One or two psychotherapies?

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*Abstract*. There is a longstanding “holy war” within the psychological profession. On one side are those who demand some kind of systematic demonstration of theoretical contentions, on the other are those who proclaim their right to do whatever is just to them. There is a strong reciprocal delegitimisation between the two parties. The former blame the latter for evading the responsibility of submitting to scientific test for efficacy their procedures. The latter charge the former with dehumanizing diagnostic systems, objectivism, determinism, bowing to the power of insurance companies. In this state of affairs, the empiricists will hardly persuade the hermeneutics to change their mind, and the other way round. Yet the dispute has a meaning, to the extent that both parties could meet on the ground of the development of a human science of psychotherapy—one that is phenomenologic-hermeneutically and dialogic-dialectically based, and is autonomous from the systematic, mostly quantitative proceedings of hard sciences.

KEYWORDS: empiricists versus hermeneutics, human science, phenomenologic-hermeneutical, dialogic-dialectical

**Introduction**

At the 2007 Winter meeting of the American Psychoanalytic Association Irwin Hoffman gave a plenary address that the audience received with a standing ovation.

Systematic, allegedly hypothesis-testing research is not likely to do anything more than generate possibilities for practitioners to have in mind as they work with particular patients. In other words, such research usually accomplishes nothing more in that regard than do case studies and therefore deserve no higher status as scientific contributions. To the extent they are accorded such higher status and authority, which too readily becomes prescriptive authority, they pose serious dangers to the quality of any psychoanalytic practice, any psychoanalytic attitude, that they affect. (Hoffman, 2009)

He challenged the positivistic idea, prevailing in the field, that clinical research can at best produce hypotheses whose validity has to be tested by empirical research. He contrasted that view with the one that he has been bringing forth for a quarter of century: «The critical or “dialectical” constructivism that I have been encouraging replaces a diagnostic, knowing, prescriptive psychoanalytic attitude with one that requires responsible, creative, improvised, and collaborative efforts on the parts of the participants to make something of the ambiguous, context-dependent reality that evolves in the course of their interaction.» (Hoffman, *ibid*.) In this view, the patient is not treated with the best technical procedure prescribed by empirical research as the best option for the presenting problem, but offered a multiplicity of possibilities that emerge from the dialogic relationship, unique for every psychoanalytic couple and ever unpredictable. Empirical research can do nothing but offer some more possibilities among which to make an existential choice—an enrichment in any case not specially appreciated by clinicians, who mostly don’t even read empirical research.

 In a panel of the 2010 Annual Meeting of the Rapaport-Klein Study Group whose background was the controversy stirred by Hoffman’a paper, one of the discussants, Jeremy Safran, stated that «Hoffman’s concerns about the use of “science” to seek prescriptive authority are well warranted. I also agree with him that the results of systematic empirical research study are as a rule of no more immediate relevance to the practicing clinician than the case study (and in some respects less so).» However, although «the medical model from which both the randomized clinical trial and the evidence based practice movement derive has serious flaws when applied to the world of psychotherapy and to a lesser extent to the world of medicine as well… to refuse to respond to the question of whether psychoanalysis works in terms that are meaningful to people is not only self-defeating for analysts—it also represents a type of disrespect for a public that has become increasingly frustrated with and resentful towards this type of response.» Safran is concerned that «one potential impact of Hoffman’s article is to justify a type of complacency among analysts—a sense that he has successfully fended off the assaults of those who demand “hard evidence” and that we can all return to business as usual.» According to him, «in perpetuating an outmoded view of science and hermeneutics as *either/or alternatives*, Hoffman maintains an unfortunate polarization. In doing so he underestimates the potential value of systematic empirical research and ignores or gives short shrift to the limitations of traditional psychoanalytic discourse.»

 Hoffman and Safran share a strong criticism towards the evidence based practice model, but differ in the remedy they propose: constructive critical dialogue versus systematic empirical research free of positivistic naïveté and hermeneutically savvy. The two other discussants, Morris Eagle and David Wolitzky (2011), charge Hoffman, among a number of other things, with total disregard of the crucial question of *accountability*: «In summary, to suggest that research on therapy outcome is merely a capitulation to political pressure overlooks the point that even if the wider society did not demand accountability, our own sense of moral and professional responsibility requires that we back up our assertions.» In the final analysis all three discussants confront Hoffman with what they see as a lack of scientific grounding, a weakness that could be tolerated in the pioneering era of psychoanalysis but is no longer excusable today, lest our discipline remains stuck at the level of an anecdotal and self-referential practice.

 In spite of some degree of agreement between Hoffman and his discussants, a gap remains wide open, and in my view cannot be possibly bridged because of a basic misunderstanding. Apparently they talk about the value of systematic empirical research in psychoanalysis. In fact they are speaking of two different psychoanalyses: one is *process-driven*, the other is *theory-driven*. Of course in both practices there are theories and there are processes. But the crucial point is: *who sits on the seat of the driver?* One psychoanalysis is the process that unfolds between two persons who meet regularly and engage in a dialogue that is as free as possible of any agenda: we say that they are free-associating, or their attention is free-floating. They are willing to be surprised at every turn of the way as they proceed with an open mind, free of any preconception (Freud, 1912). This does not mean that they don’t have theories: they may have many, provided that they do not identify with any. They are just *possibilities*, as Hoffman repeats many times, that might be helpful in the collaborative work of meaning making, and should be put aside when they are not. The second psychoanalysis is the one that is born out of the identification of the analyst with a given theory, or a given set of theories and/or procedures. Here the theory becomes what identifies one as a psychoanalyst, who says: unless your work is grounded on the Oedipus complex, or transference interpretation, or the frequency of the sessions of at least five (or four, or three) per week, or whatever, your thing is *not* psychoanalysis. On this line we had Jungian psychoanalysis as opposed to, and incompatible with, Freudian psychoanalysis to begin with, and then the many schools that, as Kohut said, despite and wage war to each other.

 In a theory-driven perspective, the only way out of authoritarian orthodoxies is empirical science, i.e. the one that submits to empirical test all theories. This is a perfectly logical and legitimate stance, unless it becomes itself an authoritarian ideology—which unfortunately is quite often the case. I refer to the most widespread ideology that is *scientism*, whose shibboleths are: 1. The only way to get valid knowledge is science, and 2. The only true science is empirical science. In the scientistic perspective empirical research is not only a way to validate or support theories and procedures—which is appropriate, lest they remain just matter of belief—but a means of knowledge that must apply to *all* kind of psychoanalysis and psychotherapy, whose results no analyst or therapist can afford to ignore. Let me clarify why I believe that such claim is unwarranted.

**Theory and meta-theory**

Hoffman has rightly underscored the co-constructive and co-creative quality of the work in the process-driven mode, and the existential uncertainty that must be embraced in order to be responsible to this moment, in this context. In this mode the analyst does not say the thing or make the move that has proved successful in similar conditions in the past, but tries to remain as open as possible to what the process demands here and now. On the other hand, if constructivism satisfies the artist, it leaves the question of science unanswered. If the process-oriented therapists content themselves with their creative freedom, they leave the science to the empirical researchers. Scientism cannot be fought with just an appeal to creative freedom. They would be wiped away, or marginalized, and scientism would win hands down. The enemy must be fought on its own ground, by means of a convincing demonstration that: 1. Empirical science is not the only science, and 2. It is not the right science for the process-driven psychoanalysis or psychotherapy.

 The alternative science is not one that we should invent; it has always been there, since the beginning of Western civilization. The Greek *theoria* is a mode «of being present in self-forgetfulness, and to be a spectator consists in giving oneself in self-forgetfulness to what one is watching. Here self-forgetfulness is anything but a privative condition, for it arises from devoting one’s full attention to the matter at hand, and this is the spectator’s own positive accomplishment» (Gadamer, 2003, p.126). One can see in Husserl’s phenomenological observation, and in Bion’s attitude of listening without memory and desire, two modern heirs of the Greek *theoria*. Husserl’s transcendental ego—an ego capable of intuitively perceiving the essence of things thanks to the *epoché*, i.e. the bracketing of all preconceptions and judgments—was rejected by Heidegger, just as Bion’s freedom from memory and desire has been deemed by Hoffman, among many others, “impossible on its face” (Carere-Comes, 2007). In *Sein und Zeit* (1927) Heidegger referred to men as being “thrown” (*geworfen*) into the world, i.e. located in a given condition that we cannot possibly bracket off. What we can do, is to own our condition and do something meaningful of it: if we project ourselves in order to fulfill ourselves, the “thrownness” (*Geworfenheit*) is overcome in the project (*Entworfenheit*). We can be wrapped up in our way of living, unreflectively following cultural myths and conventions—in which case our existence is inauthentic—or we can use the condition into which we have been thrown as the material on which to work creatively to the aim of realizing ourselves—this is the authentic existence. In such perspective, knowledge is not the result of the intuition of anything essential, but of the *hermeneutic circle*: we always start from some pre-understanding that is improved by experience, with the production of a more accurate knowledge that forms the pre-understanding for the interpretation of new experiences, and so on.

 Heidegger had to distance himself from his teacher Husserl to open the existential philosophy that he worked out in *Sein und Zeit.* In time, however, there was a rapprochement between the two. Husserl’s approach became less idealistic and more rooted in the “world of life” (*Lebenswelt*), a world that has much in common with his former pupil’s. Heidegger, on his side, became less attached to his idea that the language is the home of Being, and more attuned with a dimension that brings man nearer to Being—silence. «The Logos is not the word. More primitive than word [*Wort*], it is the premise [*For*-*wort*] of every language. The appeal of the Logos to the human being is the silence of the premise that connects man to Being.» (Heidegger, 1943, p. 383) Yet the Logos of the Western civilization is much more oriented to talking than to remaining silent and listening (Corradi Fiumara, 1985). Heidegger points out that the scientific method stemming from this orientation is based first of all on a subdivision of the field of knowledge into *disciplines*: «The things (*Sachen*) with which the discipline (*Fach*) deals can be expressed only to the extent that the discipline and its methodological apparatus allow it… The disciplines are like filters that let pass only some definite aspects of things. What belongs to the “thing” is not decided by the thing itself, its objective foundation and its “truth”, but by the discipline to which the thing has been assigned as an object of the discipline itself» (*ibid*., p. 228-229).

 When Heidegger loosened the connection between language and Being and found in silence the pristine dimension that precedes word, the formless Being out of which all forms are created, the Unknown that founds all knowledge, the Vacuum from which all energy and matter springs, he got in touch with the source of all creativity, which means a radical liberation from “thrownness”, from all cultural, familiar, idiosyncratic forms into which our existence has incarnated. *Dialogue*, therefore, is much deeper than *bricolage*, i.e. «construction or creation from a diverse range of available things» (Oxford dictionary), it is even more than the hermeneutic circle. It is the space that opens between two or more subjects capable of, and willing to, suspend or bracket off all preconceptions and expectations—to be free of memory an desire, in Bion’s terms. In particular, it is *theory freedom*, which does not mean absence of theories, but: i. freedom to use any theory, independently of any allegiance; ii. freedom to suspend any theory—to the extent that one can tolerate to stay in a theoretical vacuum, a condition of not knowing (Keats’ “negative capability”)—in order to compare different theories from a position of theoretical neutrality (which is to me, by the way, the pre-condition of any scientific, i.e. unbiased, enterprise); iii. freedom to look at things with fresh eyes—which is the pre-condition for any unmapped or uncharted existential journey.

In the space opened by dialogue (a word composed by *dià*, between, and *logos*), the Logos of the process, *its inner logic*, independent of any theory or technique of the therapist, can take the lead. It happens anyway, in spite of the therapist’s belief that the process is unfolding thanks to the goodness of their theories, but it happens more easily when the therapists do not hamper the development of the process with a rigid implementation of their theories and techniques. Rosenzweig (1936) was the first to make the crucial observation that if all existing therapies, so distant theoretically and technically from each other, are conducive to positive results, the therapeutic success cannot be a reliable factor of the validity of a theory. There must be something common to all therapeutic practices, in the diversity of the theories that inspire them. Rosenzweig discovery was confirmed by many researches in the decades that followed. In a meta-analysis of meta-analyses, Luborsky et al. (2002) found very few differences among the diverse approaches. These differences further shrink to almost nothing when they are corrected for the researcher allegiance (the most relevant result of decades of outcome research was the Dodo bird verdict, or equivalence paradox: all have won, all deserve a prize). If the common factors do not depend on the theory and technique of the therapist, they cannot depend on anything else than the inner logic of the therapeutic relationship—a logic that becomes the more clear and conspicuous, the more one steps back and the less one tries to harness it with a theoretical apparatus. The study of what happens in a relationship of therapy independently of the theory of the therapist should be logically done on a level that is meta-theoretic, i.e. superordinate to that of theories—and *meta-theory* is a good translation of the Greek word *theoria*.

**Logical and experiential necessity of self-forgetfulness**

The basic attitude of meta-theoretical practice and research (they go *junktim*, as Freud recommended, unlike theory-driven practice and research) is self-forgetfulness or self-effacement. Whether one calls it epoché or freedom from memory and desire or whatever, it is both possible and necessary. The necessity is *logically required* and the possibility is *experientially proven* by the practice of *mirroring*. Before engaging in a fruitful co-constructive/co-creative dialogue, most clients need to experience the therapist as a person who genuinely listens to and understands what they say and feel in the first place, without judging, confronting or interpreting. They badly need and look for it in a professional therapy because they have not found it in the past relationships with the caregivers, and they don’t find it in the present relationship with their partners. If the therapist starts interacting in their usual way—behavioral, interpretive, co-constructive, whatever—before the client has had the experience of being really listened to and understood, the chance that the therapy will not work very well is significant (you don’t have to put to empirical test such statement). Many therapists take it for granted that this experience has happened, only to discover at some point, to their and their client’s dismay, that it has not happened at all. Other therapists know better: they don’t take this experience for granted and introduce into their work some practice of mirroring, which consists in paraphrasing what the client has just said, being careful to avoid any judgment, confrontation, suggestion or interpretation, asking for a feed-back, going on until the result is good enough, and repeating the practice whenever the shadow of a new misunderstanding starts befogging the communication. This is the basic self-effacement that allows a healthy communication to unfold. Some couple therapists (Hendrix & Lakelly Hunt, 2008) have found that the practice of mirroring (plus validating and empathizing) between partners is the very base of the process of healing.

 Next, it is the practice of genuine dialogue that logically requires and experientially proves the possibility and necessity of self-forgetfulness. What kind of dialogue can ever happen between two people who are not capable of, and willing to, discipline themselves in the practice of suspending *all* the preconceptions and expectations that they *consciously* bring into the dialogue, plus those that come up in the course of the exchange? I call *genuine* *dialogue* the one that I have just defined, to differentiate it from the one in which one engages *without* the honest and sincere intention to put at stake one’s most cherished beliefs. In the Western civilization dialogue is grounded, since its inception with Socrates, on *not knowing*. This foundation implies that if two interlocutors decide to suspend all their knowledge to open a space free of all presuppositions and expectations, the Logos (the logic of the process, the truth of the topic in discussion) will find its way between (*dià*) the persons in dialogue.

 An objection that I often encounter is: Why should you polarize, why should you dichotomize? Why don’t you keep both genuine dialogue *and* empirical science in a fruitful and reciprocally enriching integration? As Fornaro (2009a) has pointed out, only a hybridization, not a proper integration, is possible between a context- and-process oriented approach and one that is driven by empirical science, because the logics that govern the two approaches are different and incommensurable. This said, I have nothing to object to those who choose to hybridize, but much to those who claim that every therapist should do so. Hoffman pointed out that empirical research is not just offered as an enrichment of possibilities, but privileged—to the point that the adjective *empirical* is commonly omitted, because it goes without saying that the only research worth the name is the empirical one. I would add that empirical research is not just privileged, it is rather deemed inexcusable not to follow its guide lines. “Who gave us permission not to use empirical science to the benefit of our patients?”, I was asked in a discussion online. Well, I do give myself that permission, and I will try to explain what can a process-oriented therapist do instead, for the benefits of our clients.

Let us make the case of a depressed patient who has been on antidepressants in the past and now wants to try psychotherapy (a rather common event). She knows that I am a psychiatrist and asks me if I am willing to do both things for her, psycho- and pharmacotherapy. Does empirical research offer some guideline for such a case? May be it does. May be someone has discovered that when a psychiatrist does both things together the outcome is 30% poorer than when the pill giver and the therapist are two distinct persons. So what? Even if the odds are worse than that, the statistic datum fades away before what really counts to me in the unique case of this encounter: 1. This patient asks me to do both things. 2. I think that her request is reasonable. 3. I feel that I am willing to accept. 4. I have decades of experience in hybridizing/integrating psycho- and pharmacotherapy, since when I realized that in most cases it could hardly be worse for me than trying to integrate my psychotherapy with the pharmacotherapy of another. The bottom line is that for a process oriented therapist the relevant data are those of the specific context at a given moment of the unique encounter of a client-therapist couple that is different from any other. Clinicians make very little use of empirical research, and mostly don’t even read it, because they don’t find very useful for their practice the study of factors isolated from the context, given that their practice is basically contextual.

 The attention to “what feels right at the time” is the crucial tool of process therapy. It implies the recovery of the faculty of *intuition* from the minor role to which it has been confined by mainstream research, as just a source of hypotheses that the “real researchers” will put to test in an extra-clinical context. Much more than that, intuition is *a faculty that gets at the heart or the essence of things*, producing *insights* (the insight is seeing inside, seeing what is concealed) endowed with internal coherence that unify a multiplicity of data (Fornaro, 2009b). Intuition fulfills the role of generating the insights that are essential in clinical practice. The question is then: how do we validate our insights? Firstly, the goodness of an insight obviously depends on the quality of the instrument that produces it, i.e. the faculty of intuition. For this reason Bion underscores the necessity of establishing freedom from memory, desire and understanding «as a permanent, durable and continuous discipline» (Bion, 1970a-1992, p. 315). On one side, free association and free floating attention are not free at all, being determined by unconscious drives and motives rather than by conscious intentions. On the other side, the recommendation to the analyst to work with an open mind, free from any preconception (Freud, 1912), means that the analyst should discipline his or her attention for it to remain evenly or freely suspended, i.e. not conditioned by the associative flux, nor by the analyst’s theory. Only to the extent that such discipline (implicit in Freud but made explicit by Bion) has been established, is one free from the opacities that obstruct intuition. The more the analyst can approximate this freedom, «the more confidently can he discount the origin of his observations as due to the ‘personal equation’» (Bion, *ibid*.). This clearly is an ideal condition, not a state fully and definitively reachable by a human being—just as philosophy is love and disciplined search for wisdom, not the plane of truth on which the philosopher can ever dream to settle permanently.

 Secondly, the value of an insight is to be found in its *beauty* or harmony or internal coherence. We—and our client—are specially satisfied when an insight arrives that collects all or most of the relevant material in a coherent whole. Thirdly, an insight is validated by its *heuristic power*, i.e. its capacity of furthering new discoveries. Fourthly, and more importantly of all, the value of an insight should never be taken for granted, but always examined and criticized by the discursive faculty of the mind, in the *noetic-dianoetic* dialectic of intuition (*noùs*) and reason (*diànoia*) that the Greek knew well. Thomas Aquinas picked up this dialectic (between *intellectus* and *ratio*, in his terms) in the Middle Age, and a modern version of it is the hermeneutic circle, which I would rather call *phenomenologic-hermeneutical circle* because it connects the two basic functions of *seeing* and *interpreting*. This dialectic works both internally—when I take a distance from my own intuition and examine it critically, which can lead to a new vision of things, and so on—and externally—in the dialogue with clients and colleagues.

**The dialectic between Knowledge and Unknown**

The science of the process-oriented therapy is, as we have seen thus far, phenomenologic-hermeneutical and dialogic-dialectical. A peculiar dialectic is the one between *spontaneity and ritual*, which is central in Hoffman’s *dialectical constructivism*. Spontaneity needs a ritual, a relatively fixed structure that contains it but should not become a sanctuary, because the personal participation of the analyst as a co-constructor of the process should not and cannot be eliminated: between spontaneity and ritual there is a mutual influence, a dialectic. Frank & Frank (1991) and Wampold (2001) pointed out that specific procedural ingredients—psychoanalytic, behavioral-cognitive or otherwise—serve the purpose of constructing a coherent treatment, which therapists believe in, one that provides a convincing rationale to themselves and to clients. These procedural ingredients are effective not so much for their intrinsic value, which is uncertain, but because they make up the ritual that both therapists and clients need as a *safe base*. This ritual, however, is not to be meant as an absolute necessity. Inexperienced and insecure therapists cannot do without it, but as they personally and professionally grow, they can progressively renounce it (Beitman et al., 1989). The key is *trust in the process* or, in Bion’s terms, F in O, *faith in the Unknown*, a faith without beliefs.

 The dialectic between spontaneity and ritual is certainly important, but it becomes progressively less relevant as the therapist grows more experienced and mature. A more basic dialectic is, in my view, the one that Bion (1970b) described between K and O, i.e. between Knowledge and Unknown, or formless Being and Form. Of course the therapist can allow the process to take the lead of the therapy only to the extent that they trust its guidance. Letting go of one’s theories, beliefs and rituals, warns Bion, before F in O has been established, is perceived as a most serious attack to the ego, a potentially catastrophic event. Both therapist and client can only gradually transform K in O, i.e. let go of the attachment to their certainties, the particular forms or patterns their life has taken on, and allow the Unknown to transform them in renovated forms or something thoroughly new (*transformation of O in K*). A *critical trust* is the attitude that furthers and feeds this process. We tentatively put at stake some of our cherished beliefs—every time we try to expand the space of dialogue—and see what happens. If we survive the small catastrophe of the breakdown of a small piece of our ego, and realize that we are freer and happier than before, we can proceed and put a stake a bigger piece of our identity, and so on, in an endless journey. The therapy has to stop sooner or later, but if it has been successful in this perspective, the client has built the tools to proceed on its own, because the process never ends; which means, above all, that they know *how to build working relationships with fellow travelers* in their endless journey.

 We can take the line connecting O and K as the first fundamental axis of a *general map* of the field. Whereas empirical science is basically *prescriptive*—it tells the therapist what to do or not to do with whom—phenomenological or eidetic science is *descriptive*: it describes the essential paths of the field to facilitate the orientation in the journey. A map does not tell you where to go: it tells you where you are, and leaves to you to decide where you want to go. In both approaches there are procedures and there are processes, but what makes them radically different is *the way procedure and process are integrated*. In a Gestalt perspective, one can make procedure figure and process ground, and what one gets is procedure-driven therapy; or one can do the opposite, and the result is process-driven therapy. As a therapist of the latter orientation, I have many procedures in my repertory and use them all the time. However, I never apply a procedure in an empirically supported mode, but always in response to what the process seems to require at any given moment, modifying it in any convenient way. Procedure-oriented therapy too is a genuine form of integration, inasmuch as the whole enterprise is ruled by the logic of empirical science. But one can claim that one’s clinical practice is based on empirical studies *only* if what is done has a good enough correspondence with the thing that has been empirically studied. One cannot modify it at will, giving it the meaning it takes in a particular context, and still claim that it keeps the meaning it had in the specific context of the study. One can surely hybridize the two approaches, and choose to be an empirically supported therapist some time and a process oriented therapist some other time—I have nothing to object. But one cannot do both things at the same time.

 *A therapist is a phenomenological-hermeneutic scientist* when they describe regularities or general laws of the field. In the perspective of empirical science, on the contrary, the field is split: on one side the clinicians, on the other the researchers. The researchers are the ones who tell the clinicians what to do. Psychotherapy becomes a branch of medicine—it becomes “an applied, prescriptive enterprise” (Gregg Henriques, *personal communication*). The researchers prescribe to clinicians, the clinicians prescribe to patients. As a process-oriented therapists, instead, I don’t let the researchers tell me what to think or do, and neither do I tell the patients what to do or think. At any moment, in any single session I am committed with my patient to uncover or make a meaning to the present experience. In this meaning making enterprise I draw on my intuition, which is supported by the maps of the field that the phenomenological-hermeneutic research has drawn. I use the patient’s feed-back to better understand what is happening and to improve my response to the process. The experience of the session allows to confirm or disconfirm not only my patient’s and my own ideas, but also the maps that I am using. As a clinician, I also am a researcher, a local clinical scientist (Stricker & Trierweiler, 1995) committed to an ever more accurate description of the field to share with my colleagues, because the data of the therapeutic interaction and the data of the research are the same experiential data, as the logics of therapy and research are one and the same logic.

**Two practices and two sciences**

We have come to a provisional conclusion. There are two practices, and two sciences. One is an applied, prescriptive, procedure oriented enterprise. The psychotherapist is above all a technician who, like the physician, applies the best results of empirical research for the benefit of their clients. They may believe that they have found something new and original in their work, but if the thing they have found has any value it is not up to them to decide. They must pass their discovery over to the empirical researchers, who will formalize it as an hypothesis and put it to empirical test. In case the hypothesis passes the test, it may become part of a new prescription that sounds like this: “The procedure x, which incorporates the new discovery, has been proven more efficacious than the procedure y, previously applied for the treatment of the disorder x. It should therefore from now on replace the procedure y in the treatment of z”. Of course the efficacy of x is proven only in the format in which it has been tested, which means that x must be applied in that format, not in any creative or improvised way that transforms x into something else, whose efficacy is unknown.

 The second practice is dialogue- and process-oriented. The basic difference with the former is that it is based on *unknowing*, instead of *knowledge*. Here the therapist brackets off all their knowledge and creates an open space in which a process can unfold according to its inner logic, which is unpredictable and unique for every client-therapist couple, in a co-creative and co-constructive way. The therapist’s knowledge remains on a shelf behind them, from which they can pick whatever seems to be useful at any single moment (it may be a respectable theory, as the movie seen last night), and use it freely in the present interaction, without the least preoccupation of fidelity to a manual or a standard procedure. The therapist will inform the client that their problem will receive the greatest attention, yet not as a symptom in a medical treatment, but as something whose meaning will be investigated in a dialogue, inside which all possible solutions will be explored. If they ask for a rapid symptom resolution, they may be referred to a procedure oriented therapist, or to a hybridized format. The process driven therapist uses maps that help them orient themselves in the field, even as they help the ongoing improvement of maps with their own exploration of the field. Here the therapist is the researcher, and the client is a co-researcher.

**How to build a map of the field**

This is not the end of the story, though, for two reasons. Firstly, on both sides of the fence the therapists are very reluctant to yield half of the ground to the opponents. There is a strong reciprocal delegitimisation between the two parties. On the empirical side, they charge the others of being old-time believers, sectarians, or charlatans, if they don’t accept to submit their theories to empirical test. On the opposite front, they convey the message that «those who favor and privilege systematic research are guilty of a host of evils or presumed evils, including “authoritarian objectivism,” lack of regard for the “whole person,” dehumanizing diagnostic classification systems, determinism, doublethink, the inhuman practices of HMO’s and insurance companies, damage to understanding the psychoanalytic process, bowing under to the powers that be, and favoring a “conformist” psychoanalysis» (Eagle & Wolitzky, 2011). Secondly, although the division between procedure- and process-driven therapists corresponds well enough to the characteristics of many practitioners, a growing number of them does not fit well within this dichotomy, or refuses it firmly. They are aware of the many flaws of outcome research so far, especially of the RCTs, and they shun the prescriptive practice that seems to be the natural upshot of empirical research. They expect better results from process research, and seem to point to a conjugation of empirical research and process oriented psychotherapy. What follows is a significant example of this trend:

The results of empirical research should not be taken as prescriptive principles, but as descriptions of some aspects (maps) that help orient clinical practice at this moment with this patient. The rigidity and prescriptivism of manualized psychotherapies serve the purpose of realizing rigorous efficacy studies, but in clinical practice the manuals should be known and “forgotten”. Paradoxically, some empirical studies point out that patients deem decisive for the success of therapy not so much the technical aspects (those prescribed by research on empirically supported and manualized psychotherapies), but the non technical ones that can hardly be manualized, the human and relational side of the treatment… Every good therapy should be “dialogue- and process-oriented” (Carere-Comes, 2013), i.e. guided by the process and the relationship moment by moment to avoid the risk of stereotyped and dehumanized treatments, but good therapists can (must?) anyway avail themselves of a map of empirical studies (Blasi & Rossi-Monti, 2013).

The Authors recognize the value of the dialogue and process orientation, even as they insist that the maps of the field should be based on descriptions derived from empirical studies. They can appreciate process driven therapy, and yet be definitely unwilling to let go of their claim that even this form of therapy must be empirically supported—by *empirical descriptions*, once the prescriptions have gone out of play. In this scenario, the question that comes to the foreground is: can empirical research really produce reliable maps of the field? A map is the description of a territory as a whole, not a patchwork of partial images. For instance, if the map of a city gave accurate descriptions of single districts, each compiled with different criteria from each other, it would help the orientation inside each district, but not the movement from one district to another. In other words, it would not allow a general orientation in the city, but just a local one. Of course, it would not be a good map.

 The inadequacy of empirical science to produce reliable maps was clear to Heidegger, in the passage quoted above in which he pointed out that «the disciplines are like filters that let pass only some definite aspects of things». This point has been further clarified by contemporary epistemologists (Agazzi, 2006), who observed that empirical science does not deals with *things* but with *objects*, meaning by object what any scientific method cuts out in the thing by means of the operations that are specific of that method. A psychoanalytic object is incommensurable with a behavioral object, just as every method produces its objects, specific of that method and incomparable with those of other methods. Out of the same thing (the psychotherapeutic process) one can extract a potentially infinite number of objects, as many as are the theories (the filters) with which the thing is investigated. Even worse, «there exist as many processes as there are psychotherapeutic interventions.» (Migone, 2009) The unification of all these objects is conceptually impossible in the perspective of empirical science, whose methods apply on the ground of a particular theory, the one that the research puts to empirical test. On this ground *a science* of psychotherapy can hardly exist: what does exist is *a myriad of particular sciences*, one for each of the theories that segment the field. By the same token, only a *hybridization*, not a genuine psychotherapy *integration* is conceivable between incommensurable objects.

**Psychotherapy integration**

I want to make more explicit the implications for psychotherapy integration of the discourse I have been developing so far. In a Special Section of the JPI (*The Journal of Psychotherapy Integration at 20*, 2010), Stricker (2010) writes: «Any practitioner who rejects evidence, or chooses to ignore it, would be foolish at best, and perhaps even unethical. However, this begs the question of the nature of this evidence, and, for the purpose of this article, how the evidence fits within psychotherapy integration». He goes on to say that «evidence can be found in research, in the experience of the practitioner, and in the needs of the client». There are different sorts of evidence, and the therapists, in the role of local clinical scientists, transform their consulting rooms in laboratories where they produce their own evidence, that they will confront with the one collected by other local clinical scientists, and also with the one produced by empirical research, when they find it relevant. Psychotherapy integration, in Stricker’s perspective, happens basically in the laboratory of the consulting room, by contrast to empirical research as it is commonly understood, as an *extraclinical* enterprise based on a clear distinction between clinicians and researchers, with the former producing the hypotheses for the latter (the “real” researchers) to put to empirical test. Once that clinicians and researchers are defined as two separated categories of professionals, the problem arises of «bridging the gap between practice and research» (Goldfried, 2010). Yet this problem *does not* arise for those practitioners who refuse to create that gap in the first place.

 In the same section of the JPI, Wachtel (2010) writes: «The tunnel vision associated with exclusive reliance on a single theoretical orientation—shared by single-minded loyalists of psychodynamic, cognitive-behavioral, experiential, and systemic approaches alike—is paralleled by the tunnel vision associated with exclusive reliance on a particular research methodology. The world is certainly more complicated and difficult to fully comprehend once one removes the blinders that have simplified it. But it is also more adequately understood.» In my view, a blinder that causes a most unfortunate tunnel vision is the equation research = *empirical* research, where the adjective empirical means basically *objective* and *reproducible*, and mostly also *quantitative*. What is implied by this equation is that research (“real” research) in psychotherapy, as in all human sciences, must follow the same rules and principles as research in natural sciences. This is correct, if the crucial question to investigate is *what works for whom*. If “what” means, as it mostly does, *what theories and techniques*, it goes without saying that any theory- or technique-driven approach should give empirical proof of its efficacy. If “what” means *what relationship*, one should investigate what types of relationship are more useful with what types of patients or in what phase of the treatment. In both cases, the results of the research will be used in a *prescriptive* perspective—it means that the therapist’s work is oriented by this question: what theory, technique, or mode of relationship am I supposed to apply with this patient in this phase of the treatment? And, of course, it is out of question, in this perspective, that the therapist ignores the researcher’s suggestions, which could be more properly called commands. By contrast, in process-driven psychotherapy the evidence is whatever becomes evident in the moment-to-moment, ever unpredictable interaction between patient and therapist, and the researcher is the therapist him- or herself, with the collaboration of their patients, in their ongoing effort of giving meaning to their experience in the dialogue between them, and with all that have anything relevant to say: namely spouse, relatives and friends for the latter, colleagues who have described similar experiences in the past, or are willing to confront theirs with the therapist’s for the former.

 The tunnel vision that produces the equation research = *empirical* research does not lead to psychotherapy *integration*, but to something that is more similar to a form of *integralism*, the one based on the scientistic ideology pointed out above. The differences between two types of sciences, as between two types of practices, which I have extensively discussed in the preceding sections, boil down to two basically different meanings of the word psychotherapy. The first entails taking care of a person and his or her malaise, which does not necessarily take clearly pathological forms (I would call it *psycho-therapy*, with hyphen, literally the therapy [in Greek *therapeìa*] of the soul [*psyché*]). The second refers to a treatment specifically and technically directed to a presented disorder or problem (it is *psychotherapy*, without a hyphen). The first is a dialogical-dialectical form of communication, which activates a process of self-knowledge and self-transformation. The second consists of the administration of some procedure whose efficacy for the treatment of the diagnosed disorder has been empirically supported. The first is properly a *care* (humanistic-existential model, an approach that does not separate practice from research, subject from object, knowledge from feeling), the second is a *cure* (medical model, which sharply splits the previous couples). Though there are numberless legitimate ways of combining or hybridizing the two modes, they are both autonomous forms of therapy in their own right. The ways of investigating the two approaches are correspondingly different, basically phenomenological in one case and empirical in the other. It is of paramount importance to understand and respect the *autonomy of both*, in order to avoid the integralistic (*not* integrative) claim that the care should submit to the same rules of research as the cure.

 As the categories of psychotherapy integration to which we are accustomed have become fuzzy (Stricker, 2010), what we need is a wider perspective, one that help us detect the trap of integralism that currently threatens the field. I have found such a perspective in the Gestaltmode of integration described in a previous section: as a function of our decision of making procedure figure and process ground, or vice versa, what we get is procedure-driven therapy (cure) and process-driven therapy (care), respectively. On the ground of these basic modes, which are both legitimate, we can choose to be a purely procedure-driven therapist or a purely process-driven therapist, or any combination of the two which makes us feel comfortable with. What is essential, in this perspective, is that each part acknowledges and respects the other. A goal that seems faraway, but far from impossible.

**Conclusive remarks**

The bottom line is that we have two basic approaches, founded respectively on empirical and human science. One is theoretically oriented, procedure-driven, applied-prescriptive, the other is meta-theoretically oriented, process-driven, dialogic and co-creative. The first avails itself of lists of disorders or diagnostic statistic manuals, like DSM-5, and lists of methods, procedures or principles to match the former. The second uses maps of common factors, or the basic dialectics of the field. This distinction furthers reciprocal respect and legitimization, and supports the freedom of each therapist to work in the way that best fits their personality. Of course one can test the outcome of both modes, and read the results in the light of the respective positions to claim the superiority of the one or the other. It can be and it is done, with the effect of feeding a long-standing holy war, as it is called in a report (Jaffe, 2010) that looks at our disputes from an outsider standpoint and comes to a remarkable conclusion:

Maybe there’s a middle way through the morass. Instead of rigidly dictating the “right” type of therapy up front, some health plans have shifted toward an “outcomes” system that measures a patient’s response to treatment regardless of what kind it is. In Utah, for instance, publicly funded healthcare plans follow the Outcome Questionnaire system developed by psychologist Michael Lambert of Brigham Young University. In his system, patients respond to questionnaires designed to track the effectiveness of their therapy… Improvement, after all, matters more than how the change was achieved. “I don’t care what psychotherapy the person is getting,” Lambert says. “I care whether they’re responding.”

Let us face it: the empiricists will hardly persuade the hermeneutics to change their mind, any more than the latter will persuade the former. Yet the dispute has a meaning, to the extent that it may help the ones to get rid of their scientism, and the others to take more seriously the development of a human science of psychotherapy. In the meantime, the adoption of Lambert’s position would benefit therapists of both sides, and above all clients.

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