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THE GREAT PSYCHOTHERAPY DEBATE

Bruce Wampold and Zac Imel
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Marino Pérez Álvarez
Catedrático de Técnica de Intervención y Tratamiento Psicológico.
Universidad de Oviedo

El gran debate de la psicoterapia: La evidencia de qué hace que la terapia funcione [The Great Psychotherapy Debate: The Evidence for What Makes Therapy Work] by Bruce Wampold and Zac Imel (Editorial [Publishing Company] Eleftheria, 2021) is probably the most important book on psychotherapy so far in the 21st century. The first edition dates from 2001, and this newly translated one dates from 2015. Its importance is due to at least three dimensions: a comprehensive approach to psychotherapy, a review of the empirical research, and a model of its functioning.

The comprehensive approach is based on psychotherapies that actually exist that have been concerned with studying their efficacy and seeing how it is produced. It is therefore not a school approach, but a trans-theoretical one. It offers a definition of psychotherapy that is general enough to include the different therapies worthy of the name, but also precise enough to show what psychotherapy is not. According to the authors, "psychotherapy is a primarily interpersonal treatment that a) is based on psychological principles; b) involves a trained therapist and a client who seeks help in reference to a mental disorder, problem, or reason for complaint; c) is directed by the therapist to bring about a remedy for the client's disorder, problem, or reason for complaint; and d) is tailored or individualized to each particular client and his or her disorder, problem, or reason for complaint" (p. 76). As the authors caution, "primarily" is used here to include complementary activities performed in the absence of the psychotherapist but which are part of psychotherapy.

The review of the empirical research begins (Ch. 4) with clinical trials and meta-analyses that study the *absolute efficacy* of psychotherapy relative to no treatment or various forms of control (waitlist, non-specific care) that do not involve comparison with another treatment. These studies show that psychotherapy is better than doing nothing or doing something that has no therapeutic purpose, but they do not clarify whether its effects are specific or general. Believers and practitioners of each treatment will claim that the effects are due to the specific ingredients of their therapy, but the evidence does not allow us to determine whether they are actually specific or generic (p. 191).

Chapter 5 reviews the *relative efficacy* research in which psychotherapies are compared with each other. Here, the conclusion of the famous Dodo bird verdict is reached, according to which all psychotherapies generally have similar efficacy. Particularly with regard to specific disorders such as depression and post-traumatic stress disorder, studies show similar efficacy of treatments that are, however, different from each other. Subsequent reviews confirm the efficacy of different psychotherapies. Regarding depression, seven types of therapies (fifteen if more specific variants are considered) show similar significant effects (Cuijpers et al, 2020). Post-traumatic stress disorder is also *accommodating* to a variety of psychotherapies (Norcross & Wampold, 2019; Wampold, 2019). Wampold and Immel also refer to substance abuse, taking alcohol abuse as an example where different treatments such as the twelve-step program, cognitive behavioral therapy, and motivational interviewing are not essentially different (p. 255).

The Dodo bird is good news and bad news. Good news for users, health systems, and insurance companies because psychological treatments work. Bad news for researchers and clinicians because they do not know how or why their therapies work or at least they cannot be sure because the therapies of their (reviled) neighbors also work whilst doing different things.

The model of the functioning of psychotherapy clears up the enigma of the Dodo bird. The phenomenon of the pesky Dodo bird is particularly enigmatic and puzzling for a conception of psychotherapy according to a medical model, but not for a contextual model. The main motif of *The Great Psychotherapy Debate*, in fact, the great debate itself, is the contrast between the medical model of psychotherapy and the contextual model. The medical model of psychotherapy (in analogy to the medical model of medicine and psychiatry) assumes that the efficacy of psychological treatment is due to its specific ingredients that repair deficits or dysfunctions underlying the conditions treated, whether they be cognitive schemas in cognitive therapy for depression or "unprocessed" memory in eye movement desensitization and reprocessing (EMDR). Although these psychological therapies, like all others, give importance to the therapeutic relationship, their emphasis and raison d'être lie in the specific techniques (cognitive restructuring, eye movements) that—not without reason—give name and renown to these therapies.

For its part, the contextual model assumes that the effectiveness of psychological treatment is due primarily to the therapeutic relationship and to factors that are common to the different psychotherapies. The common factors refer here to those described by Jerome Frank in his classic *Persuasion and Healing: A Comparative Study of Psychotherapy* (Frank & Frank, 1991), probably the most important book on psychotherapy in the second half of the 20th century. As the reader will recall, Frank's common factors include both those common to all psychological problems—a demoralization (anxiety, hopelessness)—and those shared by all psychotherapies—a *clinician* as a recognized (health, healing) figure, a health *site* (health center, clinic, practice), a reasonable (plausible, credible) *explanation* of what is wrong with the client and what should be done (*rationale*), and the consequent *therapeutic actions* (specific ingredients or techniques) that all therapy entails.

The explanation or *rationale* and, for that matter, the psychological knowledge that are at the basis of the psychotherapy (according to the definition introduced) is the most relevant common factor, which gives meaning to the relationship and to the therapeutic actions. The therapeutic relationship is not a mere human relationship (sympathetic, empathic, kind), but is founded on and informed by the conception of the therapy. One is not born with the gift of the therapeutic relationship, but rather it is something one is trained and practiced in (although perhaps not as much as one should be). The relationship is embodied in the working alliance that becomes the chassis of therapy. The therapeutic actions—however different they may be depending on the therapy or even however obvious they may be depending on common sense—become all the more valuable in the context of the therapy.

As Wampold and Imel point out, "The contextual model recognizes the importance of the therapeutic ingredients, but for a different reason than that proposed by the medical model. Rather than positing a deficit corrected by a specific ingredient, the contextual model posits that specific ingredients in all therapies induce the client to do something that is healthy. That is, the client engages in a health-promoting action, because the activity results in an increase in something healthy or a decrease in something unhealthy." (p. 109). This explanation could be seen as a *second-order change or change 2* that somehow all therapies make, with respect to the patients' failed solutions (*first-order change or change 1*) that led them to seek psychotherapeutic help (Fraser, 2020). It is understood that, in general, psychological therapies do reasonable and indeed reasoned things according to their explanatory

framework (*rationale*), notwithstanding the fact that they can also produce harmful effects, as Wampold and Imel (pp. 180-190) also show.

The similar efficacy supported by the contextual model, which on the "bad news" side makes many clinicians and researchers (in the orbit of the medical model) uncomfortable, is not at all saying that it is the same to do just any old thing. The meta-analyses that show this similarity are based on treatments that are therapeutic for a given disorder. The point is that a variety of treatments for particular disorders are equally effective (p. 257).

The evidence for similar efficacy that gives wings to the Dodo bird has three sources in particular: therapist effects (ch. 6), general effects due to common factors (ch. 7), and specific effects (ch. 8). Therapist effects ("an overlooked but critical factor") highlight how outcomes often depend more on the therapist than on the treatment. Therapist effects exist because the most effective therapists are probably better at forming working alliances. General effects due to common factors in turn have three pathways: the aforementioned working alliance, expectations derived from the explanation offered and the proposed treatment, and participation in therapeutic actions. Finally, specific effects also consist of three types of studies: component studies according to dismantling and additive designs, placebo-control studies (how, for example, the most credible placebos end up being new therapies), and studies of mediators and mechanisms of change, how, for example, cognitions are not really shown to be the mediating processes of the effects of cognitive therapy itself. "Researchers have made a very concrete effort to establish the importance of the specific ingredients of psychotherapy, but as reviewed in this chapter [ch. 8], there is no convincing evidence that the specific ingredients of a particular psychotherapy or of psychotherapy in general turn out to be essential in producing the benefits of psychotherapy." (p. 411).

Research has shown that psychotherapy works reasonably well for most users. However, it is nonetheless puzzling that the evidence supports different therapies. "Consequently, and unfortunately, we are still having some of the same debates about psychotherapy today that we have had in the past" (p. 413). All in all, one thing seems to be clear: the contextual model according to which the benefits of psychotherapy are due to the actual relationship, the creation of expectations through explanation and agreement about the tasks and goals of the psychotherapy, and the facilitation of psychologically beneficial processes of some kind," would account for the functioning of psychotherapy better than the medical model, according to which the benefits are due to the fact that the treatment is repairing specific psychological dysfunctions (p. 414). It goes without saying, again, that this does not refer only to the therapeutic relationship, but also to a reasonable explanation and therapeutic actions consistent with it involving the means to address the problems. The treatment matters, only it is not unique, nor is it just anything.

In the end, Wampold and Imel ask whether empirical evidence leads to therapeutic cynicism. They answer that it does not, insofar as the therapist must be convinced that the treatment is a good option for him- or herself and for the client (p. 444). However, as the authors themselves argue, it is necessary to go beyond the debate (ch. 9). In this regard, they propose the incorporation of the patient's perspective and the continuous improvement of the therapist certainly along ongoing lines (Gimeno-Peón, 2021). For my part, as a commentator and enthusiastic admirer of Wampold and Imel's book, I would go yet further, in the direction of reconceiving psychological problems in phenomenological-existential terms as reactions, survival strategies, and life situations (Pérez-Álvarez, 2021). Now, everything else that one wants to investigate further, must go through *The Great Debate of Psychotherapy*, definitely the most important book on psychotherapy so far in the 21st century.

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