



PSYCHOTHERAPY AS A HUMAN SCIENCE, MORE THAN A TECHNOLOGICAL ONE

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El panorama actual de la psicoterapia es tan próspero como desconcertante. Diferentes terapias muestran una eficacia comparable. La práctica basada-en-la-evidencia ha dado paso a una resaca de otros movimientos. La investigación de procesos lleva camino de un archipiélago de "nichos de investigadores". A fin de clarificar este panorama, se ha acudido a la filosofía de la ciencia. La filosofía de la ciencia ha permitido identificar diferentes epistemologías, reabrir la distinción entre ciencia natural positiva y ciencias humanas y resituar la psicoterapia del lado de estas últimas. Como ciencia humana, la psicoterapia sería ante todo una actividad relacional holista contextual centrada en la persona y basada en valores, más que una actividad científico-técnica centrada en "mecanismos averiados. El modelo contextual de Wampold y un enfoque fenomenológico-existencial son hitos de esta "nueva vida" de la psicoterapia, más humana que tecnológica-impersonal.

Palabras clave: Modelo contextual, Enfoque fenomenológico-existencial, Práctica-basada-en-la-evidencia, Evidencia-basada-en-la-práctica, Hipótesis-del-mundo (Pepper)

The current landscape of psychotherapy is as prosperous as it is disconcerting. Different therapies show comparable efficacy. Evidence-based practice has given way to a backwash of different movements. Psychotherapy process research leads to an archipelago of "niches of researchers". In order to clarify this panorama, we have turned to the philosophy of science. The philosophy of science has made it possible to identify different epistemologies, reopen the distinction between positive natural science and human sciences and resituate psychotherapy on the human science side. As a human science, psychotherapy is, above all, a contextual holistic relational activity, person-centered and values-based, rather than a scientific-technical activity centered on "faulty mechanisms". Wampold's contextual model and a phenomenological-existential approach are milestones of this "new life" of psychotherapy, which is more human than technological-impersonal.

Key words: Contextual model, Phenomenological-existential approach, Evidence-based practice, Practice-based evidence, World hypothesis (Pepper).

PSYCHOTHERAPY IN THE CONTEXT OF THREE CURRENT PROBLEMS

The title of this article refers to the current great debate about the characterization of psychotherapy according to a technological emphasis in a natural science framework or a relational emphasis in a human science framework. This debate is taking place both in psychology (Deacon, 2013; Healy, 2017; Slife & Christensen, 2013; Wampold & Imel, 2015), and in psychiatry (Bracken, 2014; Bracken et al, 2012; Stanghellini & Mancini, 2017; Vispe & Valdecasas, 2018). As it is in reality a perennial debate, it jumps to the foreground in the context of certain current problems. The debate refers in particular to the persistent Dodo bird, to the backlash from evidence-based practice and to the proliferation of transdiagnostic processes

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and dimensions. After reviewing these problems, the debate is restated in terms of the philosophy of science, in order to refund psychotherapy as the title suggests.

The Dodo bird, alive and kicking

The Dodo bird, referring to the similar efficacy of different psychotherapies, is still alive and kicking. If as a bird it is an extinct species, as a symbol according to which "Everyone has won and everyone must have prizes", it is still alive (Figure 1). Even though we are no longer talking about hundreds of psychotherapies (González-Blanch & Corral-Fernández, 2017), the Dodo bird continues to roam at ease. Several of the psychotherapies, in addition to cognitive-behavioral therapy, have shown their effectiveness, including psychodynamic (Leichsenring, Leweke, Klein, & Steinert, 2015; Steinert, Munder, Rabung, Hoyer, & Leichsenring, 2017), humanist (Elliott, Greenberg, Watson, & Timulak, 2013; Mullings, 2017), existential (Hale & Stephenson, 2017; Vos, Craig, & Cooper, 2015) and systemic (Pinquart, Oslejsek, & Teubert, 2016; Pol et al, 2017) psychotherapy.

Since cognitive-behavioral therapy is the most represented in efficacy studies, it is important to point out that it is not superior



enough to the others even for depression (Cuijpers, Cristea, Karyotak, Reijnders, & Huibers, 2016; Driessen et al, 2017; Wampold et al, 2017), to be able to be hailed the “gold standard” of psychotherapy (David, Cristea, & Hofmann, 2018), and neither is any other psychotherapy (Leichsenring et al, 2018). This does not mean that there are no therapies that are more effective or efficient than others for certain problems. The point to be emphasized is that none of the approaches mentioned can be ruled out due to lack of efficacy for numerous problems. For example, in the case of depression there are at least six therapies of proven efficacy: cognitive-behavioral, behavioral activation, interpersonal, problem-solving, non-directive support and short-term psychodynamics (Cuijpers, 2017).

The problem is no longer so much to do with efficacy as efficiency and cost-benefit. In this regard, it is both promising and disconcerting to see that apparently simple and yet different therapies are not less effective than cognitive-behavioral therapy. We refer to behavioral activation (Finning et al, 2017; Richard et al, 2016) and generic counseling (Pybis, Saxon, Hill, & Barkham, 2017). It is not about questioning cognitive-behavioral therapy (whose merit is indisputable), but to open the question about the nature of this phenomenon: how is it that there are different psychotherapies, some simpler than others, that are similar in efficacy? Evidence-based practice does not seem to have solved the problem.

FIGURE 1
LEWIS CARROLL (1865): THE ADVENTURES OF
ALICE IN WONDERLAND (CHAPTER 3)



Backlash from evidence-based practice

The evidence-based practice (EBP) movement has left in its wake a backlash after saying what works and does not work in psychotherapy. Now, in addition to the questionable EBP, there are relationship-based practice, practice-based evidence, evidence-based therapists and new “therapy wars”. As you will recall, EBP stemmed from evidence-based medicine from 1992, when it reached psychiatry. Its extension to psychiatry was reflected in psychiatric guidelines. The psychiatric guidelines with their pro-medication bias left psychological therapies practically off the map. In this context, guidelines for efficacious psychological treatments became necessary (Pérez-Álvarez, Fernández-Hermida, Fernández-Rodríguez, & Amigo, 2003).

It has been shown that for most of the numerous disorders there are efficacious and even advantageous psychological therapies in comparison with medication, without the side effects of the latter and with lasting improvements beyond the treatment (Pérez-Álvarez et al, 2003). Even though the psychological guidelines were trans-theoretical, the truth is that cognitive-behavioral therapy was the most represented. Cognitive-behavioral therapy and EBP became practically synonymous terms. Although the availability of guidelines for effective psychological treatments was a path to take, as was said in the last chapter of the third volume (“Camino recorrido y tarea futura de los tratamientos psicológicos” [“Path taken and future work of psychological treatments”], Pérez-Álvarez et al, 2003), it was not the way forward, and it led to continuous horse-races. The future work, it was said then, was to be the demedicalization of psychological problems and treatments, as conceived by EBP.

A step in this direction could be seen in the “dismantling” of the disorders as supposed natural entities demonstrating their “invention” and in the vindication of a contextual model of psychotherapy against the dominant medical model in the guidelines (González-Pardo & Pérez-Álvarez, 2007; Pérez-Álvarez, 2018a; Pérez-Álvarez & García-Montes, 2007). Over time, evidence-based medicine itself entered into crisis (Greenhalgh, Howick, & Maskrey, 2014), and its extension to psychiatry did as well (Bracken et al, 2012; Gupta, 2014).

Ironically, EBP had a healthy legacy in the form of several reactive movements. Relationship-based practice emerged from it. A number of qualities of the therapeutic relationship such as the working alliance, empathy, acceptance and patient feedback among others came to the fore as the heart and soul of psychotherapy (Duncan, Miller, Wampold, & Hubble, 2010). Not only does humanistic psychotherapy go back to the map of what seemed to be left out with EBP, but it also stars in the “great debate” of psychotherapy between techniques and relationships (Wampold & Imel, 2015). Evidence-based medicine itself claims as the way out of its crises “the context of a humanistic and professional clinician-patient relationship” (Greenhalgh et al, 2014, p.5).



On the other hand, practice-based evidence studies the effects of psychological treatments as they are applied in routine clinical practice, without choosing the patients, using the existing clinicians and without constraining the application to a protocol, such as EBP (Barkham, Hardey, & Mellor-Clark, 2010). While EBP relies on internal validity, without ensuring its real applicability, practice-based evidence relies on the ecological validity representative of real contexts. Given the complexity of the aspects involved in each clinical case, a practice-oriented research, rather than a protocol-oriented one, seems more applicable. Without rejecting randomized controlled trials, the hallmark of EBP, case studies are rehabilitated as a source of knowledge derived from clinical practice (McLead & Elliott, 2011; Stiles, 2010). Randomized controlled trials continue to be important, including triple blind when possible as in neurofeedback for ADHD (Pérez-Álvarez, 2018a) and perhaps also in EMDR.

Following the emphasis on techniques, the movement centered on the therapist's expertise emerges, in this case, evidence-based therapists (Galán Rodríguez, 2018, Miller, Hubble, Chow, & Seidel, 2013). It refers to the clinical excellence achieved by psychotherapists, resulting from their experience whatever the model of psychotherapy. The truth is that the variability within the same therapy is greater than between different therapies (Wampold & Imel, 2015, p.259). Even when the focus is on the clinician, the model of psychotherapy is still relevant. As Antonio Galán Rodríguez says: "To be a "superloquero" ["supershrink"] one must not adjust to specific treatment protocols, nor develop the diagnostic skills, but instead add to the chosen therapeutic model a series of concrete practices that would generate a "cycle of excellence" (Galán Rodríguez, 2018, p.15). He is referring here to deliberate practice (Ericsson & Pool, 2017). Table 1 places deliberate practice within the "cycle of excellence".

Deliberate practice is an intentional practice in which the practitioners continuously monitor themselves to create a successive improvement (Galán Rodríguez, 2018; Gimeno-Peón, Barrio-Nespereira, & Prado-Abril, 2018; Prado-Abril, Sánchez-Reales, & Inchausti, 2017; Rousmaniere, Goodyear, Miller, & Wampold, 2017). Deliberate practice is not mere professional practice with "a lot of experience". Experience does not necessarily make one an expert, including doctors (Ericsson & Pool, 2017, p. 148). The status of expert, expertise or excellence implies continuous deliberate practice beyond routine preconceptions and accommodations. In fact, a lot of experience may be harmful, as in the case of Charcot who saw in clinical practice what he himself induced with his procedures, like the infallible diagnoses of ADHD today and not only these (Pérez-Álvarez, 2018a; Pérez-Álvarez & García-Montes, 2007).

Without detracting from its obvious interest, the cycle of excellence has an arrogance similar to that of EBP, without it in the end likely leading to the balkanization of psychotherapy as its proponents believe (Miller et al, 2013, p.91). It is difficult to

conceive that a generic, external, abstract learning method is the "final solution" of the plurality of psychotherapy, whose plurality is inherent in the nature of things, not the result of professionals who have been incompetent until now. However, clinicians, like their patients, can always improve.

After all, EBP ended the "age of innocence" (Pérez-Álvarez et al, 2003, chapter 1 of vol.1), mobilizing the different psychotherapies to demonstrate their efficacy, instead of taking it for granted. Now they are back on the map, without even "therapy wars" being missing according to the headline of the British newspaper *The Guardian* referring to the "Freud's revenge" regarding cognitive-behavioral therapy (Burkeman, 2016). Table 2 attempts to summarize the hangover after the evidence party.

The proliferation of transdiagnostic processes and dimensions

The study of processes more than that of results is the subject of our time in psychotherapy (Hayes & Hofmann, 2018; Holmes et al, 2018, Kazantzis, 2018; Leichsenring, Steinert, & Crits-Christoph, 2018; Liddle, 2016). Since psychotherapies work even when we do not know how for sure, the study of processes and mechanisms arises, assuming that it is a matter of mechanisms. Another topic of the day related to the previous one is the study of transdiagnostic dimensions: common processes underlying different diagnostic topographies.

TABLE 1 COMPONENTS OF THE CYCLE OF EXCELLENCE	
✓ Determination of the baseline of one's own effectiveness (how you do it)	There are brief scales, consisting of a few items, on the progress of the client and the quality of the relationship
✓ Feedback of client progress (GPS of therapy course)	
✓ Deliberate practice	It starts by leaving time for reflection on the feedback received. The involvement, the connection, the empathy, the flexibility and the repair of ruptures in the relationship are some qualities that pave the path of excellence

TABLE 2 PARTY OF AND HANGOVER FROM EBP	
Evidence party:	
- Evidence-based medicine	
-- Evidence-based psychiatry: psychiatric guidelines	
----- Guidelines for effective psychological treatments (Treatments that work)	
Evidence hangover (backlash):	
- Relationships-based practice	
-- Practice-based evidence	
----- Evidence-based therapies (clinical excellence)	
----- "Psychotherapy wars"	



The transdiagnostic movement arises as an alternative to the disproportionate growth of diagnostic categories. Nominally, the term appeared in 2003 in the context of cognitive-behavioral therapy for eating disorders (Fairburn, Cooper, & Shafran, 2003). The year 2012 was a good year for transdiagnostics in Spain, judging by the monograph dedicated by the *Revista de Psicopatología y Psicología Clínica* (vol.17, no.3) and the book *The roots of modern psychopathology*, where at least thirteen pathogenic conditions are described common to a variety of diagnoses (Pérez-Álvarez, 2012). The recent nº 100 of 2018 of the *Revista de Psicoterapia* dedicated to transdiagnosis, suggests its current persistent relevance.

However, perhaps the decisive year of the transdiagnostic approach was 2013 with the launch of the Research Domain Criteria (RDoC). The RDoC are the National Institute of Mental Health of the USA's transdiagnostic alternative to the DSM-5 after its rejection due to lack of validity for psychiatric research. However, the DSM-5 went ahead, we could say, clinically dead, even though it continues to be used (perhaps a case of "prevarication"). As is well known, the desideratum of the RDoC project is to identify "damaged neuronal circuits" that are supposed to be the basis of disorders, within a psychiatry reconceived as clinical neuroscience. Until now, its greatest contribution has been to send the diagnostic systems (DSM, CIE) into crisis and to initiate the transdiagnostic prohibition. Transdiagnostic alternatives are now growing like mushrooms: multitudes of them in the shape of umbrellas covering a variety of diagnoses in which anxiety and depression are never lacking.

Most psychotherapeutic approaches play at their home ground, except cognitive-behavioral therapy backed by diagnostic systems. However, all are ready to exhibit their transdiagnostic version. Perhaps because it plays on the diagnostic side, cognitive-behavioral therapy is now the most prolific in reproducing transdiagnostic versions, whilst it is true that, like rabbits, they are all very similar: catastrophic thinking, repetitive thinking, automatic thinking, worry, rumination, etc. Each one has its own authors of reference. Even transdiagnostic approaches that have been around forever, such as the behavioral-contextual, psychodynamic and systemic approaches are presented under the transdiagnostic brand (Dindo, Van Liew, & Arch, 2017; Leichsenring & Salzer, 2014; Liddle, 2016), as well as the cognitive-behavioral one (González-Blanch et al, 2018).

Two problems can be observed in the transdiagnostic drift, within the refreshing alternative that it represents. On one side is the proliferation of alternatives, to the extreme of becoming equally as many or more diagnostic categories than they were supposed to replace. On the other hand, there is the continuous reference to the same diagnostic categories. For each of the problems, a double exit opens in turn.

The proliferation of alternatives raises the reasonable search for a possible general dimension. This search leads to two

different solutions resulting from the approaches and methods used:

- a) A "p" factor of general psychopathology in the image and likeness of the "g" factor of general intelligence, resulting from statistical methods (confirmatory factor analysis) (Caspi et al, 2014). The problem with the "p" factor is that it may be a statistical artefact ("mathematical necessity") that lends itself to causal reification (van Bork, Epskamp, Rhemtulla, Borsboom, & van der Maas, 2017).
- b) A pathogenic condition implied by the different transdiagnostic alternatives consisting of a kind of hyper-reflexivity loop, resulting from a conceptual distillation (metasynthesis) (Pérez-Álvarez, 2008; 2012; 2018b). The advantage of an approach like this is that it involves a conception of disorder, in this case, as a loop (situation, circuit, or vital entrapment) in which people are involved due to the circumstances. The hyper-reflexivity loop has a meta-transdiagnostic sense, not just another transdiagnostic alternative.

The continuous reference to the usual diagnostic categories, also leads to a double question:

- c) whether the reference to clinical categories is unavoidable at the moment, while the transdiagnostic language is implanted. This does not seem to be the case.
- d) whether the reference to categories is really essential, which is surely the case. If this is the case, the categories would not have to be based on symptoms (5 out of 10 DSM type ones). A categorization based on prototypes (gestalt, structural) would be more appropriate in psychiatry and psychology (Parnas, 2015; Stanghellini & Mancini, 2017). The great challenge here is to try to reconcile the welcome transdiagnostic perspective with the essential psychopathological categorization. A phenomenological approach may be the most appropriate, as it is dimensional and structural at the same time (González Pando et al, 2018; Pérez-Álvarez, 2017, 2018b; Pérez-Álvarez & García-Montes, 2018; Stanghellini & Mancini, 2017).

The study of the processes also leads to their ceaseless proliferation. Imagine an archipelago of scientific niches, populated by researchers with "beaks" specialized in extracting hypotheses about the processes that they study and based on which they earn their living, like the finches of the Galapagos Islands with their specialized beaks depending on the food available. Allow, if you will, the "irreverence" of Figure 2 as a critical instrument (Galán Rodríguez, 2018) comparing the proliferation of processes with the beaks of the finches.

It is also foreseeable that "toothbrush" theories abound, according to the image of Walter Mischel such that each individual has their own and does not want to use those of others (Mischel, 2009). For the time being, there will be neurophysiological (via RDoC), cognitive-behavioral (Hayes & Hofmann, 2018), psychodynamic (Leichsenring et al, 2018), systemic (Liddle, 2016), etc. processes. On the other hand,



eighty-three theories of psychological change have been identified (Michie, West, Campbell, Brown, & Gainforth, 2014).

If we look at the two most influential recent approaches, such as the *Lancet Psychiatry Commission* document on research in psychological treatments (Holmes et al, 2018) and the text based on standards for doctoral training in cognitive-behavioral therapy (*Process-based CBT*, Hayes & Hofmann, 2018), one cannot help but see their *bias*. In the same vein we find an important work by prominent Spanish authors in *Clínica y Salud* (Tortella-Feliu et al, 2016) as well as the special issue of *Cognitive Therapy & Research* (Kazantzis, 2018). Barlow's distinction between psychotherapy and psychological treatments, reserving the latter title for empirically supported treatments (Barlow 2004), does not solve the problem because it is unsustainable according to what has been said, as well as being tendentious.

In the first place, these approaches are partial because they focus on a plot of psychotherapy that really exists, typically cognitive-behavioral, without contemplating the map that includes other therapies that are no less effective. They are also partial due to the natural scientific (mechanistic) approach they adopt dogmatically and uncritically, without contemplating in this case the no less scientific existence and legitimacy of a human science approach, perhaps more appropriate to the nature of psychotherapy (Bracken, 2014; Healy, 2017; Maj, 2014; Rennie, 1994; Stanghellini & Mancini, 2017).

To summarize

Three problems of psychotherapy have been reviewed, which are no doubt challenging and somewhat enigmatic. It has been seen that different psychotherapies with similar efficacy persist, which would be shocking in medicine (except in psychiatry). Without denying that there are more effective therapies than others for certain problems, the important issue is that none of the great traditions can be ruled out as ineffective or pseudoscientific. It has also been seen that EBP, far from determining between psychotherapies that work and ones that do not, has reaffirmed them all. It has finally been found that the search for transdiagnostic processes and dimensions, however logical, leads to a proliferation that only reproduces the disconcerting problem of plurality at another level.

Two great alternatives open up here. One, the easy one, consists of not reading more than what fits with one's focus. In one's own cave there are no problems. Other approaches do not exist, they are disappearing or they are stupid. The other is to try to understand the variety of caves that populate the countryside without assuming that the others are cave-dwellings, even if only one. For this understanding it would be necessary to put oneself above the focus itself, on a transtheoretical, meta-scientific, not merely scientific, level, in terms of the philosophy of science. Who would have said that philosophy had anything to do with this! It has to do with this, on the one hand, because the problem, as can be seen, is not solved in scientific-empirical

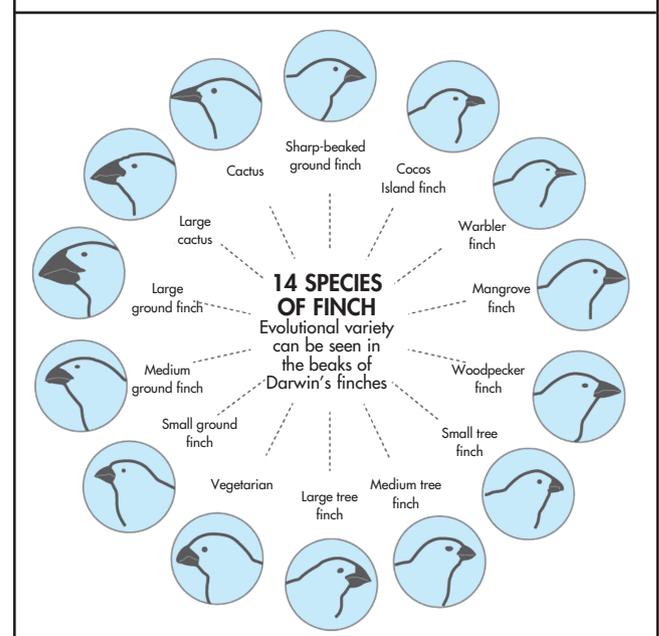
terms and, on the other hand, because the plurality of conceptions itself reveals a basic philosophical question.

PHILOSOPHY OF SCIENCE APPLIED TO PSYCHOTHERAPY: FROM POPPER TO PEPPER

The need for the philosophy of science is now recognized in clinical psychology (Hugues, 2018; Klepac et al, 2012; Lilienfeld, 2016). For example, the journal *Clinical Psychological Science* proposes an editorial line that emphasizes the philosophy of science, the history of psychology and meta-science as a remedy to the "little time dedicated to self-reflection and self-scrutiny" (Lilienfeld, 2016, p.4). The aforementioned standards for cognitive-behavioral training justify its inclusion in clinical training on the basis that "all scientific activities are rooted in philosophical assumptions about the type of observations that constitute the relevant data, the causal models and the appropriate theoretical considerations. Variations in these assumptions lead to different scientific practices." Within this, the training focuses only on the "'cosmovisions' described as methodological behaviorism (mechanicism) and contextualism/constructivism (a type of pragmatism)" (Klepac et al, 2012, p.691).

The aforementioned text *Process-based CBT* (Hayes & Hofmann, 2018) includes a state-of-the-art chapter on applied science in clinical practice (Hugues, 2018) whose title lends itself to this section. However, despite having as a framework the different world views of Stephen Pepper in his work *World Hypothesis* (Pepper, 1942/1970), the application of Sean

FIGURE 2
THE BEAKS OF FINCHES AS COMPARATIVE "IRREVERENCE" OF THE INVESTIGATION PROCESSES



Hugues (2018) is still partial. For this reason, the Pepper approach is also going to be applied. To begin with, Pepper's approach has more scope than the typical positivist approach to science represented by Karl Popper. Popper has become the default thinking mode (without thinking) in the scientific conception of psychology. Popper's approach does not really describe how science is made but, interestingly, researchers starting with psychologists usually expose what they do in Popperian terms (hypothesis, confirmation, etc.).

Four great philosophical systems

Pepper's hypotheses of the world, philosophical systems or worldviews cover practically all the theories of science that are explicitly or implicitly studied in psychology, which will allow their location on a map. Pepper identifies six world hypotheses: animism, mysticism, formism, mechanicism, organicism and contextualism, described on the basis of a root metaphor or concept-force. Leaving aside the first two, we are left with the other four. Each theory or hypothesis offers a conception of what the world is (ontology) and how its evidence is obtained (epistemology).

Formism has its metaphor-root in the *similarity* between things, revealing the class or category to which they belong. The complexity and variety of the world responds in reality to underlying general *forms*. Its basic operation is classification. Diagnostic classifications, algorithms and protocols, with their statistical basis, are examples of formism in psychology. Formism has gained scientific prestige due to its double affinity with realism and idealism. On the one hand, it implies a progressive approach to reality—there with increasingly larger samples, explained variances and confirmatory analyses. On the other, it also involves the discovery of latent forms based on amorphous data at the expense of their analysis and processing. The problem of formism is that the classifications themselves establish the reality that they believe they describe and they very often end up reifying.

The *mechanism* has its root-metaphor in the *machine* as a model of the world. Gadgets of daily use have always "seduced reason" to understand in their image and likeness the functioning of the world and the human being, from the clock, the still and the hydraulic system of the gardens that fascinated Descartes, right up to the computer. Modern science has its basis in the mechanical conception of the world. The mechanism assumes that the phenomena of the world are understood by analyzing them in their parts, each with its functions in relation to the others, according to sequences of antecedents-consequents or causes-effects. Today the computer has seduced, fascinated and abducted psychology as a model of the functioning of the mind and the brain. Cognitive or cognitive-behavioral psychology and cognitive neuroscience are fodder for processing. The problem with mechanicism is that it has ended up confusing a metaphor with reality. Thus, it reduces human phenomena to mechanical

processes (processing, computing). Its currency is: "I think, therefore I behave and I get emotional", where thinking has been transmuted into cognitions-*antecedents* of *consequent* behaviors and emotions (the typical cognitive-behavioral approach).

Organicism has its metaphor in the living *organism* as a structure of parts within a whole. The part-whole relationship also includes the relations of the organism with the environment populated by other organisms. Organicism understands that the phenomena of the world constitute parts of a larger whole such as society and historical processes. The mechanical conception to which organisms are lending themselves in the dominant mechanistic perspective is being reconceptualized in terms of organicism according to the processual philosophy of biology (Nicholson, 2018). Within clinical psychology various traditions stand out including the relational (intersubjective) psychodynamic, humanistic-experiential and phenomenological-existential traditions among others. The problem of organicism (holism) is its marginalization of academic psychology, despite the fact that it probably represents the most genuine tradition of psychology.

Contextualism has its root metaphor in the *act-in-context*. Acts constitute events embedded in plots as life goes by. As a philosophical system, contextualism has an affinity with pragmatism, as well as with the aforementioned current processual philosophy. Within psychology, its most prominent affinity is with radical (not to be confused with methodological) behaviorism, but it is not the only one. In fact, there are a variety of contextualisms besides functional contextualism (the heir of radical behaviorism at the base of the "third generation" contextual therapies), such as narrative (Sarbin), sociohistorical (Ratner, Vygotsky), hermeneutic, constructivist contextualism, etc. (Hayes, Hayes, Reese, & Sarbin, 1993). Within psychoanalysis is the phenomenological (radically intersubjective) contextualism derived from a reworking of Freud based on Heidegger. For its part, the systemic approach is also an example of contextualism. Not in vain was the name "contextual therapy" coined for a family therapy (Boszormenyi-Nagy, Goldenthal), before the famous third-generation contextual therapies. The problem of contextualism lies in the eventual dilution of the subject within a plot, relational framework or system of relations, as well as in the denial of possible unifying categories of experience, with its emphasis on change, novelty and flow. Table 3 summarizes the world hypotheses according to Pepper applied to psychology.

In the end, there are two philosophies: natural science versus human science

Philosophical systems are more or less fluid and attuned with each other. Thus, formism and mechanicism have an affinity with each other, as do organicism and contextualism. Each of these pairs corresponds respectively to the classical distinction between natural positivist science and holistic-contextual human



science. In general, the mainstream of psychology has assumed its identification as a natural science on account of the positivist scientific method. Not in vain, the “two disciplines of scientific psychology”: correlational and experimental (Cronbach, 1957), correspond to formism and mechanismism, although the correspondence between experimental psychology and mechanismism is less precise than that of correlational psychology and formism. The psychology inscribed within organicism (holism) and contextualism (narrative, hermeneutic, constructivist, etc.) is relegated as non-scientific, even when it responds as human science (social and cultural). It seems that human science does not have the scientific prestige that is conferred by the hallmark of natural science.

However, the arrogance of psychology as a natural science is at the cost of losing precisely the holistic and contextual character of psychological phenomena, decontextualized and impersonalized via statistics (formism) or via subpersonal mechanisms below the level of the person (mechanicism). This bifurcation of psychology as scientific and non-scientific has given rise to the “two cultures of psychology”: scientific culture and humanistic culture (Kimble, 1984). Without being gratuitous, the distinction suffers from a scientific prejudice that psychologists often have, which consists of taking natural science as the science that corresponds to psychology, regardless of its relevance. Psychology does not cease to be science as a human science, perhaps it is more humble but also more true.

This distinction between natural science (formism, mechanismism) and human science (organicism, contextualism) is at the basis of the great debate in psychiatry and psychotherapy that began this article. More specifically, it refers to the debate between the medical model and the contextual model (Wampold & Imel, 2015). The medical model in relation to the contextual one could be characterized by being more focused on techniques than relationships and by its confidence in the hypothetical-deductive, quantitative (statistical) method, with disdain for the abductive-inductive, qualitative (thematic, narrative, case-based) method. The medical model adopts a

theory of truth as correspondence between theory-reality, different from the criterion of truth as coherence and relevance of the holistic-contextual approach. Replication and prediction are its credentials of scientificity, rather than the description and explanation of the holistic-contextual approach. Table 4 summarizes this profile.

MAKING UP FOR LOST TIME: ON THE PATH OF HUMAN (CONTEXTUAL HOLIST) SCIENCE

What can we do, faced with the two worldviews of psychotherapy? It is not an alternative between science and non-science, but two conceptions of science. Precisely for this reason, their integration is not easy. An equal, democratic integration, runs the risk of the commission for the design of a horse that became a camel. To break through this dilemma, it is necessary to take a position on two decisive questions: the nature of psychological disorders and the very possibility of natural science in psychology and psychiatry.

Psychological disorders as social situations and dramas

From what we have seen, there are two roads. Just like the protagonist of *In Search of Lost Time*, depending if you follow the path of Swann or Guermantes, different things happen.

<p>Formism - Mechanicism Natural science (positivism) Medical model of psychotherapy Focused on techniques Scientific-practical model (technological) Evidence-based practice Hypothetical-deductive, quantitative (statistical, meta-analysis) method Theory of truth as theory-reality correspondence Replication and prediction as a criterion of scientificity</p>	<p>Organicism – Contextualism Human science (holistic, contextual) Contextual model of psychotherapy Focused on relationships Dialogical co-constructive (hermeneutic) model Relationships-based practice Abductive and inductive method, qualitative (thematic, narrative, case-based) Theory of truth as coherence and practical relevance Description, explanation, identification of phenomena</p>
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World hypotheses:	Root metaphor:	Representation in clinical psychology:
Formism ↕ Mechanicism	Similarity; class Machine; processes; mechanisms	Diagnostic classification; algorithms; protocols; statistical methods; meta-analysis Cognitive-behavioral psychology (processing, mechanisms); cognitive neuroscience; pulsional psychoanalysis (instinctive-pulsional hydraulics; “defense mechanisms”)
Organicism (holism) ↕ Contextualism	Organism; parts of a whole Act-in-context	Relational psychodynamic approach (intersubjective), humanistic-experiential, phenomenological-existential approach; prototypical classification; structural psychopathology Radical behaviorism; Functional, narrative, sociohistorical, hermeneutic, constructivist contextualism; Phenomenological contextualism (psychodynamic), Systemic approach (“contextual therapy”)



On the positivist-natural scientific side, the disorders are conceived as “breakdowns” of some internal (mental, cerebral) malfunction. In this perspective, treatment is conceived as a technical intervention to repair dysfunctional mechanisms. According to what was seen regarding the Dodo bird, the EBP backlash and the proliferation of processes, this is not the way forward, unless it is towards more of the same, an archipelago of scientific niches.

On the holistic-contextual scientific-human side, disorders are conceived as problems of life that *get entangled*, giving rise to a *situation* that it is difficult to leave without help. The entanglement is understood as a negative feedback loop consisting of circular processes of socio-functional cycles (Fuchs, 2018, p. 256). We are talking about the aforementioned hyperreflexivity loop. On the other hand, the notion of situation offers an alternative to the notion of “breakdown” and illness. The disorder is not inside the individual, nor is it outside, but rather it is the individual that is *within* a situation given the circumstances and the personality style. An example of the alternative that the notion of situation represents would be the contextual model of depression of behavioral activation (Barraca-Mairal & Pérez-Álvarez, 2015; Pérez-Álvarez, 2014; see also Fuchs, 2013, Jacobs, 2013).

In this perspective, the notion of treatment, beyond its medical meaning, deserves the meaning as “a way of working on certain subjects for their transformation” including talking about an issue in order to understand its essence and to see how to find solutions or new perspectives. Psychotherapy is thus conceived as a “transitional space” (Zittoun, 2011), a “special type of dialogue” (Stanhellini & Mancini, 2017), a meeting and reception (Valverde & Inchauspe, 2017), instead of a technical intervention of repairing damaged mechanisms.

So, from the scientific-human side, things are seen in a different way. Instead of looking for internal faults to repair, there are *problems in living* consisting of *social dramas*. Problems in living, including conflicts, crises, losses, traumas, disappointments, frustrations, worries, difficulties, fears, loneliness, borderline situations, lack of meaning, dramas, etc., are at the base of the problems encountered by clinicians, for which in reality the consultants seek and need help. As long as you think without the typical clinical disguise, problems of this

type are those that are found (García-Haro, García-Pascual, & González González, 2018a; 2018b; Valverde & Inchauspe, 2017; Villegas, 2018).

The notion of social drama situates psychological problems in the context of the world of life always in relation to others. The anthropological definition of social drama includes four processes (Turner, 1975): rupture (disruption in social relations), crisis (liminal situation, not being as before nor yet reintegrated), reparation (informal mediations, rituals) and reintegration (return to normality, possible readjustment of norms), which could well be in correspondence with the clinical process. (See Table 5). The clinical problems seen as “social dramas” recover their subjective and intersubjective sense, beyond their scientific reduction to mechanisms, as well as their ethical side (Valverde & Inchauspe, 2017).

The imposture of psychology and psychiatry as natural sciences

The underlying reason why psychology, as well as psychiatry, and psychotherapy it goes without saying, are not and cannot properly be natural sciences, is that the phenomena with which they deal are not natural, fixed, there-given entities, indifferent to our conceptions of them, but interactive entities (Hacking, 1995; Kincaid & Sullivan, 2014). Interactive entities, typically human beings, far from being indifferent, are susceptible to being influenced by interpretations, classifications and knowledge. This does not mean that everything can be any way at all. But the way they are, it has a historical ontology that appreciates the study of its genealogy and “invention” (González-Pardo & Pérez-Álvarez, 2007; Pérez-Álvarez & García-Montes, 2007; Sugarman, 2009). The self-conception of psychology and psychiatry as pretended natural sciences, for the sake of their prestige, is still an imposture, as well as being unnecessary. Because the relevant science is human science (Burston & Frie, 2006; Pérez-Álvarez, 2018c; 2018d; Rennie, 1994; Slife & Christensen, 2013).

The existence of different effective psychological therapies is due to this interactive nature, which would be unthinkable for example for a natural entity such as diabetes. The interactive nature of psychological phenomena is precisely the basis of psychotherapy.

**TABLE 5
PSYCHOLOGICAL PROBLEMS AS SOCIAL DRAMAS**

Social drama:	Definition:	Clinical correspondence:
Rupture	Gap in social relationships	Something is wrong that worries one and disrupts normal functioning. Contemplation of seeking help
Crisis	Unsustainable, public and notorious situation. Liminal situation	“I cannot stand it anymore”; crisis; “anxiety sttack”; “psychotic attack”. Search for professional help. Leave on medical grounds. Liminal situation (not well, waiting)
Repair	Informal mediations. Rituals	Psychological treatment. Change process “Transitional space”, dialogue, welcome
Reintegration	Return to normality. Readjustment of norms	Recovery. Termination of therapy. Follow-up. Discharge. Reintegration



But what is psychotherapy?

Psychotherapy is a *unique relationship* in people's lives, different even from parental relationships, couples or friendship in intimacy, trust and sincerity. The therapeutic relationship provides a *protected context* without the conditioning factors that other relationships tend to have. It also offers a *welcoming and accompaniment*. Psychotherapy assumes a *non-punitive audience* as Skinner understood its functioning, so that little by little unthinkable and not-thought-about aspects are highlighted. Psychotherapy often produces an *improvement* from the beginning and even before it starts, even just due to the relief and hope it offers to the demoralization common to every problem.

Psychotherapy offers a new *personal niche* in one's life (Willi, 1999), a *lived space* in which aspects of life are reactivated in the here-and-now of the therapeutic relationship (Fuchs, 2007), present-moments that open up to new senses (Stern, 2004/2014), a *welcoming* in which the other is recognized and accepted as a unique person (Valverde & Inchuaspe, 2017), *listening/presence* (Moix & Carmona, 2018).

The main instrument of psychotherapy is the *psychotherapist* him- or herself through the "working alliance". More specifically, the instrument par excellence of psychotherapy is the *interview*. The interview involves exploratory and therapeutic functions, often without solution of continuity. The typical distinction between evaluation and treatment, first the diagnosis and then the "appropriate" treatment, responds more to the biomedical model than to the nature of things. Any clinician who has not been seduced by the medical model will have had the experience of how patients improve *before* the therapy in the evaluation phase and how new aspects of the problem appear in the middle of the therapy. Permissive listening and open dialogue favor the *connection* of the present with the past and the future provoking nostalgia, fears, joys, sadness, hopes, insights, new perspectives, opening of horizons.

More formally, the following is a definition of psychotherapy, according to Wampold and Imel:

Psychotherapy is a primarily interpersonal treatment that is a) based on psychological principles; b) involves a trained therapist and a client who is seeking help for a mental disorder, problem, or complaint; c) is intended by the therapist to be remedial for the client disorder, problem, or complaint; and d) is adapted or individualized for the particular client and his or her disorder, problem, or complaint. (Wampold & Imel, 2015, p.37).

It is something to propose a sufficiently general definition with which different therapists could be identified and, at the same time, sufficiently specific so as not to consider just anything as psychotherapy, but it is not everything. Psychotherapy along the path of human science, starting with the contextual model, goes further. For now, the contextual model offers an alternative to the technological medical model, so the terms of the definition

take on another life. But the contextual model is not the last word. We still need to refer to a phenomenological-existential model. Allow yourself even to note where these models would go, in the space that remains. In reality, these are well-known models. The problem is that they are rarely covered by those who might be interested, as in separate worlds they are also on the same path.

Contextual model of the functioning of psychotherapy

The contextual model is not just another therapy like family contextual therapy or third-generation contextual therapies, but a meta-theoretical model of the functioning of psychotherapy (Wampold, 2017; Wampold & Imel, 2015). The contextual model is based on the relationship and common factors. The contextual model explains the functioning of psychotherapy according to three steps deployed over time: relationship, expectations and therapeutic actions, based on an initial bond. An initial bond of trust, understanding and "*connecting*" is essential. Not by chance, most of the dropouts occur after the first interview, although not always for the worse (Simon, Imel, Ludman, & Steinfeld, 2012).

The *real relationship* refers to a personal, open and honest relationship. Empathy, resonance, attunement and synchrony are aspects highlighted by different psychotherapies. The relationship includes the working alliance, consisting of agreement on the objectives, the tasks and the relationship itself. The alliance is related to the outcome regardless of the therapeutic orientation and not as a mere effect of a previous improvement, but as an active ingredient of the improvement (Wampold & Imel, 2015, p.184). It is understood that the relationship influences above all general well-being and hence the relief of symptoms.

The *expectations* do not refer only to the hope derived from the beginning of a therapy (re-moralization, placebo). They refer more than anything to the *rationale* or explanation of how the therapy understands the problem and will proceed. The important thing in the creation of expectations is not so much the scientific validity of the explanation, as its credibility, plausibility and acceptance. It does not matter so much that it is a *true* explanation (so many different ones can hardly all be true), as a *real explanation*, reasoned and credible such as offered by different therapies according to their frame of reference. The *rationale* corresponds to *mythology* within the common factors (Frank & Frank, 1991).

The *therapeutic actions* refer to the "specific ingredients" of each therapy, which the contextual model understands differently than the medical model. Instead of assuming a deficit to be remedied, the contextual model assumes that the different therapeutic actions lead to doing something that may be healthy. The therapeutic actions correspond to the *ritual* of the common factors (Frank & Frank, 1991). Psychotherapy clients may improve for reasons other than those postulated by the clinician. According to the aforementioned hyperreflexivity loop



as a pathogenic condition, different therapeutic actions can contribute in one way or another to the disentanglement and exit from the situation which constitutes the disorders. Self-distancing and self-transcendence or acceptance and commitment to reorient life beyond the “symptoms” are examples of this type of different therapies such as existential therapy and acceptance and commitment therapy (Pérez-Álvarez, 2014). Figure 3 taken with small variations from Wampold and Imel (2015, p.54) summarizes the contextual model.

The contextual model overcomes at the end the relations/techniques dichotomy. If on the one hand the techniques (therapeutic actions) do not work except in the context of relationships (expectations, rationale), on the other the relationships themselves involve technique, practice, skill, training, and continuous improvement. The therapeutic relationship does not derive from a natural endowment nor does it consist of mere empathy or anything like that. The therapist is not born but is made in practice, but not by the mere accumulation of experience as we said. Effective therapists are characterized by the capacity for the formation of the working alliance and facilitating interpersonal skills such as verbal fluency, warmth, empathy, persuasion, flexibility, etc. (Wampold, 2017). Feedback from the course of therapy, practice-based evidence, as well as excellence-based therapists, are strategies supported by the contextual model, although not exclusive to them.

The contextual model maintains that a variety of psychotherapies are effective when carried out by expert therapists. The theoretical approach would be of little importance, but it is still necessary. Without theory, *rationale* or mythology there are no worthwhile therapeutic actions. It is not simply about choosing, because often the approach has already chosen you as psychodynamic, systemic, behavioral, etc., due to life’s coincidences and perhaps personal affinities. But, knowing now that your approach is not the only effective one, how can you believe in it to apply it with the proper conviction? Does this lead to cynicism?, ask Wampold and Imel (2015, p.275). As they respond, it would be enough for the therapist to believe that the treatment offered will be effective for this client. But the

dilemmas do not end here. For now, therapists should inform clients of the existence of different effective therapies.

Whilst being the biggest alternative to the medical model, the contextual model does not have the last word. The contextual model remains in the orbit of the medical model. Even though it is its counterpart, the contextual model does not cease to be part of a dialectical tandem with the medical model with respect to which it is defined. Although it is better, it is not all there is.

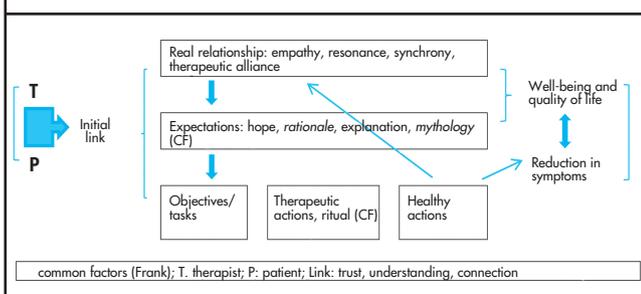
The phenomenological-existential model

A phenomenological-existential refocus is proposed on which to rethink the clinical world of psychology and psychiatry. Fortunately, this approach has a renewed and growing development within a long tradition (Stanghellini et al, 2018). The phenomenological-existential approach focuses on the understanding of the world-experienced by people, what the problems are that they are experiencing, what it is to be depressed, have anxiety, schizophrenia, etc. (Stanghellini & Mancini, 2017). This understanding involves two moments: the exploration of the changes experienced in a series of dimensions (corporality, sense-of-self, time-lived, etc.) and the capture of possible basic structures as the core of the experiences and altered actions. Thus, the phenomenological-existential approach is both dimensional (transdiagnostic) and psychopathological according to a prototypical (structural, gestaltic) classification (Parnas, 2015; Perez-Álvarez, 2018b; Stanghellini & Mancini, 2017).

The basic method of the phenomenological-existential approach is the semi-structured interview and vignettes its preferred “data” presentation (Pérez-Álvarez & García-Montes, 2018). The real-time walk-in assessment, located, personalized and told in the first person made possible by the new technologies in development (Fonseca-Pedrero, 2018) can have a new interest in this existential phenomenological contextual perspective.

The phenomenological-existential approach is not just another therapy, but the framework for an unprejudiced *attitude* focused on what happens to people (Fuchs, 2007). The biggest prejudice of clinicians is usually the medical model they profess with the diagnostic categories in mind and numerous constructs interposed between the clinician and the person-that-is-there. The *attitude* is not a mere will to understand, but implies an *aptitude* to understand based on phenomenological-existential analysis. This aptitude implies philosophical aspects. There is no escape from philosophy, says Jaspers, the difference is whether it is good or bad. According to what has been seen, the worst philosophy would be the usual Cartesian philosophy -dualist, mechanistic-, persistent in the medical model, no matter how involuntarily. Clinicians do not choose this philosophy: it is the philosophy that chooses us by default according to our way of thinking. Phenomenological-existential philosophy is the most appropriate for the psychological and psychiatric clinic, beyond even the contextual model with its skepticism, almost-cynicism,

FIGURE 3
CONTEXTUAL MODEL OF THE FUNCTIONING OF
PSYCHOTHERAPY





with no criteria for deciding between conceptions of clinical phenomena. It may be that many more “common” problems are solved with different common rationales, but serious disorders would perhaps appreciate a phenomenological-existential attitude and aptitude.

Beyond the *impasse* of the contextual model, in the *depths* of the human being, in other words, there, in the therapeutic relationship, there are people with their particular problems of the experienced world. The phenomenological-existential approach, while still being contextual, offers an ecological conception of psychotherapy as a “personal niche” (Willi, 1999) and “lived space” in order to explore and understand the world of people and to reopen their horizon of possibilities (Fuchs, 2007). This conception implies an existential relational ontology (Burston & Frie, 2006; Hersch, 2015; Slife & Christensen, 2013).

Psychotherapy as a social institution

Even as a healthy exercise to think in global terms of our local practice, it is important to state finally what kind of social institution psychotherapy is. After a long past, psychotherapy has a short history linked to current society since the late nineteenth century. Even though care practices are inherent in human vulnerability, psychotherapy offers a particular kind of well-needed care in the contemporary world. It is not to be supposed that the growing psychological disorders derive from genetic variants and mental breakdowns that have suddenly begun to occur in today’s society. In correspondence with the conception of psychological problems as social situations and dramas, psychotherapy is proposed as a social institution consisting of a type of “rite of passage”. The structure and process of the rite of passage: disruption, liminal situation (transition) and reintegration, corresponds to the process of psychotherapy (Table 6).

The concept of rite of passage offers a framework within which to understand life situations that are “entangled” whose exit requires a *space* of welcoming, accompaniment, dialogue, different from everyday spaces (Janusz & Walkiewicz, 2018; Laird, 1998). This space is performed in a clinical setting, often as a disease. But clinicians (psychologists and psychiatrists) will

recognize that they do not deal with diseases like others do. This is not to say that disorders are not diseases, but perhaps more than diseases, alterations of the way of being-in-the-world, sometimes too entangled. It is not that psychotherapy is not a clinical activity, but rather than scientific-technical clinical, centered on mechanisms, it is scientific-human, relational, person-centered and values-based. “For once, the devil does not seem to be in the details -or in the broken mechanisms or specific techniques-, but in the set of factors and actors that constitute a psychological therapy. Without supposed “mechanisms” and “techniques” there is no therapy, just as without stones there is no bridge. But, as with the bridge, what matters in therapy is the arch. The arch holds the pieces and allows the passage from one situation to another ” (Pérez-Álvarez, 2013).

CONFLICT OF INTERESTS

There is not conflict of interests

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TABLE 6
PSYCHOTHERAPY AS A SOCIAL INSTITUTION:
A PARTICULAR RITE OF PASSAGE

Classical scheme of the <i>rite de pasage</i> (van Gennep)	Separation, rupture	Liminal situation, transition	Aggregation (reintegration)
Psychotherapy	“Social drama”, crisis, “I can’t take any more”, “I need help”	Therapeutic relationship; welcoming; therapeutic actions Mythology and ritual (Frank)	Recovery, “discharged”, back to life.



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