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Introduction to psychological treatment

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2. Definition and Objectives of Psychological Interventions in Clinical and Health Settings

2.1. Definition of Psychological Intervention

An intervention is characterised by the use of specific means to address a problem. In the field of health, psychological intervention can be defined as a set of communication-based procedures used by appropriately trained professionals to establish a therapeutic relationship and, through it, address individuals' physical or psychological distress. It is thus distinguished from physical or pharmacological interventions, which are more typical in medicine.

There is currently broad consensus on the need for psychological intervention methods to be theoretically and empirically supported. This criterion is essential for distinguishing evidence-based psychological methods with scientific backing from other approaches that may be applied in similar cases but are based on everyday psychology concepts, personal experience, or theories that have not yet been validated. However, as we will see later, there is considerable debate about which validation methods are most appropriate.

2.2. Objectives of Psychological Interventions

The primary aim of psychological interventions in healthcare is to promote physical and psychological well-being through prevention, guidance, treatment, and recovery support. To understand what we mean by promoting well-being, we must view the concept as a continuum.

On one hand, some individuals may be at risk of experiencing psychological distress, and preventive interventions can be implemented to reduce this risk. More recently, attention has been drawn to the potential iatrogenic effects of certain interventions. In this regard, a new level of prevention has been proposed (Jamoulle, 1986) to uphold the principle of *Primum non nocere* (first, do no harm). On the other hand, some individuals present with a specific problem that can be addressed through psychological techniques. Finally, in some cases, even when distress cannot be completely eliminated, psychological intervention can help reduce it and improve the individual's quality of life. All these interventions involve techniques that support decision-making, reshape individuals' perceptions of the world, others, and themselves, transform emotions, thoughts, and behaviours, and enhance interpersonal skills.

2.2.1. Prevention

Although prevention is often understood as actions aimed at avoiding the initial onset of a problem, in psychological intervention, the term encompasses four levels:

1. **Primary prevention** focuses on promoting health and preventing physical and psychological distress. It targets entire populations without distinguishing between specific groups. An example would be parenting skills workshops.

2. **Secondary prevention** aims at the early detection of psychological distress and intervention to prevent its worsening. It is directed at individuals who are already experiencing distress or are at risk of developing it. An example would be early intervention programmes for individuals who report unusual experiences, such as hearing voices that others do not.

3. **Tertiary prevention** focuses on preventing relapse or the emergence of new problems in individuals who have previously received psychological treatment. An example includes programmes supporting the maintenance of substance use reduction or abstinence from compulsive behaviours.

4. **Quaternary prevention** involves preventing overdiagnosis, overtreatment, and iatrogenic harm caused by therapeutic interventions in individuals who do not require treatment or who may experience negative consequences due to unnecessary or excessively intense interventions.

2.2.2. Counselling

Counselling also known as psychological guidance, involves providing individuals with information to support decision-making or help them manage specific situations or mild distress. Although typically more limited in scope than psychological treatment, the professional may also provide advice and emotional support. It is important to note that, in practice, the distinction between counselling and treatment may not always be clearly defined and can vary across regions.

2.2.3. Psychological Treatment

Psychological treatment refers to a set of communication- and relationship-based practices aimed at alleviating psychological distress or improving physical health. Generally, the term psychological treatment is considered broader than psychotherapy. However, due to the wide range of theoretical approaches, there is no clear consensus on the definition or distinction between these concepts.

According to the Spanish Federation of Psychotherapy Associations (1993), which brings together organisations from various orientations, “psychotherapy is a scientific, psychologically based treatment that, by addressing the psychological or physical manifestations of human distress, promotes changes or modifications in behaviour, physical and psychological health, the integration of psychological identity, and the well-being of individuals or groups such as couples or families.”

2.2.4. Recovery Support

Recovery support, an alternative term to psychosocial or community rehabilitation, is a form of assistance aimed at individuals experiencing physical or psychological distress that prevents them from fully exercising their citizenship due to social barriers that hinder the full participation of people with diverse abilities. The goal is to provide

support and resources to help individuals develop their potential and achieve a fulfilling and meaningful life within the community.

Although the Recovery movement, which advocates for this concept, has had the greatest impact in supporting individuals with persistent consequences of psychological distress, as we will see later, it also proposes a shift in the mental health care model across all areas of application.

> Psychological intervention in the field of health involves the application of communication-based therapies by a trained professional who establishes a therapeutic relationship with the aim of promoting individuals' physical and psychological well-being.
>
> The intervention process involves providing support in the prevention, resolution, or reduction of difficulties through guidance in decision-making, the transformation of emotions, thoughts, and behaviours, and the enhancement of interpersonal skills.

3. Theoretical Approaches

Although we cannot provide an exhaustive review here, given the historical controversies and debates among different theoretical schools, we believe it is important to introduce a general idea of the context in which various psychological treatments are defined and applied. While more complex classifications exist, to provide an overview of the current landscape, we have chosen a minimalist classification that groups all approaches into four categories.

3.1. Psychoanalytic and Psychodynamic Approaches

Psychoanalysis is a psychological theory and therapeutic method developed by Sigmund Freud, which focuses on exploring unconscious processes to understand and treat psychological distress. Psychodynamic approaches encompass a range of subsequent perspectives based on psychoanalytic theory, sharing an emphasis on unconscious processes and the phenomena of transference and countertransference[1]

[1] Transference and countertransference are two fundamental concepts in psychoanalysis that describe the dynamic interaction between the analyst and the person in therapy.

between the analyst and the person undergoing therapy. However, in contrast to classical psychoanalysis, psychodynamic approaches often propose more focused and time-limited therapeutic interventions.

Although psychoanalysis and various psychodynamic approaches have lost influence in contexts such as Spain, the United Kingdom, and the United States, this is not the case in German-speaking countries, France, Italy, or Argentina. In general, these approaches continue to have research networks, dissemination platforms, and therapist training programmes worldwide.

Currently, while schools such as the Lacanian tradition keep Freudian theory alive, relational psychoanalysis has introduced a significant paradigm shift. Related to the Kleinian tradition and Harry Stack Sullivan's interpersonal psychoanalysis (Mills, 2005), its most important contribution is the proposal of a "reparative" relationship within therapy. This concept is shared by proponents of transference-focused therapy (Kernberg, 1984), a psychodynamic modality that works on the premise that the analytic relationship mirrors the individual's relational patterns in everyday life. Other contemporary psychodynamic approaches conceptualise therapy as a process of establishing a supportive relationship that facilitates the expression of thoughts and emotions (Luborsky, 1984). Additionally, some approaches focus on developing mentalisation skills—the ability to understand and reflect on one's own thoughts, feelings, and motivations, as well as those of others (Bateman & Fonagy, 2004).

Despite ongoing criticisms that these therapies lack an evidence base, systematic reviews of empirical studies repeatedly demonstrate the efficacy of psychodynamic therapies (Abbass et al., 2014; Leichsenring et al., 2023; Leichsenring, Klein, et al., 2014; Leichsenring & Leibing, 2003; Shedler, 2010). It is worth noting that, from psychodynamic perspectives, there is a preference for allocating fewer resources to evaluating treatment efficacy and greater emphasis on studying therapeutic processes.

Transference refers to the tendency of the person in therapy to project onto the analyst their unconscious conflicts, desires, needs, and emotions, based on past experiences, particularly early relationships with significant figures in their life.

Countertransference, on the other hand, refers to the feelings and emotional reactions that the analyst experiences towards the person in therapy. These reactions may be influenced by the analyst's own personal experiences.

The two main arguments for this stance are, first, that clinical trials assessing efficacy are often conducted in settings with low external validity, meaning they have limited applicability to real-world clinical practice, and second, that such trials focus almost exclusively on symptom reduction. In contrast, process studies examine the overall change experienced by the individual and the various ways in which it can be achieved.

3.2. Cognitive-Behavioural Approaches

Cognitive-behavioural therapies (CBT) refer to a group of approaches that focus on individuals' behavioural and thought patterns and how these interact with their environment. These therapies are based on the premise that dysfunctional patterns can be learned and, therefore, can also be unlearned and replaced. All approaches within this category place significant emphasis on empirical evidence.

3.2.1. First Generation: Behavioural Therapies

Although the term behaviour modification is often attributed to Edward Thorndike (1911) in the early 20th century, the need for brief treatments for individuals affected by the consequences of World War II accelerated the development of behavioural therapy as a therapeutic alternative to psychoanalysis (Lindsley et al., 1953). Its defining characteristic was the creation of techniques directly derived from empirical research on behaviour. From this perspective, not only was it argued that treatments should demonstrate empirical efficacy, but also that therapeutic techniques should be directly based on experimental research findings. As a result, the development of these therapies was profoundly influenced by the experimental work of Ivan Pavlov, Burrhus F. Skinner, John B. Watson, and Joseph Wolpe. These and other researchers maintained that psychology should be regarded as a natural science (Watson, 1913), contrasting this view with psychoanalysis, which they did not consider scientific.

The first generation of behavioural therapies developed techniques based on classical conditioning, such as exposure therapy, derived from Pavlov's work (1927), and techniques based on operant conditioning, such as contingency management, inspired by Skinner's research (1953, 1963). Early exposure-based techniques, such as reciprocal inhibition and systematic desensitisation (Wolpe, 1954, 1961), enabled individuals to gradually and safely confront feared stimuli, facilitating the extinction of conditioned

responses. Meanwhile, contingency management refers to a set of techniques used to modify behaviour by controlling its consequences. A notable example is the use of contingency contracts in written form to reinforce desired behaviours.

3.2.2. Second Generation: Cognitive Therapies

In the mid-20th century, a profound paradigm shift known as the cognitive revolution took place. The empirical development of research into thought processes and their influence on emotions and behaviour, often through computational metaphors, facilitated the incorporation of cognitive techniques into psychological treatments.

Albert Ellis is considered the pioneer in this field. Influenced by the psychoanalysis of Adler and Low, who had explored the concept of thinking errors, Ellis (1955) developed the idea of irrational beliefs and their treatment through rational emotive behaviour therapy (REBT). Later, Aaron T. Beck (1967), convinced that certain conscious attributions of meaning could cause psychological distress and that their transformation could bring relief, developed cognitive therapy for depression. Ellis and Beck maintained an excellent professional and personal relationship. Moreover, their therapeutic modalities share many aspects, including a Stoic philosophical foundation. However, while rational emotive behaviour therapy is more directive and explicitly challenges irrational thoughts through disputation, cognitive therapy is based on Socratic questioning techniques that help individuals recognise, in a more autonomous way, the cognitive distortions that lead to a negative view of themselves, the world, and the future.

3.2.3. Third Generation: Contextual Therapies

The emergence of relational frame theory (Hayes, 1991) has led to a synthesis of the first two generations, adopting a new perspective on behaviourism while also opening doors to the use of new elements in therapy. Relational frame theory addresses language and cognition and is considered a development of Skinner's theories (Hayes et al., 1993), constituting one of the fundamental foundations of what has been termed "third-generation therapies." In very simple terms, it proposes that human beings acquire language and establish relationships between concepts through interactions with their environment or context (in fact, this perspective is based on what is known as "functional

contextualism," which is why these therapies are often referred to as "contextual"). At a therapeutic level, it has given rise to acceptance and commitment therapy (known as ACT, from Acceptance and Commitment Therapy in English), which primarily focuses on cognitive fusion and experiential avoidance, two mechanisms considered to be transdiagnostic across various psychological difficulties (Hayes, 2004). The first refers to basing one's perception of reality on thoughts, memories, or assumptions rather than on direct present-moment experience. The second refers to the inability to engage with experiences (sensations, emotions, thoughts, or memories) and the implementation of avoidance strategies to escape from them.

Mindfulness-based cognitive therapy (MBCT; Segal et al., 2002), dialectical behaviour therapy (DBT; Linehan, 1993), particularly indicated for borderline personality disorder (BPD), functional analytic psychotherapy (Kohlenberg & Tsai, 1994), and integrative behavioural couple therapy (Jacobson et al., 2000) are other examples of third-generation therapies that, to a greater or lesser extent, take behavioural models of functioning as their starting point (Hayes, 2004; Pérez Álvarez, 2012). Finally, it should be noted that third-generation therapies and contextual therapies are often considered synonymous. However, some therapies that certain authors classify as third generation are not based on relational frame theory or functional contextualism, such as, for example, metacognitive therapy.

3.3. Humanistic approaches

Humanistic psychotherapies emerged in the mid-20th century as an alternative to psychoanalytic and behavioural approaches. In contrast to these approaches, humanistic psychotherapies focus on the importance of the present experience, personal growth, and the autonomy of the individual. A publication by James Bugental (1964) is often regarded as the seminal text that marks the consideration of humanism as a set of orientations distinct from psychoanalysis and behaviourism. This manifesto established the fundamental principles of humanistic psychotherapies, including the view that individuals are unique and complex beings who must be understood in terms of their subjective experiences and their search for meaning in life.

Viktor Frankl's logotherapy, Jacob Levy Moreno's psychodrama, Carl Rogers's person-centred therapy, Fritz Perls's Gestalt therapy, Alexander Lowen's bioenergetics, and Eric

Berne's transactional analysis were some of the humanistic therapies that emerged around the 1950s. All of these therapies emphasise the person's subjective experience, their freedom, and their capacity for choice, view the therapeutic relationship as a fundamental factor in the process of change, and aim to promote self-exploration and self-awareness as a catalyst for change. However, each approach emphasises different aspects. Respectively, the search for meaning and purpose in life (Frankl, 1946), empathetic understanding (Moreno, 1946), unconditional acceptance by the therapist (Rogers, 1951), present experience (Perls et al., 1951), the connection between body and mind (Lowen, 1958), and the identification and modification of negative patterns (Berne, 1961). On the other hand, psychodrama, person-centred therapy, Gestalt therapy, and bioenergetics are considered experiential therapies, while logotherapy and transactional analysis focus more on understanding.

3.4. Sociocognitive and systemic approaches

While the work of Ellis and Beck allowed the integration of mental processes into the behavioural tradition, and from the humanistic perspective, Frankl and Berne made proposals addressing meaning and patterns, there were other theoretical developments that, despite sharing the emphasis on thought, placed greater importance on the social context and the shared construction of meaning.

Kelly (1955) proposes that individuals use constructs that help them interpret and predict the world. These constructs are modified and adapted through experience. The Personal Construct Theory (PCT) as well as the theory of autopoiesis (Varela et al., 1974), which refers to the ability of a system to maintain and renew its own structure through internal processes, inspired the development of sociocognitive therapeutic orientations, among which the constructivist, postrationalist, narrative, and strategic approaches stand out. The work of Guillem Feixas and collaborators (2009) on implicative dilemmas, that is, equally important but contradictory values or needs, or Robert A. Neimeyer's constructivist approach to grief work (2000), continues the ideas of Kelly's PCT. With further influence from Bowlby's attachment theory (1958), Vittorio Guidano's postrationalist cognitive therapy (1994) proposes the active construction of personal meaning through dialogue and reflection. In the field of narrative therapy, the legacy of Michael White and David Epston (1990), whose theories focus on the construction of

identity and meaning through storytelling, has led to more recent authors, such as Gonçalves and collaborators (2009), to develop practical approaches that emphasise collaborative practices, encouraging creativity and innovation in the construction of alternative stories during therapy. The strategic school, founded by Giorgio Nardone and Paul Watzlawick (1990), has developed a brief treatment model focused on change through non-ordinary logics and corrective emotional experiences. Another contribution within sociocognitivism is Janoff-Bulman's (1992) work on the impact of extreme experiences on basic assumptions of benevolence, meaning, and dignity.

On the other hand, Bateson and collaborators' double-bind theory (1956) and Watzlawick and collaborators' work on interaction patterns (1967) laid the foundation for systemic therapy, focusing on the interaction between members of a social system and their communication patterns. Current systemic schools, including the Palo Alto and Milan interactional schools, Minuchin's (1974) structural school, Haley's (1973) strategic school, and more recent postmodernist (Boston, 2000) or constructivist (Reid et al., 2008) trends, offer ways to understand and intervene through the relational dynamics between individuals and the systems they are embedded in (family, couple, community, etc.). All these schools consider that psychological distress is the result of dysfunctional patterns of interaction and communication between people.

3.5. Integrative approaches

Integration in psychotherapy fundamentally arises from the idea that competition between different schools is a futile effort and that synthesizing different elements from their therapies can produce improved procedures. In this regard, Feixas and Miró (1993) understand integration in psychotherapy as an evolution from plurality toward the exploration of a common advance.

Integrative efforts began alongside the first clashes between the psychoanalytic and behavioural schools in the first half of the 20th century. The earliest proposals ranged from attempts to jointly understand concepts from both schools (French, 1933) to the development of systems that fully integrated theory and clinical practice (Dollard and Miller, 1950). However, the integrative movement in psychotherapy was organized and began to gain influence in the 1980s.

In his inaugural article in the Journal of Psychotherapy Integration, Arkowitz (1991) points out that the integrative movement focuses on three main areas: theoretical integration, common factors, and technical eclecticism. Theoretical integration recognizes that different therapies can contribute to the change process in various ways, promoting the synthesis and combination of existing theoretical and clinical approaches. The common factors approach, as we have seen, seeks to identify shared elements across various therapies. Meanwhile, technical eclecticism aims to select techniques and procedures regardless of the theoretical orientation from which they originated.

4. Elements of Psychological Interventions

As we have seen, there are different theoretical orientations. These differences are mainly reflected in the elements of treatment that each school emphasizes. While psychoanalysis places great importance on transferential and countertransferential phenomena during the therapeutic process, cognitive-behavioural therapies focus on the technical repertoire. That is, while the former emphasises the unconscious elements of the relationship, the latter argue that the primary therapeutic element is the techniques that modify learning processes. Humanistic, sociocognitive, and systemic orientations, though, like psychoanalysis, focus on the relationship, adding a profound transformation based on elements of empathy. In this regard, Rogers (1957) defines six necessary and sufficient conditions for change in therapy:

1. Two people are in psychological contact.
2. The first, the client, is in a state of incongruence.
3. The second, the therapist, is congruent or integrated in the relationship.
4. The therapist experiences unconditional positive regard toward the client.
5. The therapist experiences an empathic understanding of the client's internal frame of reference and strives to communicate this to the client.
6. The communication of empathic understanding and unconditional positive regard to the client is effective.

That is, for Rogers, change is not possible without congruence and authenticity, unconditional acceptance, and empathic understanding. Additionally, it is necessary for

the person receiving therapy to perceive it this way. Later, Lambert (1992) divides the elements that explain the results of psychological treatment into four areas: extra-therapeutic factors, expectations, specific techniques, and common factors. In this section, we will focus mainly on the elements related to the relational component and, in general, the common factors of psychological treatments due to their transversal nature. In contrast, the element related to techniques is more specific and will be addressed in other topics.

4.1. The Therapeutic Relationship

In the context of psychological treatment, the relationship between the therapist and the person is considered a fundamental element, with some humanistic authors, such as Yalom (1989), even stating that "it is the relationship that heals." In fact, the quality of this relationship is an essential element for the success of the treatment, as it allows for the establishment of a climate of trust and collaboration that encourages the expression of the person's feelings and thoughts (Hill, 2020).

4.1.1. Elements of the Therapeutic Relationship

Gelso and Carter (1985), based on classical psychoanalytic concepts (e.g., Greenson, 1967), argue that the concept of the therapeutic relationship, regardless of theoretical orientation, includes the therapeutic alliance, transferential and countertransferential phenomena, and a real relationship. The therapeutic alliance was defined by Bordin (1979) as consisting of three essential qualities: agreement on the goals of therapy, collaboration on tasks, and a bond of trust. Bordin adds that the intensity of the alliance is related to the effectiveness of therapy.

Regarding transferential and countertransferential phenomena, it is important to note that while some theoretical orientations, such as cognitive-behavioural therapies, ignore or interpret these phenomena differently, for Gelso and Carter (1994), this does not mean they do not influence the course of therapy. However, they also do not believe they block the therapy, as the relationship is centred on functional aspects such as behavioural tasks or cognitive restructuring. Yet, when transferential processes like eroticization occur and are not identified or are ignored, a shift in roles can happen that

may hinder the proper functioning of the therapeutic process, even if techniques that are initially appropriate for the presented issue are being applied.

Finally, regarding the real relationship, while humanistic traditions focus on the authenticity of the therapist, Gelso and Carter (1985, 1994) add the concept of realistic perceptions, which they define as all perceptions that are not contaminated by transferential phenomena. In fact, when these are resolved, authenticity and realistic perceptions would emerge. Just as with transferential and countertransferential processes, although psychoanalytic orientations minimize the importance of the real relationship, this does not imply that this aspect of the encounter between the person and the therapist does not have a decisive influence on the process.

We can imagine an example where there is no agreement on the goals of therapy: the person prefers to focus on the occurrence of a specific distress, while the therapist, due to their psychodynamic training, prioritizes a deeper change approach. This prevents the establishment of an adequate therapeutic alliance. The therapist interprets this preference as resistance. However, from the person's realistic perception of frustration at this lack of understanding, they express to the therapist how important it is for them to be able to live without this distress to face the change process. The therapist, after analysing their countertransferential reaction, is able to redirect the situation and initiate a process focused on that distress.

4.1.2. Characteristics of the Therapeutic Relationship

Although the therapeutic relationship is ultimately a human relationship, it is crucial to distinguish it from any other interpersonal relationship. In this sense, and unlike other relationships, its primary goal is always to bring about changes in the individual. In this regard, Feixas and Miró (1993) highlight asymmetry and the therapeutic frame as distinctive features of the therapeutic relationship.

Asymmetry refers to the fact that the therapist holds a professional role and focuses on the needs and demands of the person seeking their services. The therapeutic frame consists of a set of rules that establish the necessary boundaries and conditions for psychotherapy to be effective. These rules are divided into external aspects, such as the location of the therapy, the duration and frequency of sessions, the fees, among others, and internal aspects, such as the attitudes of the therapist required to establish an

appropriate therapeutic relationship and facilitate the change process in the individual. As can be seen in Table 1, each theoretical orientation presents some differences in terms of what therapist attitudes are deemed appropriate according to different conceptions of the therapeutic relationship.

Table 1

Therapeutic Relationship and Attitudes According to Different Theoretical Orientations

Model	Therapeutic relationship	Therapist attitude
Psychoanalytic/ Psychodynamic	Based on allowing *insight* into the person through the transferential relationship.	Reserved, neutral, self-controlled.
Behavioural	Implementation of techniques to modify the person's learning processes.	Safe and directive. It acts as a model and social reinforcer.
Cognitive	Based on collaboration to solve the person's problem.	Active and logical.
Contextual	Based on collaboration to make the person's relationship with their thoughts more flexible.	Open, cooperative.
Humanistic/ Experiential	Facilitating context for personal development.	Authentic, empathetic, warm, unconditional acceptance of the person.
Systemic	Coupling to the family system and its circular causality to alter its patterns of interaction.	Participant observer.

Adapted from Feixas and Miró (1993).

The therapeutic relationship is a fundamental aspect that significantly influences the success of psychological treatments. A well-established therapeutic relationship facilitates change and improvement in individuals. The therapeutic relationship consists of the therapeutic alliance, transference and countertransference phenomena, and the real relationship. The concept of the therapeutic alliance includes the established bond and the need for both parties to agree on goals and tasks. Asymmetry and the therapeutic framework are essential and distinctive characteristics of the therapeutic relationship, distinguishing it from other types of interpersonal relationships.

4.2. Common Factors

Referring to the verdict of the Dodo bird in *Alice's Adventures in Wonderland* by Lewis Carroll, and with the belief that different therapeutic models achieve similar results, Rosenzweig (1936) coined the term "common factors" to refer to elements common to "various methods of psychotherapy." Rosenzweig's original model included four common factors: a) catharsis, b) therapist's personality, c) therapeutic ideology, and d) alternative formulation of psychological events. Later, Jerome Frank (1961) identified four common factors shared by different forms of psychotherapy and healing practices: a) an interpersonal relationship based on trust and the perception of the therapist's competence and willingness to help; b) a socially accepted and legitimized institutional context, which itself increases the person's expectations of help; c) a justification or mythology that provides an explanation of the problems and procedures for achieving change in the person; and d) tasks, procedures, or rituals that demonstrate the therapist's competence and provide the person with a narrative for change. In a later edition of this work, Frank and Frank (1991) proposed a model of six factors: a) therapeutic relationship, b) hope, c) new learning experiences, d) emotional activation, e) self-efficacy, and f) opportunities to practice. In a review of empirical studies, Grencavage and Norcross (1990) analysed common factors related to the characteristics of the individuals in treatment, the therapists, the processes of change, the treatment structure, and the therapeutic relationship. They concluded that the greatest commonalities between models were found in the development of a strong therapeutic alliance, the opportunity for emotional catharsis, the acquisition and practice of new

behaviours, and the positive expectations of the person in treatment. These factors appear to be essential for the success of treatment, regardless of the therapist's theoretical orientation.

5. Study of Efficacy and the Intervention Process

5.1. Epistemological Paradigms

The evolution of different theoretical orientations has been marked by changes in the epistemological vision of each. While psychoanalytic ideas contain various epistemological positions that can generally be classified under interpretivism, the first generation of behavioural treatments stemmed from a positivist paradigm. That is, while psychoanalysis places greater emphasis on the interpretation of the person's subjectivity and moves away from empiricism, behaviourism, as a reaction, emphasises the observation and measurement of observable behaviour and the application of empirically validated techniques to modify it. The incorporation of cognitive elements into the behavioural model marked the integration of different epistemological and philosophical positions in general. On the one hand, the behavioural model, grounded in an empirical approach inherited from the 17th-century British movement, represented by figures like Locke and Hume, had to accept certain aspects of rationalism, a philosophical tradition of Indo-European origin embodied by thinkers such as Descartes and Kant. Meanwhile, sociocognitive and systemic currents are based on constructivist epistemologies, which argue that knowledge is actively constructed through the interaction between the subject and the object of knowledge.

The evaluation of the efficacy of treatments has been driven by the interaction between the behavioural and cognitive schools, both rooted in a positivist epistemological stance. While the empirical side introduced the idea of experimental design, the rationalist side contributed measurement tools to quantify dependent variables. In fact, it was during the rise of the second generation of cognitive-behavioural psychological treatments that the systematic evaluation of treatments using experimental methodologies became widespread. In this regard, since the 1950s, there has been an increasing activity of analysis on the efficacy and effectiveness of psychological treatments, initiated by the German-born psychologist based in the United Kingdom, Hans Eysenck, also famous for his work in personality. After one of the first

quantitative syntheses of psychotherapy results, Eysenck (1952) proposed that all therapies, except for behaviourist therapies, which he adhered to, were equivalent to being on a waiting list, meaning they were ineffective. After the development of the meta-analysis methodology (Glass, 1977), these results were refuted by the pioneering work of Smith and Glass (1977). However, the methodology used was heavily criticised by Eysenck (1978), initiating a debate on the validity of quantitative result synthesis that continues to this day. Although we now have conclusive evidence on the effectiveness of psychological treatments, the inherent biases in psychotherapy research urge us to be cautious about the magnitude of their effects (Cuijpers et al., 2019). Furthermore, while there has generally been no proven superiority of the effect of therapies from one school over another, the evidence is still insufficient today and should be contextualised in each specific issue, considering the most recent evidence (González-Blanch & Carral-Fernández, 2017).

5.2. Efficacy and Effectiveness: Evidence-Based Practice and Practice-Based Evidence

While efficacy refers to a treatment's ability to produce psychological changes that surpass those of no intervention or other standard treatments available and is therefore tested through experimental methods (prioritising internal validity), effectiveness refers to the presence of effects themselves, tested under usual conditions, prioritising external validity (Ferro García & Vives Montero, 2004). After decades in which efficacy studies were prioritised, in recent years, there has been a growing demand for resources to research the effectiveness of interventions. This is because significant differences are sometimes found between a treatment's efficacy and its effectiveness—meaning the results in the controlled conditions of clinical trials versus the application of these treatments in real-world contexts. Case studies, detailing the procedures followed and the reflection on the therapeutic process with an individual, are also advocated. This movement has been termed practice-based evidence (PBE; Barkham & Mellor-Clark, 2000), in contrast to the mainstream approach of evidence-based practice (EBP; APA Presidential Task Force on Evidence-Based Practice, 2006) originating in medicine (Davidoff et al., 1995). Some of the arguments include the fact that clinical trial samples are not representative of the individuals who seek mental health services, the influence

of socio-economic and cultural variables not sufficiently addressed in trials, and the scarcity of resources in mental health services, which hinders the integration of proposed innovations into practice. More recent approaches propose a complementary view between both approaches to generate evidence concerning both efficacy and effectiveness, as well as the implementation of therapies and the characteristics of healthcare systems that either facilitate or hinder it (Barkham & Mellor-Clark, 2003).

Currently, cognitive-behavioural model treatments have the greatest number of studies dedicated to analysing their level of evidence compared to other therapeutic schools. This phenomenon, framed within the movement of evidence-based medicine and psychology, is related to the fact that these interventions are easier to protocolise, meaning they can be manualised and administered homogeneously (Wilson, 1997), facilitating their study (Scaturo, 2001). Critics of this perspective argue that the homogenisation of psychological treatments is merely an attempt to emulate, in some way, the "safety" and "impartiality" of medication administration (Roth & Fonagy, 2005). According to these authors, this is not necessarily positive, and in fact, has not demonstrated greater efficacy (Truijens, 2018). While applying the "same treatment" to many individuals certainly makes evaluation easier, it also makes personalisation difficult, oversimplifying individuals' situations and ignoring their diversity and idiosyncrasies (Davies, 2018). However, proponents of EBP recognise that there is no easy way to create and systematise evidence, but they argue that failing to empirically evaluate therapies could endanger individuals' well-being (Vázquez & Nieto, 2003). On the other hand, it is worth noting that in real practice, although most therapists claim to apply cognitive-behavioural therapies due to their popularity and the evidence gathered under experimental conditions, in daily practice, various interventions are used, which sometimes differ significantly from what treatment guidelines dictate (Waller et al., 2012).

The prioritisation of experimental research by EBP has also influenced the priorities of professionals, particularly those combining clinical and research careers. The dominant status of positivist epistemologies over the decades has meant prioritising internal validity (clinical trial design or sophisticated statistical analysis), often neglecting the evaluation of therapeutic process quality and the socio-cultural context in which interventions take place. As quality control institutions understand our profession as

evidence-based practice, that is, based on research, those who practice it have the right and duty to evaluate our results. An exclusively experimental approach could promote a lack of attention to effectiveness under real conditions and exploration of the therapeutic process. This dichotomy is reflected in clinical practice guidelines, where some are almost exclusively based on experimental research results, while others integrate other criteria such as expert consensus (Vázquez & Nieto, 2003).

Although qualitative and mixed research methodologies have gained significant momentum in recent years (perhaps more so in the Anglo-Saxon context), the presence of these methodologies in prestigious journals remains minority. This poses a major obstacle to securing resources for those opting for these methodologies. That is, experimental and quantitative research is still valued more positively than qualitative or mixed research in terms of academic impact.

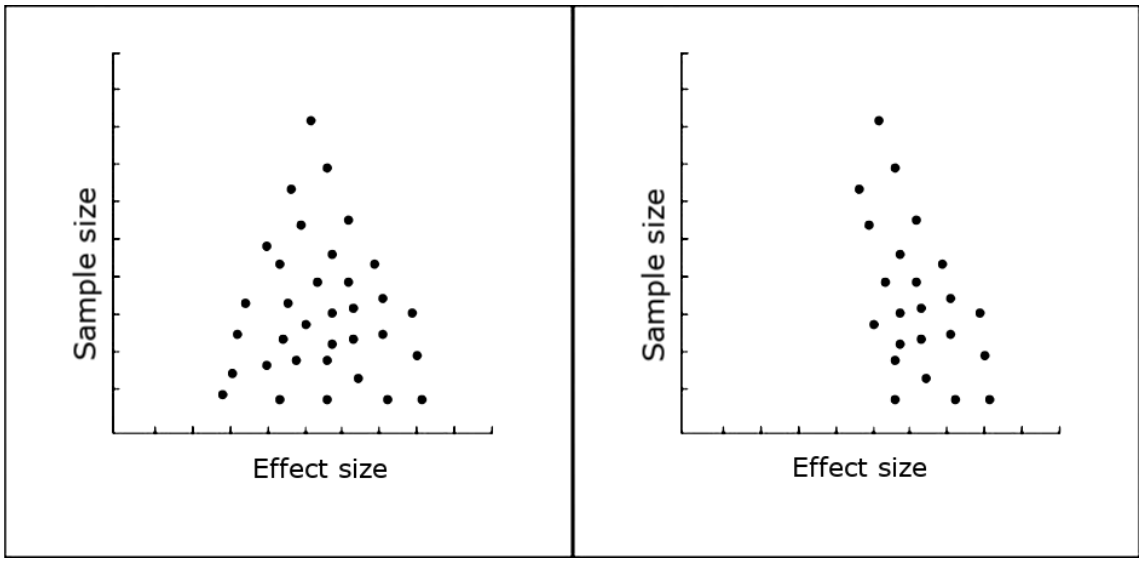
In line with the need for research to secure high-level positions within the healthcare system, it has also been observed that clinical trial results are more likely to be published when they show positive outcomes. That is, when the treatment does not have the expected effect, these results tend to remain unpublished. To prevent, or at least make visible, this phenomenon, the inclusion of bias analysis in meta-analyses has become widespread. A simple way to detect publication bias, i.e., when negative studies are not published, is through funnel plots. Theoretically, studies with larger numbers of participants will tend to cluster near the weighted average of many studies, while those with fewer participants are more likely to deviate, as they are more vulnerable to chance (for example, within a rare occurrence, it is more likely to get five heads in a row when flipping a coin than to get one hundred). When representing efficacy studies in a graph where the vertical axis is the number of participants and the horizontal axis is the effect size of the intervention, the shape of the plot should resemble a funnel or a pyramid. As shown in Illustration 6, if the left side of the funnel's wide part has many gaps, it is likely due to some studies with negative results not being published.

At the same time, psychoanalytic/psychodynamic, humanistic, sociocognitive, and systemic traditions, although they maintain a certain epistemological distance from the use of experimental methodologies, have accepted their use, especially to offer their services within healthcare systems dominated by the evidence-based practice (EBP) paradigm. Despite prioritizing interpretation and shared knowledge construction, these

traditions recognize the need for empirical evidence to support the effectiveness of their interventions, leading to a greater incorporation of experimental research methods. In this regard, meta-analyses confirm the efficacy of these approaches, although it is emphasized that the outcome measures used do not fully align with the values they advocate (Levitt et al., 2005).

Figure 1

Funnel plots from meta-analyses without publication bias (left) and with publication bias (right).



Additionally, more personalized interventions have been subjected to empirical analysis. While there have been positive results, this type of study faces added challenges, such as modifying key variables (e.g., the number of sessions), leaving the question of whether what works is the method itself or the opportunity to better develop the relationship, regardless of the theoretical model. Moreover, including diverse conditions, groups, or personalized treatment in a clinical trial significantly increases the number of participants required. A case in point is the MATCH project (Project MATCH Research Group, 1997), which compared three types of treatments for people with alcohol problems. Participants could be randomly assigned to one of three treatments (cognitive-behavioural, motivational, or 12-step model), or assigned to the treatment supposedly best suited to their clinical and sociodemographic characteristics (i.e., a total of six possible conditions), hence the acronym MATCH, meaning “pairing” in

English. This project cost $27 million, included over 1,500 participants, and failed to provide conclusive results on the differences between treatments, or between random assignment versus assignment based on participants' specific characteristics.

Subsequently, in the broader field of evidence-based practice, the study of patient preferences has expanded, with substantial evidence supporting the benefits of considering preferences on treatment outcomes (Preference Collaborative Review Group, 2008). In mental health, a meta-analysis shows patients' preference for psychological treatments over pharmacological ones (McHugh et al., 2013), and two meta-analyses (Lindhiem et al., 2014; Swift et al., 2018) demonstrate that respecting patient preferences in psychological treatment improves outcomes and reduces dropout rates, regardless of the direction of choice.

Regarding "common factors," Lambert and Barley (2001) state that they are the second most predictive element of change (30%), after extra-therapeutic factors (40%) and ahead of techniques (15%) and the person's prior expectations (15%), as previously classified. However, while common factors undeniably play a significant role, every therapist ultimately relies on some model, as it is necessary to formulate their cases. Therefore, although there may be little difference in the effectiveness of techniques across these models, it is important to recognize and be aware of the assumptions we have when adopting a specific way of viewing things.

Finally, the therapist's style is another area of interest regarding the evidence on the outcomes of psychological treatments. According to the original conceptualization by McNair and Lorr (1964), three factors seem to define therapeutic behaviour: the use of techniques, and the levels of affectivity and directiveness. Fernández-Álvarez and others (2003) developed a system for evaluating the therapist's personal style, which includes five bipolar dimensions: instructional (flexible vs. rigid), attentional (open vs. focused), expressive (close vs. distant), operational (spontaneous vs. structured), and involvement (highly vs. minimally engaged). The idea behind these models is not to identify "good" or "bad" therapists, but rather to understand how therapeutic styles interact with individuals' characteristics, leading to unique relationships. It is also important to always keep in mind the limitations of ourselves and the model we work from, to be honest, and to recognize when we are unable to handle certain situations and need the collaboration of other professionals or even referral.

6. Training Models

6.1. The Training Landscape in Spain

We have already laid the groundwork for psychological intervention; now let us examine how the acquisition of these knowledge and skills is structured. Training in psychological treatments is framed within clinical psychology and health psychology or psychotherapy programmes. Although these training programmes are highly heterogeneous on an international scale, in recent decades, postgraduate training that combines theory, practice, and, in some cases, doctoral research has become more widespread.

In the context of Spain, there are currently three parallel training programmes with different levels of accreditation:

1. **The Clinical Psychology Specialisation via Hospital Residency (Psychologist or Resident Psychologist, PIR)**, which is part of the Healthcare Specialist Training System (FSE), lasting four years. This training qualifies individuals to practice within the National Health System (NHS), colloquially referred to as "public", as access to its services only requires demonstrating the right to universal healthcare as established by the General Health Law (Law 14/1986, of 25 April). It is important to note that professionals working in the NHS may be employed through public or non-profit private providers.
2. **The Master's in General Health Psychology (MUPGS)**, an official two-year programme, which qualifies individuals for private practice and for work in non-profit or public institutions outside the NHS (such as early childhood intervention in some autonomous communities, local councils, associations, and foundations, etc.).
3. **Psychotherapy Accreditations** granted by non-profit organisations such as the Spanish Association of Neuropsychiatry (AEN), the Spanish Federation of Psychotherapists' Associations (FEAP), the Spanish Federation of Family Therapy Associations (FEATF), and the European Federation of Psychologists' Associations (EFPA), through the General Council of Psychology of Spain (COP). Currently, there is no official training programme that meets all the requirements of these associations, although some postgraduate degrees cover the training aspect of some associations affiliated with FEAP or FEATF. Therefore, the accreditation

process generally consists of demonstrating a suitable training and practical experience. The accreditations from AEN, FEAP, and FEATF are accessible to both graduates in medicine and psychology (with the clinical psychology or psychiatry specialisations being a merit, not a requirement), whereas obtaining the European Psychotherapist certificate requires membership in one of the entities affiliated with EFPA (such as the professional psychology associations in Spain). In this text, we refer to those dedicated to psychological treatment with any of these three qualifications as "therapists".

The simultaneous existence of the PIR specialisation and the MUPGS is not without controversy. While the National Association of Clinical Psychologists and Residents, as well as sectors within the professional associations and the NHS, argue that the master's degree should serve as an intermediate step between the undergraduate degree and the residency (González-Blanch, 2015), the Conference of Deans of Psychology from Spanish Universities (CDPUE) and some professional sectors defend that the two should remain independent and complementary (Carrobles, 2012). On the other hand, although the psychotherapy accreditation system is older than the PIR and MUPGS systems, no administration currently considers it sufficient to work within the NHS (which requires the specialisation via residency), and there is no clear regulation for doing so in other public administrations, non-profit organisations outside the NHS, or private practice (for which psychologists must hold the MUPGS or the PIR specialisation). However, the European accreditation was established with the aim of facilitating the free movement of professionals dedicated to psychological treatment within the European Union. If this happens, its validity should be recognised within Spain. However, in the past ten years, little progress has been made in this regard.

Within this framework of different training paths, it is important to understand that there is a de facto separation between the academic and applied fields. While there is necessary cooperation between universities and healthcare institutions, particularly in research projects, these entities hardly maintain common structures. Most university professors and researchers are required to dedicate themselves exclusively to academic and scientific tasks, while in psychology, university positions linked to clinical institutions are only just beginning to be created. The vast majority of active therapists who engage in teaching do so through associate professor roles, which means lower remuneration

compared to full-time faculty and no recognition of their research efforts, which also have little impact on their clinical professional careers. This situation discourages research on psychological treatments. The creation of linked positions would allow practising therapists to combine clinical work with research and teaching, a model that is common in medical specialities and in other countries.

6.2. The International Landscape

The Spanish system stands in contrast to those of other countries, as it is the only one that fully equates training in psychological treatment with medical specialist training. Internationally, there is a great degree of heterogeneity. Below, we will describe in more detail the Anglo-Saxon and Germanic systems, while also providing an overview of other global contexts.

In the Anglo-Saxon world (United Kingdom, Ireland, United States, Canada, Australia, New Zealand, and South Africa), although training structures vary, full professional practice in clinical psychology is contingent on obtaining a doctoral degree. This process involves both academic and practical training, culminating in a research project, which in some cases has slightly lower requirements than a traditional research doctorate. The practical component is structured similarly to the Spanish residency system, but with the key difference that trainees must independently apply for each placement. While this offers greater flexibility, it can also present challenges in securing placements. Professionals with lower academic qualifications (bachelor's or master's degrees) have more limited responsibilities but may still perform clinical duties within healthcare systems in these countries.

In German-speaking countries (Germany, Austria, and Switzerland), psychotherapy training follows a shared tradition and is conducted in non-university institutes. In all three countries, psychotherapeutic training is explicitly affiliated with a specific theoretical orientation. The commonly recognised approaches are those outlined earlier: psychoanalytic/psychodynamic, humanistic, cognitive-behavioural, and systemic. In Austria (Rollett, 1999) and Switzerland (Rubo et al., 2020), independent psychotherapy training institutes coexist with university-based clinical psychology and health psychology programmes. However, in Germany, the term "clinical psychology" is used almost exclusively to refer to research and theoretical training in psychological

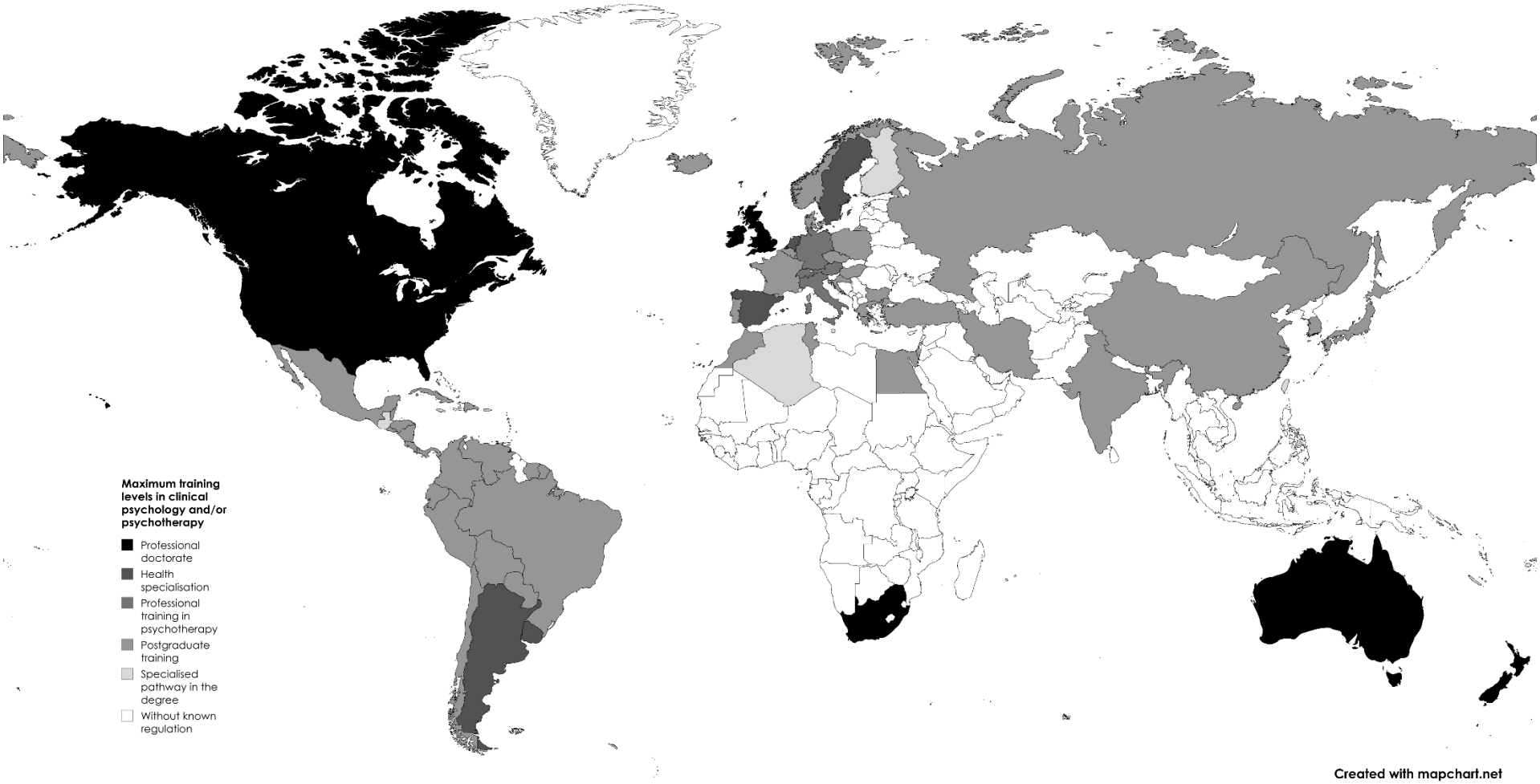
disorders and treatments, while psychotherapy is understood as a distinct professional practice.

In other European countries such as the Czech Republic, Slovakia, Italy, the Netherlands, and Sweden, postgraduate university programmes or specialised training schools affiliated with a specific theoretical orientation are required for clinical psychology or psychotherapy training. In the Netherlands and Sweden, these systems are relatively similar to the Spanish residency model. Meanwhile, in countries such as Bulgaria, Croatia, the Czech Republic, France (where both public and private training systems coexist with complex regulatory frameworks), Greece, Hungary, and Norway, specific training is available, although the degree to which it is required for practice varies. In many other Western European countries, there is either no formal specialised training, or undergraduate psychology degrees include a specialist track that is deemed sufficient for professional practice (Berdullas Temes & Fernández Hermida, 2006).

In most Latin American countries, postgraduate training programmes or specialised tracks that combine theoretical education with supervised practice are available, with partially implemented residency systems in Argentina and Uruguay. However, a psychology degree (licenciatura or bachelor's) is generally considered sufficient to undertake assessment and treatment roles, even within public healthcare systems. In Eastern European and Asian countries such as South Korea, China, Japan, and most former Soviet states, specialised training and/or accreditation is required to practise psychotherapy. Similarly, some Arab nations, including Egypt, Iran, Morocco, and Tunisia, offer postgraduate programmes and psychotherapy training institutes. In contrast, Sub-Saharan Africa, which has been heavily influenced by French and British psychology traditions, has a limited number of psychology faculties. In many cases, training is embedded within philosophy or humanities degree programmes, and postgraduate options are largely unavailable (Moodley et al., 2013). A summary of international training models can be found in figure 2. It is important to note that training landscapes evolve over time. To obtain up-to-date information, it is advisable to consult the official websites of accredited training programmes in each country, such as the relevant psychological regulatory body (e.g., the General Council of Psychology of Spain) for a specific region.

Figure 2

Training models in clinical psychology and psychotherapy according to the highest level offered.



7. Ethical Aspects

To conclude, it is essential to highlight that psychology professionals must adhere to various ethical codes. These codes establish the ethical principles and standards of conduct that should guide professional psychological practice. Among the most notable are those of the General Council of Official Colleges of Psychologists of Spain (COP), the European Federation of Psychologists' Associations (EFPA), and the ethical principles of the American Psychological Association (APA). Below, we outline some specific aspects derived from these documents that are fundamental to conducting an ethical psychological intervention process.

Firstly, we must obtain informed consent from service users before and during the psychological intervention through the continuous clarification and discussion of our actions, procedures, and their potential consequences. Standardised forms are available for different settings, and they are mandatory in certain healthcare contexts. The key elements of informed consent in psychological intervention include a description of the intervention, possible alternatives (including the option not to receive treatment or seek help elsewhere), potential risks and benefits, confidentiality policy, the right to withdraw consent—and therefore terminate the treatment—at any time, and practical conditions (structure and scheduling of sessions, fees, etc.).

Secondly, in relation to informed consent, it is crucial that service users receive a clear explanation of information recording procedures and confidentiality. It is important to remember that throughout the process, we should only collect information that is strictly necessary, and the information obtained must remain confidential. This point should be clarified from the outset so that the individual understands that we will only ask about what is essential and that this information will not be shared with anyone except in specific circumstances (which should also be made explicit). One such exception is if the individual discloses an illegal situation, which we would be required to report to the relevant authorities in accordance with the ethical codes mentioned. This can be a particularly complex issue, leading to ethical dilemmas. Any behaviour that may pose a risk to the physical integrity of the individual or others must be addressed firmly by activating the appropriate safeguarding procedures. However, there may be cases where the situation is less clear-cut. For example, if an individual experiences impulse control issues leading to minor thefts, this constitutes an illegal act and should,

in principle, be reported. However, in such cases, it may be more beneficial to address the issue therapeutically and encourage the individual to repair the harm caused—for instance, by returning stolen items or reimbursing their value. The challenge in these situations is that there is no universal guideline that applies to all cases, so each situation must be carefully analysed, weighing the pros and cons of each option and, if necessary, consulting a colleague. Another exception to confidentiality occurs when working with minors, where progress and outcomes may be discussed with legal guardians. If an individual explicitly authorises the sharing of information with a third party, this may also be permitted. Additionally, information may be shared with professional colleagues in supervision sessions or academic discussions, provided no identifying details are disclosed.

Given the complexities of confidentiality and the need to inform service users from the outset about its scope and limitations, various models have been proposed to offer guidance. One such model is that of M. Fisher (2008), based on the APA's ethical principles, which outlines six steps for presenting and maintaining confidentiality: 1) Advance preparation (the therapist must be familiar with service users' rights and their own responsibilities); 2) explaining confidentiality principles and their limitations clearly at the beginning of the process in accessible language; 3) obtaining informed consent specifying the agreed boundaries; 4) responding ethically to legal requests for information (making it clear that, in the event of a legal demand, information must be provided to authorities, with the service user given the option to discontinue treatment); 5) maintaining confidentiality boundaries throughout the process and adhering to agreements; and 6) engaging in discussions on confidentiality with legal professionals, students, and the general public. However, no standardised solutions exist for all possible cases. This is why responsible professional practice and experience are crucial for making decisions where confidentiality is a key concern.

A third aspect highlighted in ethical codes, and worth recalling, is the necessity for therapists to be adequately trained and skilled in the assessment and intervention methods required by their service users. Ethical codes also emphasise the importance of using methods that are evidence-based and not outdated. In short, all therapists must engage in continuous professional development and update their knowledge, just as other healthcare professionals do. They must also recognise their limitations in terms of

training and experience and, where necessary, refer individuals to a service that may be more suitable.

Finally, ethical codes in psychology stipulate that all forms of discrimination in professional practice must be avoided. This means that interventions should be conducted with respect and fairness, regardless of race, gender, sexual orientation, religion, ability, or any other personal characteristic. Therapists must strive to understand the diversity of individuals and adapt interventions to meet both individual and collective needs. Additionally, practitioners must remain vigilant about any biases they may hold and actively work to overcome them. Ethical guidelines also establish measures to combat discrimination in wider society and promote social justice. This may include collaborating with organisations that fight discrimination or taking steps to raise community awareness about the importance of diversity and inclusion.

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