



## THE SEVEN MAGIC SECRETS OF THERAPEUTIC EFFECTIVENESS

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*Parecería que el avance de la Psicología nos debería aumentar la confianza respecto a nuestras prácticas, sin embargo la proliferación de técnicas, protocolos, enfoques,... nos genera, más bien, una sensación de confusión; la duda sobre si quizás estamos en la opción correcta o nos estamos equivocando de paradigma terapéutico. Los metanálisis y revisiones sistemáticas procuran poner orden intentando averiguar qué terapias psicológicas son más efectivas. Desgraciadamente, los resultados no son concluyentes y más bien parecen indicar que ningún enfoque psicológico predomina sobre otro. Ante esta situación la pregunta que emerge es: ¿qué factores comparten las distintas técnicas que las convierte en eficaces? Son muchas las categorizaciones sobre factores comunes. En este artículo desvelaremos los 7 secretos mágicos (factores comunes) que consideramos clave para explicar la efectividad terapéutica. Esta clasificación no tiene ninguna pretensión más que provocar la reflexión.*

**Palabras clave:** Factores comunes, Efectividad terapéutica, Psicoterapia.

*It would seem that the advancement of psychology should increase our confidence in our practices, however the proliferation of techniques, protocols, approaches, etc. gives us a sense of confusion instead. We have doubts as to whether we are in the correct therapeutic paradigm or not. Meta-analysis and systematic reviews attempt to create order, trying to determine which psychological therapies are most effective. Unfortunately, the results are inconclusive and seem to indicate that no one psychological approach prevails over the others. The question that emerges is: what factors do the different techniques share that make them effective? There are many categorizations concerning common factors. In this article we unveil the seven magic secrets (common factors) that we consider key in explaining therapeutic effectiveness. This classification has no other claim than to provoke reflection.*

**Key words:** Common factors, Therapeutic effectiveness, Psychotherapy.

**B**eing a psychologist means having to live with the feeling that you do not know anything. And this is the best case scenario because if you think you know a lot, it means that you are simplifying the reality of psychology to a child's level.

That feeling of ignorance, of being lost, comes, in part, from the ground that we psychologists walk on every day. A field in which a huge number of theories, approaches and different practices proliferate. Meta-analyses attempt to alleviate this feeling by comparing the effectiveness of techniques coming from different approaches with the intention of determining which is the most appropriate practice. However, the official conclusion of the APA (2013) after comparing different psychotherapeutic models is that: *"In contrast to large differences in outcome between those treated with psychotherapy and those not*

*treated, different forms of psychotherapy typically produce relatively similar outcomes"*. And reviews on the subject corroborate this conclusion given that, in general, there is no psychotherapeutic model that proves to be more effective than the others (Botella, Maestra, Feixas, Corbella, & Vall, 2015).

Thus, if we are cognitive psychologists, we might begin to think that our theories are no more explanatory than psychoanalytical ones, or if we belong to a more humanist line we might conclude that our therapies are no more effective than systemic ones, or... in short, our path is not the way. Or that all paths are the way.

The resistance to empirical evidence that does not show the superiority of any approach is obvious because, despite the fact that the similarity between the approaches is already beginning to be observed (French, 1933, Rosenzweig, 1936), we feed the multiplicity more every day. And accepting the reality means changing our belief system. And that is not only difficult for our patients...

If we detach ourselves from the theoretical perspective

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with which we feel identified, and open ourselves to the almost mystical idea that “all therapies are one”, or in other words there is an underground current that makes all techniques equal, the question arises, what are the common factors among the therapies that are responsible for their effectiveness?

Several authors have presented different categorizations (see the reviews by Botella & Maestre, 2016 and Laska, Gurman & Wampold, 2014). The common or nonspecific factors are invisible, their insubstantiality means that they can be classified in innumerable ways. In these pages, we present our own way of categorizing these underground factors. This is not a categorization that claims to supplant any other, it has no claim, other than simply to carry out a reflection on the subject that may be useful to the reader.

Reality is one, nature is one. In order to understand it, we humans categorize it, and divide it into concepts. It is a very useful strategy for understanding reality, the only drawback is when we confuse our concepts with reality itself and we forget that the divisions are artificial. Reality can, therefore, be “chopped up” in different ways. The authors, based on our research and clinical experience, have reached a certain vision of the reality of psychology. This reality could be presented in this article, i.e., divided, in different ways. Ultimately, we have decided to categorize it into seven concepts.

The classification we present does not attempt to make its categories mutually exclusive. And the fact that there are seven and not six or eight is merely symbolic. We wanted to use the magic number of psychology: 7. George Miller in his study, now a classic, *“The magical number seven...”* (1956) showed that the limits of our ability to process information (short-term memory) were 7 units of meaning. Hence the 7 magical secrets of therapeutic effectiveness.

### **Secret # 1: Listening / Presence**

*The greatest gift we give to someone whom we accompany is a caring presence that is non-manipulative. Technique can be very helpful, but in the long run is of little consequence if this presence is missing*

Edwin McMahon and Peter Campbell

It is clear that listening is a common factor in all therapies. We psychologists listen. Without listening there

is no therapy. Despite the obviousness of the statement, it is curious that in the official training of psychologists, in the degree of psychology, there is not a single core subject that teaches us how to listen. It is taken for granted that we know how to do it.

What is taught are theories and protocols of action that perhaps, in some cases, instead can make listening more difficult. In order to listen, silence is necessary. In a noisy environment, it is impossible to hear the other. But the noise that prevents the patient’s words from reaching us is not always external. In fact, the most deafening noise is the internal noise. If, when the other is presenting their problem, we are looking within our theories where to fit their words or thinking about the next step of the protocol, while our mind is searching the patient continues talking, and all of these words are lost between the two.

In meditation (a key element in most third-generation therapies) inner silence is sought. The mind speaks and one must simply observe and let the thoughts pass. One must sit and be present in the here and now. From this perspective, listening would be like a meditation where the focus of attention would be on the patient’s words instead of on the breathing, and where the distracting thoughts about theories or techniques would simply be allowed to pass instead of us getting stuck on them. Just being present. We would be in a “meta-focus” mode beyond our theoretical perspective.

As Theodor Reik (1948), a disciple of Freud, used to say, in order to listen first it is necessary to have learned to listen to ourselves, and then to be able to pay “floating” attention. Listening to the patient without prioritizing any element of his speech and letting our own unconscious process work. When we listen through our theories we are already selectively addressing elements of the discourse.

In order to listen it is necessary to be brave. To have the courage not to want to understand too fast. Having courage means letting go of our psychological beliefs that protect us so much, and simply listening with presence.

Eckhart Tolle in his book *“Practicing the power of now”* (2004) emphasizes the same idea, from a more spiritual and metaphorical perspective:

*“When a log that has only just started to burn is placed next to one that is burning fiercely, and after a while they are separated again, the first log will be burning with much greater intensity. After all, it is the same fire. To be such a fire is one of the functions of a spiritual teacher.*



*Some therapists may also be able to fulfill that function, provided that they have gone beyond the level of mind and can create and sustain a state of intense conscious presence while they are working with you."*

### **Secret nº 2: Creativity**

*Creativity lives buried under the thought, "Please let me get it right. Please don't let me color outside of the lines".*

Sergi Torres

All techniques and therapies of any approach must be adapted to the patient, which involves flexibility and creativity on the part of the therapist. That is why we consider it a common or nonspecific factor, as have other authors (Bulacio, 2006).

In a psychology degree examination, we asked the students: is psychology: a) an art b) a science? To pass they must mark option b: a science. We psychology lecturers repeat this in almost all of the subjects.

During the era of the "black box" of behaviorism we relegated from academic psychology everything that was not observable (thoughts, emotions, beliefs, etc.) and we limited ourselves to behavior. We thought that this was the only way psychology could be a science. That handicap has already been overcome, but now we have another issue to solve. Where do we place the creativity of the therapist?

One of the basic premises of science is that research investigations must be replicable. Thus, if we want to consider ourselves as scientists, studies to test the effectiveness of any therapy must be able to be "copied". This means that in addition to describing rigorously the methodology and design in the article, one must detail the therapeutic protocol as well. In other words, the therapeutic protocol must be described in such a detailed way that any other psychologist could follow it in the same way. Let's be honest, that doesn't happen. The descriptions that are usually included in scientific articles and even in many doctoral theses, are a few paragraphs or a diagram, indicating the number of sessions, the duration, the objective of each of them, the topics addressed and little else (Johnsen & Friberg, 2015).

Therefore, we put a label on the treatment, but as Laska, Smith, Wislocki, Minami, & Wampold (2013) state, there is evidence that in each investigation it is applied differently. It is not surprising then that it is difficult to find

the same results when research is replicated within psychology (Open Science Collaboration, 2015).

So there are two parallel realities: what is described in the scientific articles and what actually takes place. Which is almost reassuring because we psychologists are not robots that can dispense the treatments in exactly the same way each time. However, when conducting research on the effectiveness of a treatment, the therapists in the study often feel guilty if their creativity makes an appearance in the sessions because they feel they are deviating from the protocol and therefore their research is not rigorous.

Sasser and Puchalsky (2010), in their article entitled: "*The Humanistic Clinician: Traversing the Science and Art of Health Care*" end with a wise final conclusion: "We must learn the skills necessary to live in *two worlds*: the world of classical science with its algorithms, rules, and technologies; and the world of romantic science, filled with stories, mysteries and meaning."

### **Secret # 3: Intention**

*Intent is a force that exists in the universe. When sorcerers beckon intent, it comes to them and sets up the path for attainment, which means that sorcerers always accomplish what they set out to do.*

Carlos Castañeda

For many years, in the subject "Principles of Psychology" at the Autonomous University of Barcelona, we invited a group of four psychologists from different approaches: psychodynamic, cognitive-behavioral, systemic and humanistic. There, the nuclear ideas of their approaches and practices were debated. All, of course, defended their points of view; in some cases there were points of connection, but not all. One of the questions that we always asked them was: "*from your experience it seems that you believe completely in the effectiveness of the therapies that you use, so we could conclude that the different approaches are effective. What would be the common element that you share among yourselves?*" Everyone agreed on the answer: "the intention".

They all intensely wanted the patient to improve regardless of what technique they used. How much time do we spend designing, researching therapeutic protocols and how much do we spend cultivating this attitude towards the other?

Johnsen and Friberg (2015) carried out a systematic



review of 70 randomized trials on the effectiveness of cognitive-behavioral therapy for depression. The studies had been carried out from 1977 to 2014. The results showed a high effect size, that is, the conclusion was that it was effective. However, the surprising thing is that a decrease in the effect size was observed. In other words, as the years go by, the therapy seems to be less effective. From our point of view, one of the explanations for this decrease may be related to "the intention".

The moment a new approach is created or a new therapy is designed, it is loaded with the essential ideas and intentionality of the parents of the paradigm. As time passes and the protocols jump from manual to manual, from blackboard to blackboard, they are detached from that primordial and invisible part. Thus to the new therapists there only "arrives" a recipe detached from its initial halo. Maybe, just maybe, that's why the diminishing effectiveness of these techniques has been observed.

#### **Secret # 4: Placebo**

*When you expect something to happen, your brain makes it happen.*

Dan Ariely

One of the most cited investigations regarding the common factors is that of Lambert (1986). In it, it was concluded that 15% of psychotherapeutic effectiveness comes from the placebo effect. Reducing the effect of beliefs to a percentage, whatever it may be, seems somewhat artificial given that, as Kirsch (2013) states, this magnitude cannot be determined. To what extent can you separate what a person believes, their expectations, from all the cognitive, emotional and physiological changes caused by therapy? As stated by Turner and colleagues in the journal JAMA (cf. Bayés, 2007) *"the administration of any treatment, including surgery, has physiological and psychological effects on the patient, and these effects are interrelated. Whenever the patient and the clinician perceive that the treatment is effective, placebo effects occur... The placebo effects act synergistically with the effects of the active treatment..."*

The placebo effect has been treated for many years as a strange variable, a kind of contaminant of the results. Something that should be controlled in order to be able to clearly observe the clean effect of the active ingredient in the case of a drug, or the construct supposedly responsible for the change in the case of a psychotherapy.

Little by little, the placebo effect has begun to attract the attention of researchers, not as a contaminant but as an active principle. Irving Kirsch, a tireless researcher of this mysterious effect, has attempted to show that antidepressants work simply due to this effect (Kirsch, 2010, 2016). Conducting a review of both published and unpublished trials, he realized that antidepressants only showed slightly more effectiveness than placebos. In fact, placebos reached an efficacy level of 82%. The effectiveness of antidepressants is usually checked by comparing an experimental group to which the medication is administered and a control group that receives a placebo. The designs are double-blind; the subjects do not know if they are taking the antidepressant or the sugar pill. Given the data that showed a slight superiority of antidepressants, Irving questioned whether it was because the subjects of the experimental group, that is, those who received the active substance, noticed the side effects, which made them suppose that they were taking antidepressants. To test his hypothesis, he conducted new research in which he used placebos (atropine) that produced side effects (dry mouth) similar to antidepressants. In these trials, where the subjects in the placebo group believed they were receiving antidepressants because of the symptoms experienced, no differences were observed between the two groups (experimental and placebo). In other words, the placebo is equally effective as an antidepressant.

This type of study leads us to the conclusion that by manipulating the patient's expectations, the benefits may be greater. And this manipulation was precisely what Dan Ariely and his collaborators carried out (Waber, Shiv, Carmon, & Ariely, 2008). In their study, subjects received electric shocks and to relieve their pain they were given placebo pills. Half of them were told the pills were very expensive, and the other half were informed that it was a cheap drug. As Ariely hypothesized, the "expensive pills" were more effective. It seems that a drug is more likely to be effective if it is expensive and causes side effects.

Following this line of thought, we could reach the conclusion that all that surrounds our therapies (price, location, fame of the therapist, etc.) can have a clear placebo effect; that is, it can increase their effectiveness. And therefore, we could conclude that it would be interesting to investigate all of these factors and



encourage them in practice. But is this the conclusion that we should reach?

Dumbo was an elephant with huge ears that did not know that he could fly with them. Timothy, his friend the mouse, gave him a magic feather and assured him that he could fly if he held it in his trunk. Dumbo did indeed succeed, although he remained in ignorance of the fact that his ears were responsible for this feat. At the end of the story Timothy confesses that the feather had no magic in it and that Dumbo could fly on his own.

Through what are known as “open label placebo” designs, experimental subjects who receive the placebo (unlike double-blind designs) know that they are receiving it. In other words, they know that the pill they are taking does not have any active ingredients. And surprisingly, it still causes beneficial effects (Carvalho, Caetano, Cunha, Rebouta, Kaptchuk, & Kirsch, 2016, Charlesworth et al., 2017). We are telling patients that the feather is not magic, but the feather still has an effect.

We need one more step, to convince not only patients, but also ourselves as therapists, that perhaps therapies have many feathers and that the healing effect is within ourselves. An idea summarized excellently in the title of Joe Dispenza’s book (2014): “You are the placebo”.

#### **Secret # 5: Poetry**

*The poet’s gift is to clarify without simplifying. It is almost exactly the opposite of the gift of science, which is to seek to understand through simplification.*

Iona Heath

Our words can be reassuring, stressful, clarifying, motivating, analgesic, decisive, etc. When pronouncing them we cannot know what their repercussion will be because it depends on who listens to them, at what moment, the gestures that accompany them, and many other subtle, unconscious and invisible aspects.

Ramón Bayés on the day of his 86th birthday wrote an article entitled: “The right words at the right time” (2016a). It includes an experience of the psychiatrist Allen Frances:

*“In my practice as a psychotherapist I treated a patient for fourteen years twice a week and I did not have any influence on his life. In contrast, in the emergency room I spoke with some people for fifteen minutes hardly getting to know them at all. I was pleasantly surprised that one of them approached me two years later to tell me: <Your words changed my life>”.*

Most psychologists can identify with this experience. We concentrate our efforts to provoke a change without success and one day, suddenly, our words work a miracle. Miracles that, because they occur independently of our psychological paradigm, we also consider to be a common factor. The big question is: to what are these miracles due?

One of the explanations Ramón Bayés gives us (2016b) to understand why our words are sometimes so timely is the poetic method. So what is the poetic method? He describes it like this:

*“The poetic method is the one we use spontaneously if we want to understand and enjoy in depth a poem by Machado, the sunrise from the summit, a starry night in the countryside, the smile of a child, the brightness of the eyes of a beautiful girl or a Mahler symphony. We have no choice but to face these entire events, at once, in all their complexity. Only the individual experience, acquired through participation or knowledge of previous cases, together with intuition and creativity, can, although not always, be of some help in understanding them.”*

In some cases, as Bayés points out, scientific and clinical methods fall short, they are too simplifying and analytical. The emotions, sensations, and thoughts of the other must be captured in their totality, without analysis; they must be sensed. And if we listen and feel this poetry, perhaps our words will be more likely to be timely.

*“Almost without realizing it, we may, or may not, provide another human being with the key that opens the door to something essential that remained hidden to him and can illuminate his path. It is up to us to take the first step. And rarely will we know if we have been successful. But we must try.”*

Ramón Bayés

#### **Secret # 6: Heartbeats**

*I am my neighbor*  
Publio Terencio Africano

Another common factor shared by all therapeutic approaches is that the psychotherapist and the patient are human. Both hearts beat. It is obvious, but the obvious is what is most easily lost sight of.

Both (therapist and patient) have their fears, insecurities, prejudices, obsessions, complexes, etc. The fact that one is a specialist in psychology and the other is not (or maybe he is) is just a differential detail that we find on the surface. Only the packaging distinguishes them.



Perhaps the common factor that in many studies is called the “therapeutic alliance” (Bordin, 1979, De Nadai et al., 2017, McClintock, Perlman, McCarrick, Anderson, & Himawan, 2017) refers more directly or indirectly to how we psychologists handle the fact that deep down we are dealing with ourselves.

It is not easy to be a psychologist because we can feel identified with the patient’s problems and stay stuck in their same cognitive-emotional web; or else, in order to avoid that entanglement, we can end up taking refuge behind our abstract theories and systematic protocols. From both places it is difficult to help the patient.

Empathy is one of the hallmarks of psychologists. It is one of the most studied common factors. However, this concept is usually used in only one direction: to empathize with the other, to understand their point of view and to recognize their emotion. In other words, empathy goes from the therapist to the patient, but not from the therapist to himself. He is supposed to understand, forgive and accept himself.

Compassion is another, broader concept that can go both ways. Paul Gilbert (2009) defines compassion as a deep awareness of one’s own suffering and that of others along with the desire and effort to alleviate it. It is a more global concept than empathy because it does not involve understanding any point of view, not even recognizing what kind of specific emotion the other is experiencing, but simply taking in deeply the suffering that comes with human nature (patients and therapists included).

Compassion-centered therapy (Gilbert, 2009) is an integrative therapy based on evolutionary, social, and Buddhist psychology and neuroscience with a multimodal approach. Its axis is compassion. The therapist’s compassion towards himself and towards the patient, and compassion as the objective of the patient’s learning. It is a therapy that goes together with what has been exposed in these pages since it aims to go beyond the approaches.

Compassion requires a part of us to distance ourselves somewhat from our own suffering in order to observe and accept it and from that part of ourselves, from that vantage point, we can also observe the suffering of the other. Carrying out the therapy from there, can help us to avoid becoming entangled in the same web as the patient and to admit (without taking refuge behind any protocol) that our suffering is also there. From this place, we can see the two sufferings at the same time with a certain detachment, accept them and treat them. Although it

would be more accurate to say that what is accepted and treated is just one suffering that presents different forms (that of the therapist and that of the patient). This is why our growth becomes the patient’s growth, and his becomes ours.

### **Secret # 7: Mystery**

*All religions, arts and sciences are branches of the same tree.*

Albert Einstein

Nature is one. Our longing has always been to understand it. To understand all its greatness and complexity. However, it is impossible to encompass it globally within our understanding. That is why we have divided it into parts: chemistry, physics, biology, psychology, etc. Nature, oblivious to our division, continues to behave as a whole.

Humans have gradually come to understand some of its enigmas, but many others resist us. We have begun to realize that if we want to understand, we have to go far beyond our senses. The clock marks the hours, always with the same pace but Einstein was able to surpass a fact that seemed like a basic premise and he suggested to us that time stretches and wrinkles like an accordion. And now quantum physicists suggest that the particles are neither here nor there, they are everywhere at once and only when we observe them do the positions and properties become specific. How are we to understand something so unintuitive?

We psychologists, from our position, listen to all of these physical theories like someone who watches a science fiction movie: it’s not about us. We are inside one of the cubicles into which we divide nature, attempting to understand it and we already have enough. But nature insists on being one. The division is only an illusion of scientists. When quantum physicists talk about particles that behave in such a mysterious way, what particles do we imagine they are talking about? The ones they have in their laboratories? These particles are also found in our bones, our blood, our neurons, forming our entire brain. The mystery is inside us.

There are psychological phenomena for which we have no explanation, those that Freud warned Jung not to address if he wanted psychoanalysis to be considered scientific. Within the chaos of mystery, it is logical that psychologists are faced with inexplicable facts. What



would not be logical would be if the mystery were only in the particles of quantum physicists.

So although we psychologists, when talking about nonspecific factors to explain the effectiveness of our therapies, can give explanations as generalist as placebo, intention, therapeutic alliance, etc. Even with them we cannot explain everything. In the explanatory equation that we are seeking, one of the elements with most weight is without a doubt the mystery.

## CONCLUSIONS

*Know all the theories, master all the techniques, but as you touch a human soul be just another human soul.*

Carl G. Jung

Nonspecific factors seem to be more predictive of clinical outcomes than any technique (Day, Halpin, & Thorn, 2016; Laska, et al., 2014). In fact, meta-analyses indicate high-moderate effect sizes of nonspecific factors, which are larger than those of the differences between treatments (Laska, et al., 2014). This could plunge us into helplessness. We might think that all our efforts, research, studies, etc. are useless, but that feeling would be misleading because thanks to us, regardless of our approach, many people cease to suffer. What is happening is that it seems that the key to the efficacy of what we do is not found where we think it is.

As González-Blanch and Carral-Fernández (2017) conclude in their excellent critical review on this issue published in this same journal:

*“The common factors approach expands the vision of psychotherapy by emphasizing the explanation of the change in ways that go beyond the treatment protocol and the theoretical model that guides it. Thus an oversimplified analogy of the active ingredients of the medical model is surpassed.”*

It is extremely difficult to know what causes changes in the patient. This should not be surprising given that on many occasions he himself is not aware of what has caused it. And even though he may be able to verbalize the reason for the change, we cannot be sure if his explanation is a mere rationalization, a theory that he has fabricated that has nothing to do with what has happened unconsciously. Exactly the same thing happens with us, with our theories, to a great extent; they are rationalizations with which we feel satisfied because we think that we impose order in the complexity of the psychological world.

The change switch is found floating in something that happens between us and the patients. Something volatile, ungraspable, invisible, etc. that is difficult to grasp with logic and difficult to structure. One of the most concrete labels with which the studies try to handle this concept, to lower it more to the empirical level is that of the “therapeutic alliance” (Kidd, Davidson, & McKenzie, 2017). In these pages we have allowed ourselves not to adhere even to this label, to treat the insubstantiality of the subject more freely. So we have presented a division of 7 points, aware that there could be more or fewer and they could be explained from many different perspectives. We have tried to describe something that we cannot see, touch, or smell. We have described something based only on glimpses, aware also that these glimpses are subjective.

Why in the faculties of psychology do we barely treat the common factors that exist between the therapies? Well, because they are difficult to capture on the blackboard, to catch in a PowerPoint, to evaluate in an exam, etc. They are too elusive on paper. So we remain focused on what is easiest to explain by points or with ordered scripts. When the students first enroll in psychology, they do so full of expectations, thinking that they will enter the mystery of the human mind, within the world of the unconscious, within a magical universe. Lecturers are warmed by this vision, but we know that it is not what they are going to find. From the first day we are going to affirm repeatedly that psychology is a science and we are going to structure their mind like an Excel spreadsheet so they can distinguish different pathologies, different specialties, and methodologies. Above all they must understand the differences, and divide everything up. At the end of the degree, they usually have the feeling that they do not know anything, that there are many unknown cells in that Excel spreadsheet into which we have divided psychology, many techniques of which they have heard the name but nothing else, and so begins their journey towards the postgraduate, masters and doctoral courses, hoping to find something to fill that sensation of not-knowing that is never fulfilled. A feeling that in a more or less solid way continues to endure throughout their (our) professional path.

In the field of research, nonspecific factors are simple secondary actors, the roles of protagonist are in the hands of the therapeutic protocols. What matters most in research is to publish, and for an article to be accepted, the fundamental thing is the methodology used. This leads us possibly to investigate something that is totally



irrelevant but that has an irreproachable methodology and it is published. The opposite never happens, however. Nonspecific factors, due to their almost ethereal condition, are difficult to fit into many methodologies. So we end up studying what is researchable, and not what is important. Investigating that which is researchable is not the problem. The problem is that what does not fall within the networks of science, ends up not existing. Hence our blindness. Fortunately, new, more flexible methodologies and more integrative approaches are emerging.

If we move from teaching and research to applied psychology, some psychologists choose to cling to their theories almost like a lifeline, although more and more therapists are changing towards a more integrative view and many define themselves as eclectic (Botella et al., 2015). As Corbella and Botella (2004) affirm: "a future is opening up before us that will be marked by a growing interest in integrative positions in psychotherapy".

We lecturers, researchers, and applied psychologists, etc. are all too tense. We are lost in a sea of data. Decentralized. Perhaps our comprehensive gaze is aimed more at our patients than at ourselves. Before us we have the mystery of human nature and we intend to understand it from within. We long to understand and control it perfectly. If we were our patients we would surely tell ourselves not to demand so much, to stop analyzing so much, to trust our intuition more and all the potential that we carry inside.

Probably the "scientific part" of the reader has found this article to be not very rigorous and lacking a more theoretical foundation. And it is because the present pages did not aim either to be a revision or to offer an alternative taxonomy to those that already exist on non-specific factors. It did not even aim to come to any conclusions. In fact, rather than ordering our ideas, the intention was to disrupt them, because reflection is encouraged when we have to reorganize our ideas in a different way. This article therefore does not appeal to the scientific part but to the humble part of the reader, the part that recognizes that human nature is a mystery.

That humble part is what allows us to open our minds and as Kuhn (1962) said, opening our eyes leads us to new paradigms. Humility is the most powerful resource we have in walking towards the convergence of the different approaches, directing ourselves towards what is most essential and leaving space for everything that we do not understand. And the most wonderful thing is that

this same humility multiplies our awareness of how fascinating our profession is.

#### CONFLICT OF INTERESTS

There is no conflict of interest.

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