a psychologist), the accumulated knowledge allows us to elaborate rules that do not always have to be strictly followed, but which always guide the practice.

The value of a certain naivety

A significant number of therapists have tackled with seriousness and commitment the effort to analyze their treatment model, focus on a specific objective, refine it and subject it to public scrutiny. Empirically validated treatments are clear examples, although they are not the only ones. Other equally serious professionals have approached the same work but the results have been disappointing and their attempts have not been made public; indeed, it is well known that there is a tendency to publish studies that turn out well (González-Blanch & Carral-Fernández, 2017). In relation to the first group, it does not seem unreasonable to think that their efforts have produced something valuable; and considering the high level of knowledge and experience that we have accumulated in this very complex field of work, it would not be surprising if, like in a sprint among elite runners, the differences among the participants were very little. This would explain the efficacy shown by so many treatments, and the absence of marked differences between them.

Widening the range of tolerance to what we deem to be a valuable therapeutic proposal may seem naive, and undoubtedly means that some not very useful practices receive undeserved credit. The question is whether we can and/or should afford to pay that price in the effort to avoid losing valuable proposals that scientific rigor would

keep away. In these moments we are dominated by the spirit of suspicion and rivalry, which leads to bitter and ultimately useless debates. Can we transcend this attitude, and allow ourselves to grant a vote of confidence liberally? Some professional contexts where psychotherapeutic interventions are carried out face an overwhelming and heterogeneous healthcare demand, in which all of the contributions (from standardized procedures to actions that are very little systematized) find their place. In the search for a coherent organization of the enormous arsenal of resources offered by current psychotherapies, "perfect" could be the enemy of "good".

What was always there

What if it turns out that we have inadvertently already developed some basic ideas about how to manage these debates? Regardless of the theoretical framework of reference, the core of the therapeutic intervention, or the techniques used, there are some key ideas (described in some words or others), which we try to convey to patients: that reality is not a matter of white-black, but of nuances; that we have to be flexible, instead of clinging to dogmatic ideas or principles, especially inherited ones; that patience should be cultivated, especially in complex tasks that require a long journey; that our relationships with others enrich us and these relationships must fulfill certain characteristics so that they really benefit us; that being included in broad social networks enriches us; or that maturity involves developing tolerance to frustration, compassion (towards oneself and towards the other) and trust (in oneself and in others). What if we adopt that attitude when it comes to debating about the efficacy of psychotherapy?

TO CONCLUDE

The limitations of space force us to disregard others involved in this debate, such as the service providers (public health or private insurance) and especially the patients themselves. The latter are increasingly positioning themselves as a client or consumer who hires a service of which they wish to be informed (Grodzki, 2013), but they are still oblivious to the academic ins and outs of psychology. However, as part of a particular interpersonal relationship that configures the background of psychotherapy, it is the patient who will mark its course.

Accepting these absences, and based on the prudence

of addressing a fascinating but very complex challenge, we believe that there are a number of points that we can establish according to some basic criteria of coherence, congruence and functionality:

✔ After many efforts by numerous practitioners over the years, we have succeeded in developing psychotherapeutic interventions that help. But we have also advanced in the discrimination of those that do not.

✔ We have ended up developing ways of approaching the evaluation of psychotherapy (such as the adoption of randomized clinical trials, but also hermeneutic and idiographic perspectives) that may be confronted, but have shown their worth, which suggests that integrating could turn out to be more productive than discarding.

✔ The fact that operational proposals have been made public is an undisputable criterion of quality, but it is not the only one.

✔ There is no feasible psychotherapeutic intervention without a relationship that supports it, without a particular context that frames it, without a model that gives meaning to it all, or without techniques that have a specific effect or that serve as a vehicle to unfold the relationship.

These are assertions that can be derived from our foregoing analysis, which, going beyond the bibliographical references that support them, seem to be a coherent and plausible response to the debate in which we are immersed. A debate that could not be less complex than the psychotherapeutic task itself…

CONFLICT OF INTERESTS

There is no conflict of interest.

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