

PSYCHOTHERAPY AND PSYCHIC CHANGE, BETWEEN EVIDENCE BASED ON PRACTICE, AND PRACTICE BASED ON EVIDENCE. A RELATIONAL REFLECTION ON PSYCHOTHERAPY IN THE XXI CENTURY

LA PSICOTERAPIA Y EL CAMBIO PSÍQUICO, ENTRE LAS EVIDENCIAS BASADAS EN LA PRÁCTICA, Y LA PRÁCTICA BASADA EN LAS EVIDENCIAS. UNA REFLEXIÓN RELACIONAL SOBRE LA PSICOTERAPIA EN EL SIGLO XXI

Alejandro Ávila-Espada, Ph.D.¹

Complutense University, Madrid, Spain
ORCID: <https://orcid.org/0000-0003-4821-4211>

This article was published in Spanish. This is the English version.

Link to the Spanish version: (<https://doi.org/10.33898/rdp.v31i116.401>).

How to reference this article:

Ávila-Espada, A. (2020). Psychotherapy and psychic change, between Evidence based on Practice, and Practice based on Evidence. A relational reflection on Psychotherapy in the XXI Century [La Psicoterapia y el cambio psíquico, entre las Evidencias basadas en la Práctica, y la Práctica basada en las Evidencias. Una reflexión relacional sobre la Psicoterapia en el Siglo XXI]. *Revista de Psicoterapia*, 31(116), 29-52. <https://doi.org/10.33898/rdp.v31i116.401>

Abstract

This paper proposes a reflection, from an intersubjective and relational perspective, on the following questions: What are the interventions and treatments in the context of current clinical practice in Mental Health? What kind of scientific theory and method is applicable to clinical practice? What is and what is not a pseudo-therapy, and what are the biases of this pseudo-controversy? What evidence should we recognize as relevant and incorporate into our interventions? Are we aware of the need to evaluate our healthcare psychotherapeutic practice? How should we evaluate our interventions, to contribute to their improvement, and to the increase in the quality of subsequent interventions? Is it a mainly quantitative or qualitative evaluation? After examining these questions, it is proposed to focus our attention on the quality criteria of a psychotherapy based on the dialectic between practice and research, as well as on identifying some of the mega-trends that are expected to mark the evolution of the needs of psychotherapy throughout the 21st century, around which some ways of reflection are opened.

Keywords: Evidence-based psychotherapy; Megatrends in Psychotherapy; Pseudo(psycho)therapy; Quality of care; Mental health.

Received: May 15, 2020. Accepted: June 2, 2020.

Correspondence:

E-mail: avilaespada@psi.ucm.es

Postal address: Facultad de Psicología. Universidad Complutense. Campus de Somosaguas
28223 Madrid. Spain

© 2020 Revista de Psicoterapia



Resumen

En este trabajo se reflexiona, desde la perspectiva intersubjetiva y relacional sobre las siguientes preguntas: ¿Cuáles son las intervenciones y tratamientos que se producen en el contexto de la práctica clínica actual en Salud Mental? ¿Qué clase de teoría y método científico es aplicable a dicha práctica clínica? ¿Qué es y qué no es una pseudoterapia, y cuales los sesgos de esta pseudopolémica? ¿Qué evidencias debemos reconocer como relevantes e incorporar como criterios para valorar nuestras intervenciones? ¿Tenemos conciencia de la necesidad de evaluar nuestra práctica psicoterapéutica asistencial? ¿Cómo debemos evaluar nuestras intervenciones, para contribuir a su mejora, y al incremento de la calidad de las intervenciones ulteriores? ¿Es una evaluación principalmente cuantitativa o cualitativa? Tras examinar estas cuestiones se propone centrar nuestra atención en los criterios de calidad de una psicoterapia basada en la dialéctica entre práctica e investigación, así como en identificar algunas de las megatendencias que se prevé marcarán la evolución de las necesidades de la psicoterapia a lo largo del siglo XXI, en torno a las que se abren vías de reflexión.

Palabras clave: Psicoterapia basada en la evidencia, Megatendencias de la Psicoterapia, Pseudo(psico)terapia; Calidad asistencial; Salud Mental.

At the beginning of the third decade of the 21st century, we continued to ask essential questions about our clinical practice and its social and scientific relevance. What are the interventions and treatments that become relevant in the context of current mental health clinical practice? What kind of theory and scientific method is applicable to this practice? What is and what is not a pseudotherapy? What evidence should we recognize as relevant and incorporate into our interventions in these contexts? How to evaluate our interventions, to contribute to their improvement, and to the increase in the quality of subsequent interventions? What are the quality criteria of a psychotherapy? In what follows, I will reconsider some of these questions, with their derivatives, and will offer bases for their discussion as well as to outline the main answers that commit us as clinicians and, at the same time, responsible agents before our society and the people with whom we work.

All reflection is made from a theoretical and epistemological context, and is marked by the conceptual traditions that mark the training and practice of any clinician, and especially in our field, mental health. In my case, and gathering an experience of five decades (1970-2020)², I can verify that I have undergone numerous transformations that include the initial rejection of Cartesian philosophical conceptions, my immersion in neo-positivism, my subsequent involvement with dialectical thought and phenomenology, plus a stage of passage through naturalistic and descriptive empiricism until reaching social constructivism and intersubjective and relational thinking, where the understanding of man integrates psychodynamic, humanistic, systemic, constructivist and social conceptions. Of all the turns in my career, marks have remained that are part of my context of understanding, which rather than being integrated into a synthesis, have left open questions to continue being explored. The questions that I have drawn as the axis of this reflection will be answered from this context of plural understanding, but based on an axis in which subjectivity is constructed based on processes read principally - but not exclusively - from psychodynamics, but resulting from the social construction that frames the deployment of subjectivity in all the planes of manifestation of intersubjectivity, from the biological to the social.

What are the relevant interventions and treatments in the context of current clinical practice in Mental Health?

To answer this question, I will stop to consider the interventions that affect the processes of the human condition (such as socially constructed inhabited subjectivity) and identity, which makes the person in the culture.

I will begin by establishing the relevance of psychodynamics in the understanding and explanation of the human being (the human condition of the biological being known as the human species). Inferring, formulating and verifying psychodynamic processes in the clinic has been the main contribution of psychoanalytic theories, which share in their application - albeit to a different degree - with humanistic, constructivist and systemic perspectives. Its central contribution is the result of the

dialogue that has existed for more than five decades, between researchers in human development, memory, emotion, processes of psychic change and interpersonal relationships, all within the framework of advances in neuroscience (necessary framework for the knowledge of the subject of the experience), and with the contribution of the new perspective contributed by quantum physics and the theory of dynamic systems for the understanding of psychic processes. In the context of these influences, the core of psychodynamics has evolved from the framework initially proposed by Freudian drive theory, to focus on the description, understanding and explanation of intersubjectivity.

Fonagy and Kächele (2009) have already established the ambiguity of the term “psychodynamic psychotherapy”³ since it denotes a very heterogeneous range of approaches to psychological treatment that have in common the intellectual inheritance of psychoanalytic theory, which is no longer based on a unitary body of ideas, as was Freud’s claim, but assumes in certain assumptions, which are listed below

- (a) A shared notion of psychological causation, that mental disorders can be meaningfully conceived as specific organizations of an individual’s conscious or unconscious beliefs, thoughts, and feelings. This notion is, in essence, shared by cognitive-constructivist, systemic and humanistic approaches.
- (b) Psychological causality extends to the non-conscious part of the mind, since in order to understand conscious experiences, we need to refer to other mental states of which the individual is not aware. This idea is also supported by trauma psychology, in its various approaches.
- (c) Mental functioning is organized to avoid the discomfort that arises from conflict (interpersonal, intrasubjective) in order to maximize a subjective sense of security.
- (d) Defensive strategies are a class of mental operations that appear to distort mental states to reduce their ability to generate anxiety, distress, or displeasure. Individual differences in predisposition to specific strategies have often been used as a method of classifying individuals or mental disorders.
- (e) Various assumptions are made about the processes of normal and abnormal development of children and adolescents, but therapists are invariably oriented to the developmental aspects of the problems presented by their patients.
- (f) Relationship representations linked to childhood relational experiences are assumed to influence interpersonal social expectations, including relationships with the therapist, and shape representations of Self.
- (g) These representations of relationship are inevitably reproduced and updated in the course of psychological treatments, being one of their characteristic processes, since they allow their manifestation, observation and change. (Elaborated from Fonagy & Kächele, 2009, p.1337)

In addition, Blagys and Hilsenroth (2000) defined psychodynamic psychotherapy as an intervention strategy that focuses on emotion, on exploring attempts to avoid feelings and thoughts that cause discomfort, on identifying patterns (relational, emotional, cognitive, motivational), which characterize the subject through exploring past experience and with special attention to interpersonal relationships, to the therapeutic relationship itself, as well as to the exploration of the fantasies and desires that influence the current experience that people have of themselves and their environments. The emphasis on knowledge of the patterns (relational, emotional, cognitive, motivational) that configure the subject's identity and its manifestation in the different areas of expression of human behaviour, even though the emphasis is more on some patterns than others, is shared for virtually all contemporary approaches to psychotherapy. As I understand it, perhaps the main distinguishing note of psychoanalysis, and of the psychotherapy based on it, is its ethical interrogation for its own truth, a knowledge and acceptance of itself and of the moral sense of one's acts and experiences, where the Truth, subjective, constructed, and unattainable as absolute, guides the search for self-knowledge in every human being. Something more ambitious than the therapeutic change that is the clinical purpose, but that is both its origin and goal.

I will highlight here the relevance of the conceptual turn provided by the theory of intersubjectivity. It is an epistemological perspective (Rodríguez Sutil, 2018) that tries to understand psychological phenomena not as a product of intrapsychic mechanisms that occur in an "isolated mind", but as constituted in the intercommunication of mutually interacting worlds of experience. Its object of study is identified as an intersubjective field. To access it, the "empathic-introspective" method is used (which Heinz Kohut (1984/1986) had already formulated from considering the hermeneutics of subjective experience) and which is carried out through relational participation. To understand the processes of the subject in relation, what is investigated and what is intervened is: a) the principles that organize the experience of the person who is the patient (through its detection through empathic connection); b) the principles that organize the experience of the person who is the therapist (through introspection) and c) the intersubjective field created between them (linking them), which in turn includes them (and configures an experience of mutuality). That is, with the intersubjective perspective, the psychodynamics of the subject is no longer the object of central interest, but properties that are part of the observed system.

I have already pointed out that the intersubjective perspective converges with the contributions that research on human development has made in the last decades of the 20th century, in dialogue with Neuroscience. This is a series of evidences that can be summarized in the following principles, and that are especially relevant to our relational approach, while making differences –without denying convergences– with fundamentally cognitive approaches:

1. Human development (and change) happens in a trans-subjective context

- (in which subjectivities originate)
2. Emotions are the core action (operating as somatic markers of all meaningful experience), and thus precede cognition.
 3. In intersubjective communication, the non-verbal predominates (that is, the patterns of implicit non-verbal, pre-symbolic relational knowledge). The somatic-emotional experience is formulated before language, not formulated, but pre-configured (as Implicit Relational Knowledge).
 4. The dynamics of empathic connection (which lies in the system of mirror neurons) regulates the possibilities of connection-disconnection, from communication in the dyad to the social group.
 5. Inference of intent directs experience, and thus opens the privileged space of cognition.
 6. The time of development is that of opportunity, not a chronological sequence. The psychic regulation of physiological needs through the Bonding System integrates the system that structures early development. That it will continue in the attachment system, configuring itself through characteristic patterns.
 7. Development (and psychic change) takes place in the dialogue between minds. It is observed in the progressive construction of the capacities of mentalization.
 8. Development (like psychic change) is not linear nor does it follow a progressive trend, but is chaotic and dynamic.

Thus, the human condition, if it is full, that is, if it can be expressed as inhabited Subjectivity, derives from Intersubjectivity (patterns of implicit relational knowledge marked emotionally) and from Intentional Cooperation (field configured as Cognition). It derives from a space focused on the “we”, which was configured in the structure of the Mirror Neuron System, where development is specific to each subject and their contexts, and is articulated in social identification (Self that we attribute to others + feeling of “being-like-you” activated in the encounter with others) that is the result of preserving the shared space centered on the us. The progressive affirmation of the basic Feeling of the Self in the person, is organized through the Recognition that it receives in its intersubjective links, and is the final expression of a healthy development process⁴.

The configuration of Personal Identity that manifests itself as the maturity of human subjectivity requires a dynamic and contextual balance, at different times of the life cycle, of the seven motivational systems (Lichtenberg, Lachman, & Fosshage, 2011) that regulate action and human experience (Psychic regulation of physiological needs; Bonding with individuals; Affiliation with groups; Caring for others; Self-assertion and Exploration of preferences and abilities; Responding with Opposition / Withdrawal; and Sensuality (Sensory satisfaction, sexual arousal and liberation). In this evolutionary interdetermination, the nuclear patterns that organize subjective experience are configured: Identity, dominant attachment pat-

tern, quality of mentalization processes, emotional expression and regulation, and all of them are integrated into the quality of Relationality achieved by the person in his development. The deficits, dysregulation faults in any of the aforementioned aspects, manifests itself through human suffering, which can crystallize into lasting psychopathological symptoms and syndromes, which in turn also operate as pathological adaptations that allow the recovery of possible psychic balance, be it at the level of anxiety and its regulators (e.g., obsessive and phobic processes), in emotional dysregulation (changes in mood), in dysfunctional interpersonal relationships, or in the sacrifice of the connection with reality that is seen in the so-called psychotic experience.

Summarizing the answer to our starting question, the relevant interventions and treatments, in the context of clinical practice in Mental Health, are those that allow us to access all the levels involved in subjectivity: the emotion that configures the intersubjective connection, which allows , with the progressive consolidation of the capacities of mentalization, to use the inference of intentions in the dialogue with the other, and the recognition that the other gives to the subject to configure his feeling of himself, and as a synthesis of all this, from the emotion felt to the constructed knowledge, to configure the identity in which the subject thinks of himself, subject of himself and in the world. We can reach this field of experience through clinical psychodynamic, humanistic, systemic and cognitive-constructivist traditions, provided that we accept the complexity and radical impossibility of fully describing, hierarchizing, understanding and explaining the psychic processes of human nature.

What kind of scientific theory and method is applicable in clinical practice in Mental Health?

For more than two decades⁵ we have been installed in an idolatry of the so-called “scientific evidence” as a criterion to give value to intervention methods in clinical practice in Mental Health. I will emphasize that the scientific method is a very necessary requirement in the advancement of knowledge, as long as it is understood in an open meaning to its main purpose, to widen the horizon of knowledge in all facets that are relevant to a phenomenon capable of being observed, accepting that observation will always be limited by the instrument of observation, and by the complexity of the phenomena to be observed, in constant interaction with the observer and with other phenomena and conditions that make it possible. We will not go into the complex dimensions of truth here, but let us point out that the complexity of the human psyche cannot be reduced to the observable and encodable categories of its manifestations, nor to the limitations of the observer. Assuming the honesty of the scientist who wants to account for the truth of what is observed, which is our main goal, let us recognize that we have been carried away by an impossible equivalence. In the complex object of study that is human behavior, the laws of the biological are not applicable, principally or exclusively, and therefore

the extrapolation of the methods of “evidence-based” medicine to psychology will be unsuccessful, because it does not consider neither the specificity of the psychic (which is structured as subjectivity) nor of the context that makes subjectivity possible and the very nature and human existence, the social⁶.

To grant scientificity to Psychotherapy, for each theory, method or technique, a series of myths that do not correspond to the nature of objects and phenomena have been accepted as facts verified by the ideology of “Evidence-based Psychotherapy” that constitute it. Among these myths are: 1) That the theory, method and / or technique (psychological) has sufficiently identified and isolated the active principles of the treatment; 2) That the method and / or technique is sufficiently described so that it is rigorously applicable and in the same way with any person and condition; 3) That two or more any theories, methods and / or techniques are truly comparable to each other, avoiding the different levels of processes and phenomena that they imply; 4) That the precise application of a method and / or technique can be carried out without taking into account the variables introduced by the person applying it; 5) That the concrete social, anthropological-cultural and economic context of gender, in which it is applied, does not bias the results; 6) That the results of the treatment are observable, and frequently, that they can be in the short term, when the expected valuable effects of the psychological intervention must be maintained in the medium and long term. And these are not all the myths that we assume to support the studies that provide us with this scientific evidence for the chosen interventions.

Any clinician who is honest with his/her experience, and who respects the truth beyond his own beliefs, and his/her identification with a theory or method, will recognize that it has never been possible to apply a theory and a method and/or technique of In the same way, or that he or she is involved and manifests in the same way, in two different moments of intervention and / or with two different people. That subjective experience sometimes gives us an illusion of similarity does not imply equivalence or identity. In the clinic, each moment, each experience, each relationship, each action are unique and singular. Can we then, for the sake of supposed scientificity, erase those differences?

These questions have accompanied all the theories relevant to psychotherapy and have plunged them into strong contradictions. They have received special attention from all approaches that have not agreed to reduce their object of study to supposedly objective observations of behavior. Among the approaches, each with its nuances, that have looked at the complexity of the human psyche face to face is Psychoanalysis, Humanistic Psychotherapy in its multiple variants, Psychotherapies more genuinely cognitive than behavioral, and especially the constructivist (and social) approach, Systems Theory and Systemic Psychotherapy, and many other variants, some arising from the dialogue between different theories, including those that hold a flexible integrative position⁷.

I will stop now to consider how this implies the main “Demon” chosen by the

ideal science that pretends to be Psychology: Psychoanalysis.

Due to its inalienable nature of human and social science, Psychoanalysis has come into conflict with the excessive pretense of explaining psychic processes and human behavior as a priority based on its biological bases, and with the methods of psychobiology and neurology. The manifestations / consequences (at least some) of the psychic processes are observable, but the processes themselves are not, although neural or biochemical correlates can be established (Westen and Gabbard, 2002a, 2002b). Psychoanalysis is, notwithstanding conventional academic psychology, a Psychology that includes, but is not limited to inferences about consciousness or observable behavior, although its processes (dynamisms) have a problematic identification and categorization. Within psychoanalysis itself, the tension between heuristic and hermeneutical approaches has accompanied its contemporary history (see, among others, Poch and Ávila, 1998; Fonagy et al., 2001; Levy, Ablon, & Kächele, 2012; Leuzinger-Bohleber and Kächele, 2015; Leuzinger-Bohleber, Solms, & Arnold, 2020).

Irwin Hoffman, in a seminal work (2009), defended that a non-objectivist hermeneutical paradigm is the most consistent with psychoanalysis, since it allows the analyst to adopt the existential uncertainty that accompanies the understanding that there are multiple good ways of being, both in the moment as in life in general, and that the decisions made by the person who is the analyst / therapist are always influenced by culture, sociopolitical mentality, personal values, countertransference and other factors, in ways that never they know each other completely. Hoffman argues that a critical and nonconformist psychoanalysis always strives to expose and challenge such foundations in the choices of its participants. The “consequent uniqueness” to each interaction and the indeterminacy associated with the free will of the participants make the individual case study⁸ for Hoffman the most especially suitable for advancing scientific “knowledge” in our field. But the complexity of the clinical and its contexts go far beyond the wealth of unique experience that can be lived in the analytic or psychotherapeutic relationship. Transcending Hoffman’s critique, I agree with Safran (2012) that we must ask ourselves if we can reconcile a non-objectivist hermeneutical paradigm for the singular dimension of the experience that is lived in the therapeutic relationship, with a mixed hermeneutic-heuristic paradigm in which the systematic description -as far as possible- extends the richness and extension of the field of observation to all possible observation perspectives. Understanding that yes, we should embrace a broader perspective, dialectic, and not a mere positioning between the hermeneutic and the heuristic, while we reflect on the cultural biases of any scientific approach, without giving in to individualism, pragmatism and the predominant technocratic tendency in North America that has taken us out of our most holistic positions and European existential-social-humanists, an aspect that was already underlined by Aron (2012) and that are our natural context of scientific understanding and explanation.

But in this era, marked by the *Zeitgeist* of scientific evidence, a controversy

has arisen that contributes to confusion, rather than to the demand for truth that Science seeks. It is an attack on the supposedly “non-scientific”, attributing the term “Pseudotherapy” to any strategy that does not provide evidence that formally derives from studies carried out with the canons and procedures of the experimental method. On this false controversy, contaminated by more political-professional than scientific purposes, I will speak next.

What is and what is not a pseudotherapy? The biases of this pseudo-controversy.

Pseudotherapy has been defined as “the substance, product, activity or service with the intended health purpose that is not supported by scientific knowledge or scientific evidence that supports its efficacy and safety” (Ministry of Health ..., 2018)⁹. Thus defined, from the context of medical practice, the aforementioned document qualifies that the absence of demonstration of its efficacy should not always be considered as a synonym of ineffectiveness (as De Celis, 2019, stresses), although the use of the term “pseudotherapy” is associated with the alleged lack of scientific evidence, and thus has been used in advertising campaigns by some associations and corporations, which have mixed the arguments about the different levels of evidence, which may be desirable in each context of intervention, with disqualification systematics of theories, methods and techniques that do not coincide with the dominant “scientific fashions” in the academic context. Not infrequently, disinformation strategies have been used that associate clinical thought school terms, the scope of which is very general (e.g., Psychoanalysis, Hypnosis, Gestalt ...) with a supposed lack of contrast through the research evidence, a statement many times intentionally biased¹⁰, for ignoring the numerous research and practice-based evidences, widely collected in scientific and professional publications, and sometimes also due to the disinterest of the professionals themselves in accounting for their practice and effects.

The character of “pseudo” is thus attributed by extension to a (psycho) therapy that has not documented reaching certain levels of canonically established “scientific” evidence¹¹, in a hierarchy ranging from double-blind clinical trials, experimental designs, and quasi -experimental, up to clinical and descriptive studies. What are the “acceptable” levels of evidence respond to scientific and professional policy criteria, changing according to local interests, but which essentially ignore the fundamental problem, the impossibility of conducting genuine clinical trials and / or experimental designs of groups that study the processes and results involved in psychotherapy. The formal use of experimental procedures does not resolve the epistemological objections mentioned.

The response to this “tyranny of scientificity” has been taking place from very different institutions whose scientific tradition is well established, and which for the most part belong to the biological and medical sciences. The primacy of quantitative indicators over qualitative ones when assessing the quality of research has been refuted. An example of this is the San Francisco Declaration of Research

Evaluation (2012)¹² that establishes as a main recommendation that quantitative indicators of prestige and appointment of journals be stopped as a quality measure of research work (e.g., Impact factor), and instead a qualitative and unique evaluation of the quality of each work is carried out for decision-making in hiring, promoting or financing researchers and research studies.

It is no longer sustainable to call “pseudo-therapies” strategies and techniques, applied for clinical purposes, that identify the psychological processes on which they intervene, that describe -as far as possible- their actions and techniques, and that are carried out by professionals appropriately trained and ethically committed¹³. Still less can the research reports that account for its application, the processes involved and their results, and ongoing studies be ignored¹⁴.

What evidence should we recognize as relevant and incorporate as criteria to evaluate our interventions?

Let us now deal with the “evidence”. The misnamed “Evidence-based clinical practice”, as we have already described, is a theoretical artifact derived from a scientific fiction, which has revolved around verifying effects and results of nominal strategies and techniques, supposedly indicated for specific problems¹⁵, but without stopping to consider especially the link between the processes that will make the change possible and the effects and results that allow it to be described, for each situation, context and specific people in which those interventions are applied. An evidence-based treatment preaches that for a certain psychopathological clinic (e.g., a phobic symptom), a certain intervention (e.g. exposure¹⁶) will be effective or more effective than another, making this pathological condition stop interfering in any person and situation in which it has occurred or manifested. But, as I have already stressed, neither the symptoms nor the psychopathological syndromes originate and manifest themselves in the same way in two different people, nor in two different contexts, nor are the treatment interventions carried out identically, nor are the clinical ones that apply them behave and influence in the same way, nor the complex interdeterminations that occur in the therapeutic relationship are replicable case by case, intervention by intervention. We are mistakenly weighed down by the ideal assumption that the action of the active principle (e.g. pharmacological) will produce equivalent effects in different individuals afflicted with the same disease or pathogen, although we know that this “ideal” and imperfect condition for biological agents is nothing replicable in psychic, interpersonal and social processes. But no psychological practice (and technique) of supposed clinical action that is implemented by and with human beings is adequate for this objective parameter required by the clinical trial (active ingredient vs. placebo and / or inert agent; vs. no treatment). Every action on psychological processes has a complex qualitative dimension, and an even more complex psychologically and socially constructed over-determination. We do not have the neutral clinician, nor the precise technique, nor the active ingredient, which must operate selectively at the target

of each pathological indicator, in each person, in each intervention context. The biological metaphor, still imperfect in its own realm, is inapplicable here, except as an ideology, but not as a scientific premise.

What, then, is the specific activity of psychotherapy? From our level of analysis, it is an intervention that mobilizes the psychodynamic processes that we have described as characteristic of the evolution towards maturity of human subjectivity, which produces (or mobilizes) diverse structurally significant effects, although not directly observable, but dynamically integrated in the experience that the person has of himself and others and that is built on the integration of emotions, cognitions and actions. These are effects that occur:

- In response to the person's perception of being the object of help (Perceiving that their own experience is contained and sustained in a bond).
- Because the Personal Agency system and management of one's pro-active capacity are activated.
- Because psychic processes are activated, reorganized and regulated at the levels:
 - o Cognitive: Improving the quality of Mentalization processes; and the quality of the Inference of Intentions; with its expression through language.
 - o Emotional: Improving the quality of emotional display (with greater capacity for recognition and expression of both positive and negative emotions) through the verbal and non-verbal.
 - o Interpersonal: It is advanced through the progressive sophistication of relational patterns (from blocking to dyadic, triadic, and social regulation interaction).
 - o Motivational: As a joint and articulated work of the seven Motivational Systems mentioned above.
 - o Bonding: How I work with Attachment Patterns, which evolve towards a higher quality Relationality.
- Through the evocation, representation and regulation of the traumatic experience (that is, through the reorganization of the implicit memory -from trauma- with narratives connected to the Self's own representation that can integrate the split emotions).

These are the effects that will be observed, although with variable delay, as results: a) When observing and evaluating defined symptomatic changes (evaluable symptoms); b) By observing and evaluating changes in psychic processes (because there are changes in the patterns that determine or structure the processes); By observing and evaluating changes in relationship patterns, in their social and interpersonal expression.

The investigation of the change process helps us understand how the structural determinants that are observed as effects / results change in the medium, long and very long term. We have clear evidence, through numerous descriptive investi-

gations, that the relationship process that is therapeutic (that is, that favors and is related to change; see Stern, 2004; Boston Change Process Study Group, 2010):

- It has a dyadic nature (that is, it occurs mainly at that level of interaction: that of Implicit Relational Knowledge).
- Requires Fitting and Directionality (that is, it improves the fit between the participants, configuring the direction of change).
- It requires both disorder and creative negotiation (between both participants).

This process of relational change requires a time of action and consolidation whose duration cannot be established in advance, and which takes place from brief but significant interventions to very long interactions, either in chronological time, or in its symbolic prolongation as a therapeutic relationship. internalized. We will now concern ourselves with identifying the structural characteristics of psychic change that are at the core of psychotherapeutic action.

In every process of genuine change, the integration of the relational Self is experienced and increased (Ávila Espada, 2005, 2013). It is a process of vitalization, trust, solidarity and understanding between the self and the Other (through the internalization of the regulatory interaction). And it has been found that this is structural change, because:

- There is a stable and lasting change in the patterns of experience (of itself, of the other, of the world) and of patterns of behavior, which depends on neuroplasticity, which in turn is dependent on experiences lived or to be lived: the relationship, therefore, is the main mutative agent.
- Adaptive resources and subsequent integrators have been built, allowing repair capacities, derived from living / participating in, repair experiences.
- The recognition processes (of Self and Other) that take place in intersubjective communication have been activated. These are decisive for the construction, consolidation and repair of the sense of Self (and of the representations of the Other).
- Meanings have been reconstructed at the level of Implicit Relational Knowledge (IRK). The meeting moments are then representative of the change in interaction that is registered in the IRK.
- There has been a change in the type of regulatory interaction that occurs with the interpersonal object (and its representation).
- There has been a change at the local level of communication, in the process of assembling intentions.
- And, finally, there has been a change in the interactive process (deep dimension of conflict and defense, which is not just mental representation). Defense (s) are no longer seen as an obstacle to dismantle or refine, but as a necessary construction in the evolution of subjectivity, to transform relationally.

In conclusion, answering the main question from which we started, any psy-

chotherapy that does not contribute significantly to any facet of structural change could be described as pseudotherapy. It would be insofar as it simulates or suggests (operating the suggestion) that there are observable results in behavior, which, although they may have relevance¹⁷, do not produce lasting change in the person, do not positively mobilize their agency, do not reactivate their psychological development, or promote qualitative gains of relationship, that allow the person a psychic life for himself with others in the world more fully. The true therapeutic action is the one that mobilizes development (stopped or failed), not the one that stifles the perception of suffering and favors a pathological adaptation disguised as normality.

Are we aware of the need to evaluate our healthcare psychotherapeutic practice? How should we evaluate our interventions, to contribute to their improvement, and to increase the quality of subsequent interventions? Is it primarily a quantitative or qualitative assessment?

Questions about what kind of evaluation we need to appreciate the changes induced by the strategies we deploy, and also to identify the very activity of the processes that mobilize those changes, remain key questions. Our roots in natural science tend to lead us to “measure” changes, either through qualitative categorical estimates, or through similes that attempt to quantify processes and effects, which are essentially qualitative. Any approach we make to psychic processes will be crossed by this contradiction. We quantify to represent the changes, but it is a mere estimate that requires interpretation and to be placed in the subjective context, it is not the expression of a natural continuous or discrete quantitative variable.

Of course, we have to account for our interventions, which are carried out for both a social and a subject that demands help. Beyond the private practice in which the clinician and the subject are participants immersed in constant mutual evaluation, any clinical practice that is carried out within the framework of an institutional and social program requires to be evaluated and to report its results. However, the effects and results of the intervention with mental health problems require a broad perspective, where the short, medium, long and very long-term effects can be discriminated, and where its context of observation, based on people, it is extended to the cohorts, to the social groups, and crucial are the evolutionary tendencies towards a healthier society, which responds to the many problems that both advanced societies have and those that suffer the effects of globalization without being recipients of their benefits. It is not by chance that, in any reflection on the evolution of mental health in human groups, we are crossed by the ethical questions of climate change and the limits of global development, a problem in which we are all included.

All evaluation requires the use of instruments to carry it out. For this reason, we have to answer the question: with what evaluation instruments or techniques can we “measure” or “infer” the effects and results of psychotherapeutic interventions? Answering this question appropriately requires other work, but let’s move

on to some aspects.

Let us clarify our objectives, and put in correspondence our evaluation strategies, and the possible techniques to use. In this search we find the main tools developed in the last decades, and which is shown in Table 1, focused on intervention with adult subjects.

Table 1. *Assessment objectives relevant to psychotherapy and examples of instruments*

Assessment objectives	Examples of procedures and instruments ¹⁸
Objectives / Results, based on their definition by clinical criteria	CORE-OM; OQ-45.2
Symptomatic changes, using conventional psychopathological semiology	SCL-90-R; SA-45; BRPS; PANSS
Adjustment and Social and Adaptive Functioning, as well as Quality of Life	SAS-II; SFS, WHOQOL, QLS
Conventional psychodynamic diagnosis in Mental Health, with a multiaxial structural categorization system	OPD-2; PDM-2
Description of the variables and dimensions of the therapeutic process	PQS, APS
Changes in the main psychic processes (changes in patterns and processes)	SWAP-200, PHI, RADIO
• Integrating health indicators and psychic processes	WAI-S; WATOCI; CMOTS
• Valuing Treatment Motivation and Therapeutic Alliance	RF (AAI); TESEM, MEMCI
• Quality of Mentalization processes and Reflective Functioning	BDSEE, PANAS, ACQ
• Expressed emotion, Affect	CCRT-LU(S); RAP
• Relational Pattern (Adaptative or Maladaptative)	AAI ; CAA; CaMiR; AAPR; PACS
• Dominant Attachment Pattern	CAPS-DX; DES
• Quality and intensity of the traumatic experience	AF-5; LAEA; DS
• Selfconcept	EFY
• Ego functions	EAP-92
• Subjective perception of the change that has the client	VPEG
• Components of the group process, in group interventions	
Processes with which the person who is the clinician, their style of interventions and other personal variables, contribute to change	EPT-C/PST-Q; EPT-ToM
• Therapist's personal style	IPR
• Empathy	TLAP
• Latent Therapist Action Plan	CQ, TRQ
• Countertransference and emotional reactions of the therapist	

Once we have been able to verify that our techniques are adequate to their object, that is, the best knowledge and respect for the characteristics of human subjectivity, we must deploy an evaluative commitment that accounts for our actions and their effects. It is not just a problem with choosing assessment techniques. What we lack -at least in part- is to become aware of the importance of our involvement as agents of a strategy to help mental health problems in people and the community. We are not just “emergency” clinicians, but also ethically committed

clinical agents. Ethics does not respond primarily to the urgent, but rather claims meaning for our practice. For this reason, the clinician who works in his natural context, the consultation - private or institutional - is also a researcher who observes and evaluates his interventions. If as clinicians we systematize some facets of our practice, incorporating evaluation strategies and techniques, this will allow us to better understand our resources and possibilities, and at the same time we will contribute to improving the quality of current and future interventions. For this we require institutional support, but also an ethical commitment to improve our practice, serving both the client's needs and our own.

Conclusions: Claiming the quality criteria that give value to psychotherapy and a consideration on its megatrends of evolution in the 21st century

The evaluation of a psychotherapy must focus on verifying to what extent it meets the quality criteria that are required of it. Tizón (2009) has already formulated these criteria including the following: *Accessibility* (Facility with which consultants can obtain care when they need it); *Adequacy* (Form of provision of care or therapy, according to the state of technological development, compared to its "canonical" definition); *Continuity* (The necessary care is coordinated between different professionals, devices, organizations and over time); *Effectiveness* (The techniques or procedures are provided in an appropriate way, according to the average technological development or "real effectiveness"); *Efficacy* (Ability of a technique to solve the problems for which it is indicated); *Efficiency* (Consumption of efforts, economy, personnel, undesirable repercussions, etc. of a technique); *Safety* (Degree to which procedures are free of chance or potential danger); *Opportunity* (Degree to which care is provided when needed); *Satisfaction from the perspective of the consultant and their relatives* (Contrasting collection of opinions and evaluations); *Improvement in the quality of life* (Variation in the quality of life, evaluated according to the usual systems, between the "before" "during" and the "after" - in the short, medium and long term - of a therapy); *Autonomy / heteronomy balance* (Degree of incorporation of patients and their families in the decision-making processes of the technique and in the exploratory and therapeutic processes and procedures used). All these indicators must be verified in all psychotherapy, but very especially in public assistance programs in mental health, without neglecting the importance they have in private, institutional or clinical care.

To those described by Tizón, I would add the requirement of an institutional and personal commitment to the necessary specialized and accredited training of psychotherapy professionals¹⁹, and the ethical requirement of updating in the vast field of knowledge provided by the clinic. It is not only knowing the advances that the investigation contributes, but the opening to the evolution of the clinical knowledge, rich in casuistry and with special sensitivity to social and cultural differences. It is also an ethical requirement not to use the evidence, always partial and limited that the research provides, to imply (to the public, but also to the

professional) that a “treatment that has received evidence indicators at this or that level is a treatment cash. Remember that it is contrary to professional ethics to promise success in treatments.

Let us now examine the probable megatrends that are already observed in relation to the evolution of the needs of psychotherapy in the 21st century, some of which are already advanced and manifest (see Ávila Espada, 2003), but to whose concretion we must contribute, claiming their importance.

The most essential, to meet quality requirements, is the public protection of basic psychotherapeutic services, with a broad and flexible bio-psycho-social concept, key to the right to mental health²⁰. By promoting different levels of care: preventive interventions (primary, secondary, tertiary), therapeutic and rehabilitative, at the service of the clients and their families. The fact that public services have to be built and cared for until they reach sufficient quality, which must then be maintained, does not mean that their initial limitations should be used to discredit them.

In line with the above, community services must be given priority in the first line as a fundamental intervention strategy, both preventive and therapeutic. Psychotherapeutic intervention in primary care and in the community social services network has been shown to be the most efficient strategy for mental health, and the one that probably has the best cost / effectiveness ratio in the medium and long term.

Without forgetting the importance of the ethical integration of Information and Communication Technologies (ICT), Artificial Intelligence, Virtual Reality and Neurotechnology that can contribute to the service of the person and their mental health, but not to replace to the professional of help, still less to the full therapeutic relationship. Attention to mental health will in essence always be personal, direct and humane, even if it is helped by technological facilitators. Let us draw attention to the urgent need for neurotechnology, and access to neurodata, to be legally restricted to avoid or mitigate as much as possible the risks of using artificial intelligence that violates mental and behavioral privacy, a sense of identity and the person's own autonomy of choice, which may also be highly determined by differences in access to possible improvement technologies, or by discriminatory biases (of the person or of the social or cultural group) that such neurotechnology could promote²¹.

The gender perspective, and the acceptance of psychodiversity, characteristic of human nature, where a distinction is made between being different and “being sick,” must be recognized and integrated into the ethics of clinical practice, which includes especially acceptance of the complexity of respectful human sexual behavior with the other. The human being possesses autonomy, has the capacity for self-organization linked to interdependence (his intersubjective nature), belonging to the social and ecological realities in which he or she is located as a person, and possesses adaptive capacities to the vicissitudes of everyday life (eg stress, mourning) that are not pathologies that require treatment as if they were illnesses, but psychological and social help available for their recovery.

And, finally, as the main strategy to promote the quality of psychotherapy,

give priority to specialized training and continuing training for psychotherapists, but also for different health professionals, each in their range of action. Clinician training is a life project.

And outlining this horizon for the course of the 21st century, our challenge is to demand a commitment to the truth that is the genuine scientific purpose, a truth that will have to be constantly under review as regards the human being. In the era where post-truth has become notorious and habitual as news and in which global communication navigates without filters, what most damages the advancement of knowledge and the improvement of clinical practice is silence and passivity in the face of lies, intentional or its rebound among the followers of any belief, social, scientific or professional. It is in this context that the so-called “Evidence-Based Psychotherapy”, a by-product of “Evidence-Based Medicine” has been enhancing its discourse, which, with the good intentions of leaving behind quackery or masked manipulation of aid, has used its arguments to undermine the central elements that constitute psychotherapy: a human relationship, which abides by ethics, and which is carried out by professionals adequately trained in the long trajectories of knowledge and experiences of more than a century and a quarter of practice clinic with psychic suffering and contributing to the development of personal subjectivity and transformative commitment to society. If relational factors are relegated to a mere facilitation of “techniques”, the biomedical model will regain its priority, and psychotropic drugs will be seen as essential for the regulation of neurobiological processes. Wherever the constitutive and creative tension of subjectivity could unfold, the psychotropic drug will regulate its deficiencies. It will undoubtedly fail, but the human being will alienate his possibilities by submitting himself to the social and economic control that is exercised over collective and individual health through psychotropic drugs.

We have gone through stages - which are still present - in which we have become the banner of absolute solutions that do not satisfy us. Among them is the fallacy of the integrative solution in the theory and technique of psychotherapy (because every good clinician will *de facto* integrate different perspectives and resources in their aid strategy, but they will not overcome their doubts and contradictions by embracing an integrating and overcoming theory of the previous ones); the proposal that “common factors” would provide the basis for overcoming the differences between the different schools of clinical thought, when the essential thing that is common is that if there is clinical psychotherapeutic intervention it is because two people are involved in a relationship with a shared purpose (see Lingiardi, Holmsqvist, & Safran, 2016; Norcross and Lambert, 2018); And, although in a context more directed to public and professional opinion than at scientific opinion, we have been affected by the false controversy of pseudotherapies, because although there are deceptive practices and deception, it is a manipulation to use that argument to attack everything that does not It coincides with the limited possibilities offered by rampant empiricism, without the refuge of a “Scientific Psychotherapy”, when

Psychotherapy, without renouncing the truth and constant knowledge, can only be a Human Psychotherapy²².

The accepted definition of “Evidence-Based Practice in Psychology” (EBPP) establishes that it is the integration of the best available research with clinical experience (the opinions of experts), in the context of the characteristics, culture and preferences of the patients (APA, 2006; Sackett, Rosenberg, Gray, Haynes, & Richardson, 2000). The purpose of the EBPP is to promote effective psychological practice and the improvement of public health by applying the empirically supported (not exclusively experimental) principles of psychological assessment, case formulation, therapeutic relationship, and intervention (APA, 2006). We accept this formulation as a frame of reference, but we cannot ignore all the qualitative implications: the crucial value of clinical experience, context and culture, and the centrality of the therapeutic relationship in any intervention strategy, and as a whole of a treatment program. The professional (and the researcher), as observers of the clinical fact, are inevitably participating observers in what is observed, and their neutrality and objectivity are illusions to be contextualized from ethical and technical limits. That the manifest behavior, mainly interpersonal, can be observed, only provides information on a partial level. That the psychophysiological variables can be recorded and interpreted, again only provides information from another partial level. That the person can report their experience, contributes another partial level. Beyond the interdetermination and integration of all these levels being complex and problematic, singular human subjectivity will always be essentially unattainable. Rather than opting for simplistic reductionisms, we must demand prudence and flexibility. The essential in the clinic will always be the help that is possible at all times and in every context. There is no absolute or permanent evidence.

For all of the above, and in its broad meaning, Psychoanalysis, and especially the relational and intersubjective aspect from which these reflections have been elaborated (Ávila Espada, 2015), offers its proposal to provide a human and social science of subjectivity, which places special emphasis on the psychic processes that constitute subjectivity and that operate outside or at the limits of consciousness (e.g. dissociated), including the construction of experience, the experience of Self states and their nuclear schemas (or unconscious organizing principles). As we have been describing, it is specified in comprehensive, explanatory and action models using methods aimed at the (re) construction of the Self and the recognition of subjectivity (hermeneutics, heuristics and clinical-therapeutic), and it is in constant transformation and dialogue with other perspectives, as the evolution of contemporary psychoanalysis has well shown, from its origins, but more especially in the last half century²³.

Our option is to work to be clinicians aware of our shortcomings, but to take advantage of our fertile resources, fortunately well described by the researchers of the psychotherapeutic clinic (Levy, Ablon, & Kächele, 2012) and who have been providing an extensive compilation of evidence that corroborates the value of ps-

ychodynamic interventions (Leichsenring, 2004; Westen, Novotny, & Thompson-Brenner, 2004; Shedler, 2010, 2015, 2018). Our goal is ethical: to work supported by practice-based evidence, constantly enriching our conceptual baggage, as committed clinicians, of the articulation between clinical wisdom derived from both research and practice, with a contextual understanding of the meaning of each of the strategies that we develop in and for the society in which we live, and whose improvement we intend to contribute. There is no personal “cure” without environmental transformation, although the rates of transformation of people and societies are different. As clinicians we are responsible for our permanent updating in the conventional domains of our activity (evaluation, treatment, prevention) and as psychotherapists who work with people we know that the relief of subjective suffering and structural change cannot be separated, neither in the level of the individual, nor on the social level. For this reason we have been trained and informed -as relational psychoanalysts- but also from other conceptions that support the relational nature of psychotherapy- by the Attachment Theory, the Mentalization Theory; advances on the specificity of human development, emotion and social cognition and its links with change; and essentially to know more and better the processes of Change, where Social Anthropology, Neuroscience and ethical commitment are articulated in the defense of the survival of the human species and its values, precisely when they are most threatened.

Acknowledgments:

To my colleagues Carlos Rodríguez Sutil and Isabel Caro Gabalda for their critical reading of this work and their valuable comments that have helped me to clarify some aspects of this paper.

The author declares that he has no conflicts of interest.

Notes

- 1 Clinical psychologist. Professor of Psychotherapy, Complutense University. Honorary President of the Institute of Relational Psychotherapy (Madrid). He was founder and first President of FEAP and IARPP-Spain. Editor of the e-journal Clinical and Relational Research. Among his works: *The interpersonal tradition. Social and cultural perspective of psychoanalysis* (Ágora Relacional, 2013) and *Relational Horizons* (IPBooks, 2018) Contact: aviloespada@psicoterapiarelacional.com
- 2 My first relevant contacts, and since then continuous and permanent, with the field of mental health and the knowledge and practices involved in it, took place in 1970, at which time my university training trajectory turned to Psychology, turning from my previous interest in Contemporary History.
- 3 If the term “psychodynamic psychotherapy” is ambiguous, much more so is the term “psychoanalysis” or “psychoanalytic theory”, since both encompass very different conceptions that cannot be included as a singular expression.
- 4 Healthy human development implies the satisfaction of the main evolutionary needs of every human being, which can be met if the quality of the social-family context facilitates or provides (continuously or discontinuously) sufficiently in the face of the following

- phenomena: 1) Social orientation - Imitation and intentional inference; 2) Empathetic Resonance / Mirroring; 3) Expression - differentiation of emotions; 4) Co-construction of communication patterns; integration and differentiation of self-representation; 5) Self-representation is expressed in a consolidated way in the intersubjective bond through the Attachment System (which can vary in its forms / patterns, from the Secure, to the Ambivalent-Resistant, the Insecure-Avoidant, or to the Disorganized).
- 5 From the first structured approaches that make scientific evidence of a method of diagnosis and / or treatment (around the mid-1990s) an ideal standard for practice in Medicine, and which are subsequently transferred to Psychology (in the following decade).
 - 6 The understanding of this problem does not favor the fact that Psychology has been placing itself in the “Health Sciences”, abandoning its place in the “Social and Human Sciences”. Although the recognition and inclusion of the Psychological in the applied field of Health is very necessary, with the implications of endowments in all areas, the minimization or denial of its nature as a complex science, more social and human than biological, it has contributed very negatively to its scientific advance, by imposing a methodological reductionism by which it loses the richness of phenomenology and hermeneutics, prioritizing an empiricist heuristic that prevents it from accounting for the complexity of its object of study.
 - 7 There have also been frequent “radical” integrative proposals, in which it is assumed that an Integrative Theory will surpass previous theories, which are seen as partial and obsolete. This “hard integration” should not be confused with the richness that technical eclecticism brings (which *de facto* many professionals use) supported by a flexible interpretation of the psychological theory on which the clinician relies.
 - 8 The “individual case” can be a valuable object of investigation if we can respect the richness and complexity of the “data” it offers, whose analysis requires methodological approaches ranging from naturalistic description to qualitative assessment, among other possibilities.
 - 9 “Plan for the Protection of Health against Pseudotherapies” presented in 2018 by the Ministry of Health, Consumption and Social Welfare and the Ministry of Science, Innovation and Universities of Spain, based on a document prepared in 2011 by a working group created in 2007 by the Health and Consumption Commission of the Spanish Congress of Deputies.
 - 10 Criticism of very broad conceptual traditions, such as psychoanalysis, has been, and sometimes continues to be, commonplace. Generic, while avoiding - not always due to ignorance - the broad body of relevant research produced. See an updated compilation of research contributions on psychoanalytic psychotherapy at: https://www.psicoterapia-relacional.es/Portals/0/eJournalCeIR/V14N1_2020/Listado-de-Referencias-Evidencias-Psicoterapia-Psicoanalitica_Compilacion-Prof_Alejandro-Avila-Espada_UCM_vActualizada.pdf
 - 11 A compilation of evidence level criteria and general references of this type for psychological therapies, which follows the traditional criteria that are based on the applicability of experimental designs to psychotherapy can be seen at: <https://webs.ucm.es/info/psclinic/guiaretrat/index.php> (directed by Prof. María Crespo at UCM) and has been the subject of several academic manuals in Spain in recent decades (e.g., Pérez Álvarez, Fernández, Fernández, & Amigo, 2003)
 - 12 Titled “Putting science in research evaluation” held on December 16, 2012 at the annual

- meeting of the American Society for Cell Biology in San Francisco and initially signed by 78 research institutions and 154 leading researchers from around the world, which have been joined by institutions and researchers that currently number more than a thousand. See at <https://sfdora.org/>
- 13 On the training of psychotherapy professionals, we will return to insist, in the last part of this work, because accreditation and updating frameworks are necessary, which must be constantly reviewed.
 - 14 Since an investigation, at any level, is carried out and its results are published, many years can pass.
 - 15 The syndromes and clinical entities that clinical psychopathology identifies are not real entities, and include a wide set of specification possibilities. The symptoms are obviously less specific, in the vast majority of cases.
 - 16 The proposed and applied techniques, identified with theoretical labels, frequently mask the essential similarity between different procedures supported by different theories, when strategies and techniques with new names are not reinvented, without even recognizing the origin of the proposal. This has been happening frequently with the strategies and techniques of the so-called “3rd generation therapies”, where psychodynamic or humanistic strategies and techniques are renamed as behavioral and cognitive.
 - 17 Many of the partial achievements that make up “observable results” are preconditions for other achievements of greater structural scope that could occur later, if the mobilized processes lead to change. For example, psychoeducation is almost always very valuable, which gives the subject greater capacity for observation and understanding of the processes; likewise to gain control capacity of the somatic manifestations of the anxiety; Identify, perceive and express the emotions felt; Know the perceptual biases and cognitive distortions; and many others.
 - 18 See complete data and references at: https://www.psicoterapiarelacional.es/Portals/0/eJournalCeIR/V14N1_2020/Listado-de-Referencias-Evidencias-Psicoterapia-Psicoanalitica_Compilacion-Prof_Alejandro-Avila-Espada_UCM_vActualizada.pdf
 - 19 See, as an example, the training and accreditation criteria of the Spanish Federation of Associations of Psychotherapists (See: <http://www.feap.es/index.php/preguntas/psicoterapeutas-interesados-en-acreditarse>; http://www.feap.es/images/feap/documentos/ACREDITACION_PSICOTERAPEUTAS.pdf) and also those that other professional organizations and corporations have been developing, such as the EAP (<https://www.europsyche.org/>) or the EFPA (<http://www.europsy.cop.es/index.php?page=Psychotherapy-Introduction>). In all these or other criteria and systems, what is essential is the quality of the training programs and the commitment of trainers and professionals, and not the mere formal fulfillment of requirements.
 - 20 Specially relevant is the recent debate published online (<http://espacio-publico.com/en-defensa-del-derecho-a-la-salud-mental>) started on January 8, 2020 based on the text by Joseba Atxotegui “The difference is not a disease”, where numerous relevant visions are collected for understanding this problem.
 - 21 See the NeuroRights Initiative at Columbia University in New York City (<https://nri.ntc.columbia.edu/content/our-story-0>)
 - 22 Recently, some advocates of Evidence-based Psychotherapy have nuanced their arguments claiming the character of Human Science for Psychotherapy (Pérez Álvarez, 2019). Resolving the contradictions derived from the previous dogmatic positions will require a greater perspective.
 - 23 From its earliest days, Psychoanalysis has evolved with numerous tensions between its own dogmatism and openness to human and social reality. Due to their transcendence, beyond Freud’s proposals, we will cite Ferenczi and Jung as pioneers of this evolution, and later theorists and clinicians such as Sullivan, Fromm, Winnicott and Kohut, Mitchell and Stolorow, plus a plethora of contributors emerged in around them, or from them (Coderch, 2006; Coderch and Ávila, in press).

References

- American Psychological Association Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, 61, 271–285. <https://doi.org/10.1037/0003-066X.61.4.271>
- Aron, L. (2012). Rethinking “Doublethinking”: Psychoanalysis and Scientific Research—An Introduction to a Series. *Psychoanalytic Dialogues*, 22(6), 704–709. <https://doi.org/10.1080/10481885.2012.733650>
- Ávila Espada, A. (2003). ¿Hacia dónde va la psicoterapia? Reflexiones sobre las tendencias de evolución y los retos profesionales de la psicoterapia. *Revista de la Asociación Española de Neuropsiquiatría*, 23(87), 67-84. Retrieved from: http://scielo.isciii.es/scielo.php?pid=S0211-57352003000300005&script=sci_arttext&tlang=en
- Ávila Espada, A. (2005). Al cambio psíquico se accede por la relación. *Intersubjetivo: Revista de psicoterapia analítica y salud*, 7(2), 195-220.
- Ávila Espada, A. (2013). La relación, contexto determinante de la transformación. Reflexiones en torno al papel de la interpretación, el insight y la experiencia emocional en el cambio psíquico. *Temas de Psicoanálisis*, 6. Retrieved from: <https://www.temasdepsicoanalisis.org/2013/07/04/la-relacion-contexto-determinante-de-la-transformacion1/>
- Ávila Espada, A. (2015). Psicoterapia psicoanalítica relacional. Lugar de encuentro de la evolución del psicoanálisis. In J. Guimón (Coord.), *Un cuarto de siglo de psiquiatría psicodinámica* (pp. 41-62). Madrid, Spain: Eneida.
- Blagys, M. & Hilsenroth, M. (2000). Distinctive activities of short-term psychodynamic-interpersonal psychotherapy: a review of the comparative psychotherapy process literature. *Clinical Psychology*, 7(2), 167-188. <https://doi.org/10.1093/clipsy.7.2.167>
- Boston Change Process Study Group (2010). *Change in Psychotherapy (A Unifying Paradigm)*. New York, NY: Norton & Company.
- Coderch, J. (2006). *Pluralidad y Diálogo en Psicoanálisis*, Barcelona, Spain: Herder.
- Coderch, J. & Ávila-Espada, A. (en prensa). Algunas razones que explican la transformación del psicoanálisis en muchos psicoanálisis. *Revista PsiRelacional*.
- De Celis, M. (2019). De qué hablamos cuando hablamos de pseudoterapias. Plan para la Protección de la Salud frente a las Pseudoterapias. *Revista Clínica Contemporánea*, 10(1), 1-5. <https://doi.org/10.5093/cc2019a7>
- Fonagy, P., Kächele, R. & Krause, E. J. (Eds.) (2001). *An Open Door Review of Outcome Studies in Psychoanalysis* (2nd ed.). London, United Kingdom: International Psychoanalytical Association.
- Fonagy, P. & Kächele, H. (2009). Psychoanalysis and other long term dynamic psychotherapies. In M. Gelder, N. Andreasen, J. Lopez-Ibor & J. Geddes (Eds.), *New Oxford Textbook of Psychiatry* (2nd ed., pp. 1337-1349). Oxford, United Kingdom: Oxford University Press. <https://doi.org/10.1093/med/9780199696758.001.0001>
- Hoffman, I. Z. (2009). Doublethinking Our Way to “Scientific” Legitimacy: the Desiccation of Human Experience. *J Am Psychoanal Assoc*, 57(5), 1043-1069. <https://doi.org/10.1177/0003065109343925>
- Kohut, H. (1986). *¿Cómo cura el análisis? [How does Analysis Cure?]*. Buenos Aires, Argentina: Paidós (Work published in 1984).
- Leichsenring, F. (2004). Randomized controlled vs. Naturalistic studies. A new research agenda. *Bulletin of the Menninger Clinic*, 68(2), 115-129. <https://doi.org/10.1521/bumc.68.2.137.35952>
- Leuzinger-Bohleber, M. & Kächele, H. (Eds.) (2015). *An Open Door Review of Outcome Studies in Psychoanalysis* (3rd ed.). London, United Kingdom: International Psychoanalytical Association. Retrieved from: http://www.ipa.world/ipa/IPA_Docs/Open%20Door%20Review%20III.pdf
- Leuzinger-Bohleber, M., Solms, M. & Arnold, S. E. (Eds.) (2020). *Outcome Research and the Future of Psychoanalysis. Clinician and Researchers in Dialogue*. London, United Kingdom: Routledge. <https://doi.org/10.4324/9780429281112>
- Leuzinger-Bohleber, M. & Target, M. (Eds.) (2002). *Outcomes of Long-Term Psychoanalytic Treatment. Perspectives for Therapists and Researchers*. London, United Kingdom: Whurr Publishers.
- Levy, R. & Ablon, J. S. (Eds.) (2009). *Handbook of Evidence-Based Psychodynamic Psychotherapy. Bridging the Gap Between Science and Practice*. Totowa, NJ: Humana Press. <https://doi.org/10.1007/978-1-59745-444-5>
- Levy, R., Ablon, J. S., & Kächele, H. (Eds.) (2012). *Psychodynamic psychotherapy research: Evidence-Based Practice and Practice-Based Evidence*. Totowa, NJ: Humana Press. <https://doi.org/10.1007/978-1-60761-792-1>
- Lichtenberg, J. D., Lachman, F. & Fosshage, J. (2011). *Psychoanalysis and Motivational Systems. A new look*. New York, NY: Routledge.
- Lingiardi, V., Holmsqvist, R. & Safran, J. D. (2016). Relational turn and Psychotherapy Research. *Contemporary Psychoanalysis*, 52(2), 275–312. <https://doi.org/10.1080/00107530.2015.1137177>
- Ministerio de Sanidad, Consumo y Bienestar Social y Ministerio de Ciencia, Innovación y Universidades. (noviembre, 2018). *Plan para la Protección de la Salud frente a las Pseudoterapias*. Retrieved from: http://www.ciencia.gob.es/stfls/MICINN/Ministerio/FICHEROS/20181108_Plan_Proteccion_frente_pseudoterapias_VF.pdf

- Norcross, J. C. & Lambert, M. J. (2018). Psychotherapy Relationships That Work III. *Psychotherapy*, 55(4), 303-315. <http://dx.doi.org/10.1037/pst0000193>
- Pérez Álvarez, M. (2019). La Psicoterapia como Ciencia Humana, más que tecnológica. *Papeles del Psicólogo*, 40(1), 1-14. <https://doi.org/10.23923/pap.psicol2019.2877>
- Pérez Álvarez, M., Fernández, J. R., Fernández, C. & Amigo, I. (Coords.) (2003). *Guía de tratamientos psicológicos eficaces I. Adultos; II. Psicología de la Salud; III. Infancia y Adolescencia*. Madrid, Spain: Pirámide.
- Poch, J. & Ávila, A. (1998). *Investigación en psicoterapia. La contribución psicoanalítica*. Barcelona, Spain: Paidós
- Rodríguez Sutil, C. (2018). Relational Psychoanalysis. A New Psychoanalytic Epistemology. In A. Ávila (Ed.), *Relational Horizons. Mediterranean Voices Bring Passion and Reason to Relational Psychoanalysis* (pp.29-54). Astoria, OR: IPBooks.
- Sackett, D. L., Rosenberg, W. M., Gray, J. A., Haynes, R. B. & Richardson, W. S. (1996). Evidence based medicine: what it is and what it isn't. *BMJ*, 312(7023), 71-72. <https://doi.org/10.1136/bmj.312.7023.71>
- Safran, J. D. (2012). Doublethinking or Dialectical Thinking: A Critical Appreciation of Hoffman's "Doublethinking" Critique. *Psychoanalytic Dialogues*, 22(6), 710-720. <https://doi.org/10.1080/10481885.2012.733655>
- Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist*, 65(2), 98-109. <https://doi.org/10.1037/a0018378>
- Shedler J. (2015). Where is the evidence for "Evidence-based" therapy? *Journal of Psychological Therapies in Primary Care*, 4, 47-59.
- Shedler, J. (2018). Where Is the Evidence for "Evidence-Based" Therapy? (rev.). *Psychiatr. Clin. N. Am.*, 41(2), 319-329. <https://doi.org/10.1016/j.psc.2018.02.001>
- Stern, D. N. (2004). *The present moment in psychotherapy and everyday life*. New York, NY: Norton.
- Tizón, J. L. (2009). Atención basada en pruebas: ¿Es evidente la evidencia? *Quaderns de Salut Mental*, 6. Retrieved from: https://psicoterapiarelacional.es/Portals/0/Documentacion/JTizon/Tizon_2009_Asistencia-basada-en-pruebas_Quaderns6.pdf
- Westen, D. & Gabbard, G. (2002a). Developments in cognitive neuroscience: I. Conflict, compromise, and connectionism. *Journal of the American Psychoanalytic Association*, 50(1), 53-98. <https://doi.org/10.1177/2F00030651020500011501>
- Westen, D. & Gabbard, G. (2002b). Developments in cognitive neuroscience: II. Implications for theories of transference. *Journal of the American Psychoanalytic Association*, 50(1), 99-134. <https://doi.org/10.1177/2F00030651020500011601>
- Westen, D., Novotny, C. M. & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. In American Psychoanalytic Association, & Alliance of Psychoanalytic Organizations, *Psychodynamic Diagnostic Manual PDM Task Force* (pp. 691-764). Silver Spring, MD: Alliance of Psychoanalytic Organizations.