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Clinical Research and Empirical Research

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ABSTRACT. – In this article, the author intends to show how the integration between clinical research and empirical research can function according to the model of reciprocal disturbance between data and observations produced by two distinct knowledge systems. The author highlights how there is a strong influence of clinical research on hypotheses that are tested in empirical studies and the potential effect of empirical data on the clarification and focusing of fundamental issues for clinical practice and treatment success. Subsequently, the author discusses the enhancement of 'good practices' compared to errors and important repudiation of factors that determine the outcome of therapies. Consequently, the author's interest focuses on training courses with a perspective that favours an approach where the attention of the trainee clinician is balanced between observable 'anchor points' (borrowed from research) and intuitive in-depth analyses and descriptive patterns derived from clinical experience that enrich psychoanalytic literature.

Key words: Empirical research; psychoanalysis; knowledge models; models integration; factors of therapies effectiveness.

Clinical and empirical research

It is undebatable to say that there is a lack of effective communication between clinical practitioners and researchers in the field of psychotherapeutic treatment, especially in that of psychoanalysis, despite both of these having congruent objectives, purposes and the same objects of observation. I am referring to the need to increase our knowledge about mental suffering in order to provide the best possible cure for patients. Researchers who pay attention to clinical needs and who are less self-referential realise this and try to confront the problem (Tasca *et al.,* 2015; Lo Coco, 2020). Clinical practitioners appear less interested and only recently have we observed a tentative opening up to the role that empirical research can have in psycho-

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analysis (Niccolò, 2018; Vigna Taglianti, 2018). The IPA (International Psychoanalytic Association) seems interested in the results of empirical outcome and process research.

(Leuzinger-Bohleber & Kachele, 2015; Kachele *et al.,* 2000) and tends to favour and finance concrete research projects. I have focused on empirical research in psychotherapy from the beginning of its development, from the first studies in Italy in this field. This has allowed me to help try to understand the problems that have gradually characterized and will characterize the discussions between researchers and clinical practitioners, as well as understand the sense of the different approaches to the problem of comprehending and treating mental disorders. In this endeavour, I have been helped by the fact that I have always carried out intense clinical work, even in psychiatric contexts, and have therefore had access to both psychoanalytic and psychiatric training. This was a position that allowed me to live these contradictions from the inside, undeniably with a certain amount of suffering. Contradictions that risk, if they are unresolved, to disallow an integral and compatible vision to form of the potential contributions of different approaches to our competency to treat. Colleagues that I spend time with, and whom I consider to be expert psychoanalysts, have in various occasions, demonstrated polite interest for this rather eccentric passion of mine for research, but other than that, they did not really seem interested in the subject. For example, in clinical discussions, explicit references to research results in order to help face a problem were not perceived as an available resource, while if I used these data and presented them as though they were my intuitive clinical observations that came to me at the time, they were significantly more appreciated. This can appear as paradoxical but in reality, if we consider the roots of this apparent contradiction, we can identify a number of factors and circumstances that can help us to comprehend and maybe modify this state of affairs. Trying to outline this context, in its various aspects, and develop its potential is the main aim of this article. It is not possible, in this context, to penetrate the meanders of epistemological thinking that characterized the initial phases of the confrontation, based on reciprocal vetoes between researchers and clinical practitioners, nor can I explain in detail the actual results of clinical research and their possible implications in clinical practice, as we have done elsewhere (Fava & Gruppo Zoe, 2016). The purpose of this article is that of facilitating the access of clinical practitioners and in particular those who are in training, to the potential contributions of empirical research. For this reason, it is necessary to develop a new common language that moves away from the prototypical language of researchers and from that of clinical practitioners and that allows us to transmit information in a useful and efficient manner. As Shedler (2010) underlines ‘many researchers take for granted that the clients of research are professional clinical practitioners, but many studies and meta-analyses are not written clearly for them… they are extremely complex, technical and difficult

to decipher… if clinical practitioners are indeed the intended 'consumers' of psycho-therapy research, then psychotherapy research needs to be more consumer relevant.' Clinical research and empirical research can be considered like two different ways of understanding aspects of reality, from two perspectives and with different methodologies. In our daily lives, in many fields, we use knowledge that comes from our scientific culture and contextually from our experience and also from out intuition of the moment. The competence of doing originates from the intertwining of these two components (Polanyi, 1967; Friedson, 2001). Empirical research in psychotherapy refers to those practices that have allowed for the incredible development of knowledge and techniques that characterize modernity. Whereas, with clinical research we mean the 'central nucleus of classic psychoanalytic research' that originates from the psychoanalytic situation itself and is an integral part of it. This is described as 'a circular process of discovery whereby, together with the patient, idiosyncratic observations of unconscious fantasies and conflicts are successively visualized, symbolized and finally put into words at different levels of abstraction' (Leutzinger-Bohleber, 2018, p. 270) in the context of personal and biographical uniqueness.

Carrying out empirical research in a worthwhile way in the field of therapeutic practices, that are inspired by knowledge and the psychoanalytic method, has been a controversial subject: the majority of psychoanalysts see a reductionist attitude and doubt that the very subjective influence and the complexities of the discipline can be object of a scientific approach, in the paradigmatic sense of the term. This position is definitely valid and, in some ways, insurmountable if we were to hypothesize that the methods and the results of empirical research can outright substitute results from clinical research on both a theoretical and applicative level. However, this radical empirical position is unsustainable for many reasons that span from the role that clinical intuition and experience have in building scientific hypotheses and determining therapeutic action, to the 'technical' limits of research methodologies. However, it is necessary to consider that the distance that separates the world of clinical experience in psychoanalysis from that of empirical research makes it more difficult, complex and delicate to use clinical experience to construct hypotheses that must be verified empirically.

There are many limits to empirical research that make it useless without a strict integration with clinical competence, also defined as the totality of basic theoretical knowledge, of derivatives of experience, of the capacity to identify clues and intuitions in the moment. These abilities are learnt with practice and are in part implicit. Moreover, this process is made more complex by the role of the patient in the management of the therapeutic relationship; not surprisingly Giaconia (Giaconia, Pellizzari, & Rossi, 2000) speaks of a competence in being cured as a complementary aspect to the competence to cure. I am referring to the specific contribution that the patient can give to the process of

change and to the evaluation of the role of the patient in therapeutic work (Bohart & Wade, 2013). This is a field of investigation that increases the variables of the process that must be taken into consideration. Furthermore, it is difficult to assert that a result that derives from a statistical average can be applied unequivocally to a single patient, as what may be effective in many situations, may not be in others. It is not possible to disregard the role that the therapist as a person may have in the construction and deconstruction of the object of treatment (what it is appropriate to do or say in a particular moment) and not consider the research biases, such as those tied to the observation period, which is usually shorter than the natural duration of illness. It is also not possible to consider a single extrapolated variable from a complex context, as often happens in empirical studies, when we must then put it into practice, regardless of other variables with which it is connected with or interacts with. Additionally, statistical systems based on correlations which are used in most studies, do not seem to guarantee sufficient certainty in cause-effect relationships and the effects could be due to underlying variables that have not been considered by the researchers. Not all therapeutic factors have been studied thoroughly: some areas that concern, for instance, thought transformations that start from the intuitions of participants in the therapeutic process and the construction of innovative metaphors (Ogden, 1994), have not been studied systematically like many other aspects of intersubjective processes that characterize the therapeutic relationship and its evolution. Many researchers ignore results from studies in similar or complementary fields. This is facilitated by the request to publish on very specific topics that are very specialized, with the risk of remaining trapped in a deformed and reductionist vision of reality. Research in psychopharmacology and in psychotherapy tend to for example ignore each other, there are few independent comparative studies and studies on the effects of combined treatments.

On the other hand, even systems based on clinical experience and their successive theorizations show that next to brilliant intuitions are also evident limitations from which we obtain: incompatible and contradictory theoretical/technical models, a proliferation of schools, and fideistic and identitary attitudes carried out in an inflexible way in therapy. Vigna-Taglianti (2018) highlights some risks connected to a way of conceiving the focusing of patient problems, that he defines an 'agnostic drift' which, in its radicalized form, exposes problems that *'range from arbitrariness of clinical observations that are 'stressed' to validate a certain hypothesis or theoretical position, at the risk of having a 'hermetically closed' point of view, looking for narcissistic confirmation rather than the capacity for self-critical reflection, to pay attention to cases that confirm the hypothesis rather than cases that bring difficulties, at the risk of subconscious constructions and falsifications and lastly of the repetition and conformism in institutional discussions.'* (ibidem, p. 244).

In the absence of empirical confirmations, the field of psychoanalysis, and also other forms of psychotherapy, risk becoming a Babel of languages, opinions and points of view that are more or less contradictory, unintelligible for those who, for instance, must decide with regard to the choice of a certain type of therapy or organization of public and private psychiatric healthcare. Thus, confirming Nietzsche's aphorism: '*Convictions are more dangerous enemies of truth than lies*'. In other words: '*By placing the focus of explanation into a domain incompatible with controlled observations and testable hypotheses, psychoanalysis deprives itself of the interplay between data and theory which has contributed so much to the growth of 20th century science.'* (Kachele, Krause, Jones, Perron & Fonagy, 2000).

The only acceptable solution, given these premises, seems to be that of integrating the two knowledge systems, respecting the specific characteristics of each, as happens in many fields, particularly in the applicative phases of knowledge, that is, in our case, in clinical practice. Ultimately, it seems legitimate to think that only the mind of the clinical practitioner, in a specific moment of the therapeutic relationship understands the essential aspects of what is happening and can consequently act in harmony with the other member of the therapeutic relationship, the patient, who is in turn influenced by his or her conceptions of the nature of the problem and on how to resolve it. Nevertheless, the mind of the clinical practitioner must be open to accept contributions from neuroscience, from cognitive psychology, from infant research, and from empirical research on the effectiveness and on therapeutic factors in order to use them at the right time. I am referring to the role that the knowledge of results from research can have in terms of 'perturbing' the beliefs and convictions of a clinical practitioner. For example, a good physician knows about research results, knows the intrinsic limitations of research methodologies, and precisely for this reason, does not apply this knowledge mechanically. He or she integrates it with direct experience in many cases, with their intuition that can make them highlight a symptom that is not evident or a complexity that is tied to the synergy of different pathologies, and also keep in mind the somatic and psychological characteristics of the patient that will influence the efficacy and the compliance to treatments, the respect of useful behavioural norms and the level of stress. It's what is called, even in empirical psychotherapeutic research contexts, the 'personalization of treatment'. We must be open to the eventuality that '*when you think you have all the answers, life changes all the questions*' (Charlie Brown).

Therefore, one must know how to have an open perspective about knowledge, in which data from empirical studies and knowledge from clinical research is established reciprocally like those perturbing cognitions that set off 'implementing equilibrations' (Piaget, 1972) that make up the foundation of the evolution of our conceptions of reality (Mattana & Fava, 2017). Here, I am referring to, on the one hand, models that are acquired through personal

life experiences, personal analysis, theory formation and supervision - that make up the basis of our clinical conceptions - and, on the other hand, to research data and in particular 'hard findings' that cannot be ignored, especially because every patient has the right to health. It is indicative how one of the forefathers of evidence-based medicine (EBM) (Sackett, 1997), was aware of the limitations of classic efficacy treatment studies, and believed that the problem is not what is certain (empirically proven) in medical practice, but whether what is certain is effectively known and put into practice. Contextually, researchers cannot neglect the enormous mass of clinical observations and the sophisticated theoretical models produced from clinical research on which efficacy treatments are based on for that matter. Indeed, it is now an 'indisputable fact' that psychoanalytic psychotherapy, based on clinical principles is effective, as is shown in '*thousands of studies and hundreds of meta-analyses*' (Lambert & Ogles, 2004; Leichsering & Rabung, 2009). However, the fact that the efficacy of psychodynamic psychotherapies is in general established as fact, this does not mean that this is valid for all models, for all therapists and for all patients and in all situations. After all, the most precious role that we can attribute to empirical research is that of challenging what we believe to be true.

Results of empirical research in psychotherapy

Presenting a summary in an adequate manner of the results currently at our disposal is not possible in this context, even if we were to only refer to process studies that may interest clinical practitioners most. At the end of this article we shall suggest some texts that are appropriate for a more in-depth analysis. To summarize very briefly process research has given value to the importance of certain common factors to treatments that work and that concern: i) descriptive constructs of how the therapy is undertaken, where the following elements of the therapeutic alliance are present: individual therapy, couples therapy or family therapy, and cohesion in group therapy; ii) strategies in the management of the relationship as a positive consideration (validation), management of emotional expression of experiences, promotion of treatment credibility, appropriate self-disclosure, gathering feedback, and resolution of the fractures (crises) in the relationship; iii) quality of the therapist, relative to the person and not their strategies or abilities, where we include aspects such as: flexibility, authenticity, empathy, and reactivity in countertransference responses; iv) personalization factors, that is, which specific characteristics of the patient must we adapt the therapy to, such as attachment style, preferences and expectations, coping styles, culture and levels of reactance (resistance to therapeutic work and/or to change) (Fava & Papini, 2020).

Furthermore, the following are also relevant: i) studies on specific therapeutic interventions and in particular those carried out by Ablon and Jones' group (Jones, 2000; Pole, Ablon, & O'Connor, 2008; Katzenstein, Pole, Ablon & Olsen, 2012) that evaluate structures of interaction that characterize therapeutic relationships and the correlation between type of intervention and the result, using the Psychotherapy Process Q-Set method (PQS); ii) studies on the influence of the therapist or 'therapist effects' that study the role of the characteristics of the therapist in the therapeutic process (Wampold & Immel, 2015; Muzi & Lingiardi, 2020).

Research and clinical practice: the interconnections

In reality, the task of structuring the exchange of perspectives, *id est*, 'that interplay of data and theory', between clinical research and empirical research might not be that difficult. This is due to different reasons:

- *The majority of process research, namely research that explores the therapeutic process, even, but not only in relation to the outcomes of therapy, is fundamentally based on constructs that originate from clinical practice*, as a work alliance, and the quality of interpersonal relations, the development of reflective or meta-cognitive capacity, types of therapeutic interventions and more. In fact, hypotheses tied to the main theories and theories of technique that are normally used in clinical practice are formulated and tested. These hypotheses define the 'protective belt' that, according to Lakatos, surrounds every theoretical assertion, which is in itself unverifiable (Conte, 2005): when the hypotheses that are based on a theory are disproved, or vice versa confirmed, the theory on which they are based can be weakened or reinforced, respectively. Typically, the researcher tries to verify the trend of certain variables that usually refer to theoretical assumptions and compares good outcomes treated by clinical practitioners with those of poor outcomes. It is interesting to observe that therapeutic behaviours, which we can evaluate with appropriate templates or instruments, starting from the recording of sessions, are not necessarily present in the consciousness of therapists, so they are situated in an implicit dimension. Clinical convictions and the theories that underlie them, can therefore be confirmed or challenged partially, giving the clinical practitioner the possibility of remodulating them. The clinical practitioner interested in research can have confirmation of what he or she considers they know and/or broaden and/or modify their own perspectives. This is particularly important if we consider the potentially negative effects of certain theoretical beliefs, highlighted also by clinical literature, for instance, those correlated to a presumed 'neutrality' of the analyst, in its first formulation. Studies suggest that not only 'wild' or

mentally disturbing therapeutic interventions, but also certain practices that are considered to be correct, can become potentially pathogenic or not effective (Peterfreund, 1983). The fact that meta-analyses demonstrate that a consistent number of patients does not obtain satisfying results from treatments and that a certain percentage actually worsens, is a stimulus to analyse in more depth, even on an empirical research level, the possible causes of therapeutic failings.

- *As a consequence of the tight link with theoretical systems and theories from traditional techniques, results from empirical studies of efficacy and process have supplied confirmation to many assertions that concern the conceptualizations used by clinical practitioners. However, frequently they bring about certain modifications or relevant clarifications.* Neuroscience and empirical research have placed greater emphasis and weight on factors such as the work alliance, the real interpersonal relationship, development and modalities of cognitive and reflective processes, the function of memories, the role and characteristics of the therapist, thus contributing to the progress of our conceptions and the efficacy of our treatments. A very interesting example is that of the function of memories under the effects of glucocorticoids during traumatic experiences. The produced effect is that of impeding the deposit of episodic memory but not that of semantic memory and implicit experiences (emotional learning). Consequently, for traumatized patients it can be impossible to remember, not so much the facts per se, but their presence when the facts were taking place, giving rise to dissociative phenomena that characterize dissociative personality disorders. The impossibility of remembering the traumatic experience in a vivid and personal way, is not the product of repression, but of impossibility. The clinical utility in distinguishing between the splitting of something that was originally integrated, and the relative dissociation to what has never been integrated (Stern, 1997) modified therapeutic strategies, and prior to that allowed us to distinguish between a dissociative experience and repression (McWilliams, 2011).
- *Results from certain studies can on the other hand appear to disturb our convictions and in particular those that concern the superiority of our personal therapeutic model.* The fact that different therapies, that are theorized differently, can reach similar results. This is the famous 'Dodo verdict': '*Everybody has won, and all must have prizes*' Dodo stated, a character in 'Alice in Wonderland'. The difficulty in demonstrating the superiority of a technique over others is in fact a datum that is rather strong, even when considering only independent and well-designed studies (Luborsky *et al.,* 2002). The explanations for this phenomenon are numerous: the importance of so-called common or 'aspecific' factors, the fact that therapists are not totally coherent with their theoretical premises

and so may use prototypical interventions from other approaches (Ablon, 1998; Kazenstein *et al.,* 2012), and the fact that there is a deep, albeit unrecognized, osmosis of practices and concepts, for example between cognitive and psychoanalytic therapists. Lastly, the fact that patients with the same descriptive and categorical diagnosis who participate in studies are different in certain aspects that make them more or less adapted to certain types of intervention. This concerns even the comparison with pharmacological therapies, especially with certain pathologies, for instance, mood disorders (Fava & Zuglian, 2016). All these factors deserve particular attention and have important practical implications. 'Aspecific' factors heavily influence outcomes of treatments and we attribute very broad percentages to these, even up to 90% (Wampold & Immel, 2015), for the variance in results. This has taken some to believe that 'all therapies are the same'. This conclusion is, as we will see, wrong and should be replaced with: 'for a therapy to work, we must respect the criteria that come from our knowledge on common factors and on those that are personalized'. Generally, 'efficient' therapists or rather, effective treatments have 'aspecific factors' that tend to be adequately considered and managed (Norcross *et al.,* 2018, 2019). For instance, a relational style that continuously underlines the failures of patients, that comments or behaves in a hostile, rejecting, depreciating, and critical way towards patients, even if in an implicit manner (Von der Lippe *et al.,* 2008), or situations when therapists are inflexible in the application of strongly structured methods and treatments, are correlated to negative outcomes. Suggestions and advice on behaviours outside of sessions can also be correlated with poor outcomes (Ablon *et al.,* 2006). The absence, non-consideration or rupture without reparation of the work alliance entails probable negative outcomes (Hilsenroth, Cromer & Ackermann, 2012). An expert therapist perhaps does not need to reflect on these and other 'common' aspects of the therapeutic relationship and is able to spontaneously manage these, but it is evident that in training courses and in institutional contexts it is necessary to seriously confront this issue. The importance of a correct management of 'aspecific factors' makes these a necessary element even though it is not sufficient. Furthermore, and here we complicate matters, one should ask oneself in what way these aspecific factors are really so aspecific: 'common factors' are not so obvious as their name suggests, nor are they easy to manage.

- *Another disturbing aspect concerns the specific techniques that therapists from different orientations actually use compared to those foreseen by their theoretical systems.* Studies demonstrate that therapists from different orientations use prototypical interventions from other orientations, which are advantageous to the therapy. For example, cognitive therapists can use prototypical treatment modalities from psychodynam-

ic therapies. In my experience as supervisor of a team of therapists from different backgrounds I have found confirmation of Ablon and Jones' group observations, that is that therapists from cognitive training can pay close attention to the subjective experiences of patients in order to handle the therapeutic relationship. They use interventions that can be considered as interpretations of transference. Vice versa, cognitive techniques such as questioning the patient on how he/she thinks the therapy is going (patient feedback) can be very useful for improving the quality of the therapeutic relationship and the vitality of the work alliance. This has motivated, for instance, my current interest for 'private theories' that therapist and patient construct on the basis of the nature of the problem and on how to work through it (Werbart, 2006; Chichi *et al* 2019). I am also interested in the ways in which psychoanalysts build their ideas about the nature of the problems of a patient and on the pathways towards change. Indeed, in good outcome therapies, both the diagnosis and the possible pathways to change seem to be the product of a co-construction and reciprocal influencing on behalf of both members of the therapeutic relationship. Empirical studies seem to highlight the need for a sort of deconstruction/reconstruction of across-the-board therapeutic schemes in different orientations. This concerns classical psychoanalytic models even more so, from the Freudian theory of drives to Ego psychology, from the tradition of Object relation theory to Self-psychology, up until the contemporary relational movements. McWilliams (2011), a psychoanalyst who was very attentive to research results, and whose influence led her towards clinical practice observed that '*most therapists seek to assimilate a diversity of models and metaphors, whether or not they are conceptually problematic in some way*.' '*Effective therapists seem to me more often to draw freely from many sources than to become ideologically wedded to one or two favored theories and techniques. In general, they distrust those who base their professional identity on the defense of only one way of thinking and operat*ing.' (Chapter 1). In a recently published study that was conducted at the *Centro Milanese di Psicoanalisi* (Milanese Center for Psychoanalysis) we were able to observe the same phenomenon, that is, the use of different interpretative models in function of the patient's specific characteristics, a phenomenon called 'informed eclecticism' (Sabucco *et al.,* 2020: www.cmp-spiweb). The readings and therapeutic solutions that the different approaches suggest can be considered as a sort of toolbox for the psychoanalyst's reference. The different descriptions of specific problems and solutions that we find in literature can thus be considered as precious guides for personalized and specific interventions, rather than rules that should be applied indiscriminately. The discovery, at times brilliant, of specific patterns of functioning, as well as the most adequate technique to use,

have often given rise to generalizations and theoretical models that have been applied indiscriminately rather than used to suggest a particular intervention for a specific situation.

- *Since different clinical subtypes react in different ways to different types of therapy, or rather of intervention, empirical research has developed the concept of 'personalized treatments'.* This concerns the research area that examines the specific characteristics of patients that contribute to determining the choice of certain types of therapy or therapeutic interventions. The concept of personalization of treatment is connected to the idea that patients with the same nosographical-descriptive diagnosis, but who are different for other variables, can benefit in different ways to different types of treatment. There is ample research on this topic that is based on pre-treatment predictors that refer to a specific patient characteristic, such as sociodemographic conditions, personality dimensions, cognitive constructs, psychodynamic constructs, social and relationship constructs, attachment styles and the seriousness of symptoms. Biological, genetic and neuroimaging variables, which were less studied in this perspective, are currently object of interest on behalf of the scientific community. The need to personalize treatments involves current diagnostic systems directly, as they tend to create groups of patients by mainly considering what ties them together, rather than what differentiates each individual situation from another. The descriptive-categorical systems, such as the DSM-IV and the DSM-V do not allow us to collect specific information on single patients and thus can only give us generic suggestions on how to set up treatment. For instance, the interest of a patient on working on himself or herself, and the trust in the type of therapy that is proposed or that he or she chooses freely discriminates groups of patients with the same diagnosis but who are very different with regard to the most effective therapeutic strategies. Patients, as we can observe by analysing comparative studies of different types of treatments, mainly utilize therapies that enhance their pre-existing characteristics and their cognitive and relational resources, that is, that take into account the resources of the patient, rather than their difficulties or symptoms (Elkin *et al.,* 1989; Sotzki *et al.,* 1991; Shea *et al.,* 1990; Huibers, 2015). The use of more sophisticated and precise diagnostic instruments can allow for more accurate and specific therapeutic choices. Presently we have instruments such as the Psychodynamic Diagnostic Manual (PDM) and the Operational Psychodynamic Diagnosis-2 (OPD-2) available. The first of these allows for a better understanding of the internal mechanisms of mental functioning and categorizes patients based on conceptualizations that have a psychoanalytic origin. The latter, is particularly useful in evaluating the situation of every single patient, including prognostic variables and personalization

factors. Even though the OPD-2 refers to psychoanalytic type constructs, it gives more value to going forward by starting from an accurate observation of mental functioning in different areas and then analyses this in depth. It is therefore also adapted to being used in institutional contexts where there may be therapists from different orientations and in varying training course contexts (Papini & Fava, 2019).

Empirical research and clinical research in training contexts and in the organization of services

If clinical practitioners know how to manage both aspecific and specific factors, and thus research results have a sense of confirmation or of *openness* for them, this stimulates new ideas and favours a more open mind, both in public and private mental health services and also in training contexts; the knowledge of research results seems essential. No ignorance should be permitted for those who are responsible for public health. Here efficacy studies are particularly relevant as they tell us which types of intervention have the probability of being most effective. There is abundant literature on the advantages and limitations of efficacy studies that refer to different methodological problems and they define structural failures. Indeed, efficacy studies and complementary naturalistic ones, or 'effectiveness' ones, tell us if certain treatments work, but, by nature, they do not tell us what effectively makes them work, even though they give the 'impression' that they validate the theoretical convictions of who executes them (Wampold, 1997). From what I have already stated, we can understand that the efficacy of a treatment depends on many different factors and that the success of a therapy can depend on implicit factors that were not expressly predicted by the theory of those who carry them out, or even by the circumstances of the life context or 'extra-therapeutic factors' (Asay & Lambert, 1999; Lambert & Barley, 2002). However, if a type of treatment has shown to be effective for a particular disorder, this type of treatment should be taken into consideration in the programming of services and in the proposal of adequate treatments: we know that unfortunately the type of suggested therapy varies based on the function of the therapist's orientation, without an overall vision and based only on a few criteria that are supported by research and that are generally accepted. Although it is true that efficacy studies have strong limitations, if a therapy demonstrates its efficacy in many studies and meta-analyses, it should be contemplated. People in charge of services and administrators should base their data on the best research, on the best therapies to offer, on the best training courses and the most effective clinical supervision to present. Whoever has the responsibility of treating also has the moral obligation of knowing the results of these studies so that they can

send the patient to the best type of treatment possible and to honestly inform them that a particular therapy is not available in their service, even though it is potentially effective. Psychoanalysis and psychotherapy, based on psychoanalytic concepts, have strong support from efficacy studies relative to many disorders, even serious ones and only recently has this evidence begun to appear in guidelines for treatments (Piano Nazionale di Azioni per la Salute Mentale, 2013). We also know little, from an empirical point of view, on the utility of combined interventions, that is, on which additional treatments can be integrated with pharmacological ones and psychotherapeutic ones, and within these, if there are more specific treatment indications that exist. Up to now, in the field of efficacy research, the tendency to confirm the value of determined therapeutic approaches has prevailed and we have little data on the effects of utilizing combined psychological, rehabilitative, psychoeducational and pharmacological therapies. Both clinical experience and empirical studies, when they are carried out (Bellino *et al.,* 2002, 2008; Cuijpers *et al.,* 2015), show that combined and integrated interventions are generally advantageous. We can also presume, with good reason, that the management of 'aspecific' factors can be the common basis of many types of interventions that act on different levels in the context of institutional teams, that involve operators with differing competences and functions, and that appear in the clinical literature (Correale, 2006).

The potential contribution of empirical research to the structuring and planning of training courses involves both perspective problems and content ones. If we consider the relevance of the management of aspecific factors that we see in studies, it seems obvious that the focusing and attention to the totality of these aspects should be the first objective in a training program. We know that we are not stating anything new here, and that in a way or another educators keep in mind or foresee their management, but we do not know up to what extent they do this and if they do it completely. For instance, up to what point is importance given to the construction of a therapeutic work alliance and the individuation of treatment for the fractures in the alliance or up to what extent are the empathy, flexibility, and authenticity of the therapist valued? The insertion in training courses of research results could sensitize students and also educators on the value of aspecific factors. On the other hand, as we have underlined many times, the objective of empirical research is not, and should not be, that of substituting pre-existing therapeutic models, but rather it should be a stimulus for a constant improvement of quality, safety and treatment efficacy. However, attention towards the efficacy of treatment and common factors easily contrasts the approaches that value 'purity' and the coherence of methods, as well as the faithfulness to respective reference founders of different approaches. The question of coherence, not inflexibility, of therapeutic models should not be underrated as it is functional to the focusing in of concepts and practices

that are well-defined and that can be studied in their application, in their effects and therefore can be taught. The complementary empirical perspective should not foresee confused forms of eclecticism, but contrarily, should precise definitions of those therapeutic factors on which therapeutic results depend on and interventions should be chosen based on the characteristics of the patient.

Clinical intuition that gives the possibility of 'giving a voice to' mental contents that do not reach an adequate level of awareness and representation is one of the instruments that contribute mainly - in a psychoanalytic perspective - to the possibility of making psychic contents editable and making way for change processes. On the other hand, we should ask ourselves if in the context of training courses, it is useful and opportune to develop this last type of competence without the support of a phenomenological attitude of observation. Or without taking into consideration many other aspects that have characteristics of evidence and prognostic value. For example, the analysis of those circumstances that predispose people to treatment, such as those evaluated in the first axis of the OPD-2 (experience of illness and prerequisites for treatment). In other words, to base training *only* on sophisticated intuitive instruments can mean risking valuing only 'what cannot be seen': 'what really counts is only what is hidden and is therefore concealed' this is what Meltzer and Harris (1967) define as 'delirious learning'. Or learning due to 'adhesive identification' or by 'projection identification'. The latter is characterized by a mechanical and somewhat arrogant reproduction of the idealized object (ibidem). Indeed, the development of this fundamental capacity based on participatory intuition (réverie), entails a lot of experience, sensitivity and good supervision. This is because it lends itself to give space to phenomena (*e.g.* subconscious projections and transference of the therapist onto the patient), to the influences of the moment's theoretical *mainstream* and of certain theoretical credences that excite the therapist, and to other determinants that have to do with the story and personal experiences of the therapist himself or herself (Hunter, 1996). This can contribute to presenting the interpretative action in a dogmatic and oracular way and creates passive dependence on behalf of the student. Consequently, training, based only on this type of approach favours sectarianism - *id est*, an overestimation of specific techniques and an underestimation of the therapeutic relationship that the literature indicates as being the principle driver of change independently of different techniques. From the patient's point of view, there would be an increased risk of inappropriate restitutions reproducing a disaffirmation experience that often characterizes the pathogenesis of mental suffering. Increasing the accuracy of phenomenological observations by anchoring to specific observational points, as we are used to doing when we use instruments, and reflecting the mentality of empirical research, can allow for subsequent in-depth clinical analyses that

guide and orient comprehension dimensions based on participating intuition. The Three-level Model of clinical observation developed by the *Project Committee on Clinical Observation* (Bernardi, 2015) of the IPA to improve systemic clinical observation of patient transformation during psychoanalyses seems to point in the right direction.

Conclusions

From what we have seen the integration of clinical and empirical research seems to be not only opportune but also possible in a context that foresees the overcoming of old ideological and identity barriers and a simultaneous increased attention on the efficacy of therapy and treatment indications. Naturally, self-referential paths are always possible, both for clinical practitioners who are afraid of stepping outside their boundaries (Frances, 2016), and by researchers who are always more conditioned by publication pressures towards more specialized and fragmented research needs. Research results must be digestible for clinical practitioners, without useless technicalities and must be placed in a broader perspective spectrum, bringing results from many different studies and highlighting the contradictions, problems and perspectives. The language should refer to specific clinical situations, which implies a clinical competence in researchers as well. An appropriate area in which to bring the results and methods of research is that of clinical discussion with the possibility of also using evaluation instruments that are adapted to underline particular diagnostic aspects and manage the therapeutic relationship such as: CCRT, SASB, IVAT, PQS, PTI, SWAP (Fava *et al.,* 2005, 2016, 2020) or that of developing research in institutional contexts managed directly by clinical practitioners with supervision and support from expert researchers for methodology, encoding and statistical analysis. In other words, the opportunity to integrate clinical and empirical research can happen in institutional and educational private and public contexts. This perspective does not take anything away from specific psychoanalytic training, nor from the necessity to resort to constructs that originate solely in clinical practice. We think that, in some ways, research data completes this, it supports it and stimulates it, retrieving the sense of the word ‘theory’ literally means ‘flowing of the Gods’ (from the ancient Greek for Theory = theos + rheo (God + stream) , that is, the movement of ideas concepts and practices.

Suggested reading

In this article, in order to give an overview, many topics have only simply been outlined. For a more in-depth view on the issues dealt with here I

suggest reading '*La psicoterapia psicodinamica basata sulla ricerca*' by Levy, Ablon and Kachele (2015) and, in particular, the chapter on the efficacy of long-term treatment by Rabung and Leichsenring (page 45), the chapter by Katzestein, Pole, Ablon and Olsen (page 419), that by Levy (page 453) on the evaluation and differentiation of therapeutic interventions and also chapter 12 edited by Hilsenroth on the therapeutic alliance. In the appendix you will find the Psychotherapy Process Q-Set Coding Manual. Another suggested reading is '*La competenza a curare: il contributo della ricerca empirica'* (2016) by Fava and the Zoe Group, a book in which we have considered empirical research, in its various articulations, starting from the work of collecting data from the 27th task force of the APA (Norcross, 2011, 2018) highlighting potentiality, limitations and application in clinical practice and in training.

REFERENCES

Ablon, J. S., Jones, E. E. (1998). How expert clinical practitioners' prototypes of an ideal treatment correlate with outcome in psychodynamic and cognitive-behavior therapy. *Psychotherapy Research, 8* (1), 71-83.

Asay, T. P., Lambert, M. (1999*).* The empirical case for the common factors in therapy: Quantitative findings*.* In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.),*The heart and soul of change: What works in therapy* (pp. 33-56). Washington, DC, American Psychological Association.

Benjamin, L. S., Cushing, G. (2000). *Interactions Manual for Coding Social in Terms of Structural Analysis of Social Behaviour*. Salt Lake City: University of Utah.

Bernardi, R. (2015). *The three-level Model(3LM) for observing patient transformations. Time for change: tracking trasformations in Psychoanalysis-the three model.* London: Karnac Books.

Bellino, S., Zizza, M., Di Lorenzo, R., Bogetto, F. (2002). Terapia combinata del disturbo depressivo maggiore: revisione della letteratura. In *Giornale italiano di Psicopatologia*, *8*, 401-416.

Bohart, A. C., Wade A. G. (2013). The client in psychotherapy. In M. J. Lambert (a cura di), *Bergin and Garfi eld's handbook of psychotherapy and behavior change,* 6th ed. (pp 219-257). Hoboken, NJ: Wiley.

Chichi, M., Fava, E., Margola, D., Galvano, G. C., Nuzzaci, V., Chiari, P., Reatto, L. L., & Linciano, A. D. (2019). *Private theories of patients and therapists in comparison: A multiple-case study in the preliminary phases of the psychoanalytic treatment*. Relazione presentata alla 5th Joint European & UK Chapters Conference, Society for Psychotherapy Research (S.P.R.), 'Separation and Unity', Cracovia, Polonia, 19-21 settembre.

Conte, M. (2005). La psicoanalisi come programma di ricerca. Una lettura della psicoanalisi alla luce della epistemologia di Imre Lakatos. *Ricerca in Psicoterapia*, *8*, 181-194.

Correale, A. (2006). *Area traumatica e campo istituzionale*. Roma: Borla

Dreher, A. U (2000), *Foundations for conceptual research in psychoanalysis*. London: Karnak Books.

Cuijpers, P., de Wit, L., Andersson, G., Huibers, J.H. The combination of psychotherapy and pharmacotherapy in the treatment of adult depression: A comprehensive meta-analysis. *Journal Evidence-Based Psychotherapies, 15*(2), 147-168.

Elkin, I., Shea, M. T., Watkins, J. T., & Imber S. D. (1989). National Institute of Mental

Health Treatment of Depression Collaborative Research Program: general effectiveness of treatments. *Archives of General Psychiatry, 46*(11), 971-982.

Fava, E. (2017). Intervista ad E. Fava sulla ricerca empirica in psicoterapia (a cura di G. Mattana). Testo disponibile sul sito: https://www.spiweb.it/ricerca/ricerca-empirica/ricerca-empirica-in-psicoterapia-intervista-a-emilio-fava-a-cura-di-g-mattana/ Consultazione: 04/08/2018.

Fava, E., Gruppo Zoe (2016). *La competenza a curare: il contributo della ricerca empirica.* Milano: Mimesis.

Fava, E., Magni, M., Ferrario, D. Camarda, P. (2016). La supervisione con metodi derivati dalla ricerca. In E. Fava, Gruppo Zoe (a cura di), *La competenza a curare: Il contributo della ricerca empirica.* Milano: Mimesis.

Fava, E. D., Ferrario, D., Sanna, B., Taino, D., Tajani, M. (2010). Valutazione multistrumentale degli interventi psicoterapeutici e integrati. *Epidemiologia e psichiatria sociale, allegato 'Accreditamento e salute mentale'* 19.4, n. 4, 241-251.

Fava, E., Papini, S. (2020). La ricerca fa bene alla formazione? In L. Corbelli & L. Bonalume (a cura di), *Come posso esserti utile?.* Milano: Alpes.

Fava, E. D, Zuglian, P. (2016). La personalizzazione dei trattamenti nei disturbi dell'umore. In E. Fava, Gruppo Zoe (Eds.), *La competenza a curare: il contributo della ricerca empirica* (pp. 69-86). Milano: Mimesis.

Frances, A. (2016). Dove va la psicoanalisi? *Psicoterapia e Scienze Umane*, *50* (3), 458-461.

Friedson, H. (2001). *Professionalism: The third logic.* Chicago, IL: University of Chicago Press.

Gelso, C. J., Carter, J. A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology, 41*(3), 296-306.

Gelso, C. J., Hayes, J. A. (1998). *The psychotherapy relationship: Theory, research and practice*. New York, NY: Wiley.

Giaconia, G., Pellizzari, G., Rossi, P. (2000). *Nuovi fondamenti della tecnica psicoanalitica.* Roma: Borla.

Huibers, M., Cohen, Z., Lemmens, L., Arntz, A., Peeters, P. M. L., Cuijpers, P., De Rubeis, R. (2015). Predicting optimal outcomes in cognitive or interpersonal psychotherapy for depressed individuals using the personalized advantage index. *PLoS ONE*, *10*, 11.

Hilsenroth, M. G., Cromer, T. D., Ackermann, S. J. (2012). How to Make Practical Use of Therapeutic Alliance Research in your Clinical Work. In R. A. Levy, J. S. Ablon, H. Kächele (a cura di), *Psychodynamic Psychotherapy Research. Evidence-Based Practice and Practice-Based Evidence* (pp. 381-400). NewYork, NY: Humana Press.

Hunter, V. (1996). *Psicoanalisi in azione. I modelli teorici e la loro applicazione clinica*. Roma: Astrolabio.

Jones, E. E., Pulos, S. M. (1993). Comparing the process in psychodynamic and cognitive-behavioral therapies. *Journal of Consulting and Clinical Psychology, 61*(2), 306-316.

Jones, E. E. (2000). *Therapeutic action: a guide for psychoanalytic therapy*. Northvale: Jason Aronson.

Kachele, H., Krause, R., Jones, E., Perron, R., Fonagy, P. (2000). *An Open Door Review of Outcome Studies in Psychoanalysis. Report prepared by the Research Committee of the IPA at the request of the president.* Testo disponibile al sito: https://www.ipa.world/IPA_Docs/Open%20Door%20Review%20III.pdf

Katzenstein, T., Pole, N., Ablon, J.S., Olsen, C. (2012). Combining Idiographic and Nomothetic Approaches to Single-Case Research. In R. A. Levy, J. S. Ablon, H. Kächele (a cura di), *Psychodynamic Psychotherapy Research: Evidence-Based Practice and Practice-Based Evidence*. New York, NY: Humana Press.

Lakatos, I. (2001). *La metodologia dei programmi di ricerca scientifici*. Milano: Il Saggiatore.

Lambert, M. J., Barley, D. E. (2002). Research Summary on the Therapeutic Relationship

and Psychoterapy Outcome. In J.C. Norcross (a cura di), *Psychotherapy relationship that work* (pp. 17-32). New York, NY: Oxford.

Lambert, M. J., Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. Lambert, A. E. Bergin, F. Garfield (Eds.), *Handbook of psychotherapy and behavior change,* 5th. ed. New York, NY: Wiley.

Leichsering, F., Rabung, S. (2009). Analyzing effectiveness of long-term psychodynamic psychotherapy reply. *Journal of American Medicine Association, 301,* 932-33.

Leuzinger-Bohleber, M. (2018) La ricchezza della ricerca psicoanalitica contemporanea. Osservazioni epistemologiche e metodologiche, alcuni esempi e il metodo di osservazione clinica a tre livelli. *Rivista di psicoanalisi, 2*, 225-238.

Leuzinger-Bohleber, M., Target, M. (2002). *Outcomes of psychoanalytic treatment: Perspective for therapists and researchers.* Philadelphia, PA: Whurr Publishers.

Leuzinger-Bohleber, M., Kachele, H. (a cura di). (2015). *An open door review studies in psychoanalysis of outcome and process,* 3rd Ed. International Psychoanalysis Association.

Levy, R.A., Ablon, J.S., Kächele, H. (a cura di). (2012). *Psychodynamic Psychotherapy Research.Evidence-Based Practice and Practice-Based Evidence*. New York, NY: Humana Press. [tr. it, 'La psicoterapia psicodinamica basata sulla ricerca' (2015). Milano: Raffaello Cortina].

Lo Coco, G. (2020). Il rapporto tra clinica e ricerca. L'efficacia dei trattamenti psicoterapeutici: nuove evidenze e sfide metodologiche. In L. Corbelli, L. Bonalume (a cura di), *Come posso esserti utile?* Roma: Alpes.

Luborsky, L., Crits-Cristoph, P. (1998). *Understanding transference: The Core Conflictual Relationship Theme Method* (2nd ed.). Washington, DC: American Psychological Association.

Luborsky, L., Rosenthal, R., Diguer, L., Andrusyna, T. P., Berman, J. S., Levitt, J. T., Seligman, D. A. & Krause E. D. (2002). The dodo bird verdict is alive and well-mostly. *Clinical Psychology: Science and Practice, 9*(1), 2-12.

Luborsky, L., Rosenthal, R., Diguer, L., Andrusyna, T. P., Berman J. S., Levitt J. T., Seligman D. A. & Krause E. D. (2003). Are some psychotherapies much more effective than others? *Journal of Applied Psychoanalytic Studies,* 5(4), 455-460.

Mattana, G. (a cura di). (2017). *Ricerca empirica in psicoterapia. Intervista a Emilio Fava.* Disponibile al sito: *https://WWW.spiweb.it/ricerca/ricerca-empirica-in-psicoterapia-intervista-a-emilio-fava-a-cura-di-g-mattana/* Consultato: 16 ottobre 2019.

Meltzer, D., Harris, M. (1986). *Il ruolo educativo della famiglia* (pp 42-50). Torino: Centro Scientifico Editore.

McWilliams, N. (2011). *La diagnosi psicoanalitica.* Roma: Astrolabio.

Muzi, L., Lingiardi, V. (2019). Diagnosi in transizione: l'influenza della personalità del terapeuta. *Ricerca Psicoanalitica, XXX*(1), 73-90.

Nagel, E. (1967). *Psicanalisi e metodo scientifico.* In S. Hook (a cura di), Psicoanalisi e metodo scientifico. Milano: Einaudi.

Nicolò, A. M. (2018). La ricerca come sfida per lo psicoanalista. *Rivista di psicoanalisi, 2*, 225-238

Nietzsche, F. (1878). *Umano, troppo umano*. Tr.it. (1979). Milano: Adelphi.

Norcross, J. C., Wampold, B. E. (2011). What works for whom: Adapting psychotherapy to the person. *Journal of clinical psychology*, *67*, 127-132.

Norcross, J. C. (a cura di). (2011). *Psychotherapy relationships that work* (2nd ed.). New York, NY: Oxford University Press.

Norcross, J. C., Lambert M. J. (2011). Psychotherapy relationships that work II. *Psychotherapy*, *48* (1).

Norcross, J. C., Lambert M. J. (2018). Psychotherapy relationships that work III. *Psychotherapy*, *55* (4).

Norcross, J. C., Wampold, B. E. (a cura di) (2019). *Psychotherapy relationships that work*

(Vol.2): Evidence-based therapist responsiveness (3rd ed.). New York, NY: Oxford University Press.

Ogden, T. H. (1994). The concept of interpretative action. *Psychoanalythic Quarterly*, *63*(2), 219-245.

Papini, S. P., Fava, E. D. (2019). L'integrazione nella valutazione diagnostica dei fattori terapeutici correlati agli esiti: Il sistema di diagnosi psicodinamica operazionalizzata (OPD-2). *Ricerca Psicoanalitica, XXX*(1), 37-55.

Papini, S. P., Zuglian, P., Ferrari, A., Conte, M., Fava, E. D. (2016). La diagnosi dimensionale: il metodo OPD (Diagnosi Psicodinamica Operazionalizzata). In E. D. Fava e Gruppo Zoe, *La competenza a curare. Il contributo della ricerca empirica*. Milano: Mimesis.

PDM Taskforce (2006). *Psychodynamic diagnostic manual*. Silver Spring, MD: Alliance of Psychoanalytic Organizations.

Perry, J. C., Petraglia, J., Olson, T., Presniack, M., Metzger, A. (2012). Accuratezza nella interpretazioni delle difese. In R. A. Levy, J. S. Ablon & H. Kachele (Eds.), *Psychodynamic psychotherapy research. Evidence-based practice and Practice based evidence.* New York, NY: Humana Press, Springer; [tr. it, 'La psicoterupia psicodinamica basata sulla ricerca'. Milano: Raffaello Cortina (pp. 345-386)].

Peterfreund, E. (1983). Trad. It. (1993). *Il processo della psicoterapia psicoanalitica*. Roma: Astrolabio.

Piaget, J. (1973). *L'equilibrazione delle strutture cognitive.* Torino: Boringhieri.

Piano Nazionale di Azioni per la Salute Mentale (PANSM), approvato dalla Conferenza Stato Regioni nella seduta del 24 gennaio 2013, www.stato.regioni.it2

Polanyi, K. (1967). *La Conoscenza Inespressa,* trad. it, Roma: Armando.

Sabucco, G., Fava, E., Agazzi, G., Riva, E., Scwheizer, K. (2020). *L'eclettismo consapevole: uno studio presso il Centro Milanese di Psicoanalisi.* Quaderni del Centro Milanese di Psicoanalisi; www.cmp-spiweb.it

Shea, M. T., Pilkonis, P. A., Bechkam, J., Collins, J. F., Elkin, I., Sotski, S. M. (1990). Personality desorders and treatment outcome in the NIMH Treatment of Depression Collaborative Program. *American Journal of Psychiatry, 147*, 711-718.

Shedler, J. (2010). The efficacy of psichodinamic psychotherapy. *American Psychology*, *65*(2), 98-109.

Smith-Hansen, L., Levy, R. A., Seybert, C., Erhardt, I., Ablon, J. S. (2012). The Contributions of the Psychotherapy Process Q-Set to Psychotherapy Research. In R. A. Levy, J. S. Ablon, H. Kächele (a cura di), *Psychodynamic Psychotherapy Research. Evidence-Based Practice and Practice-Based Evidence* (pp. 381-400). NewYork, NY: Humana Press, Springer.

Sotzki, S. M., Glass, D .R., Shea, M. T. (1991). Patient predictors of response to psychotherapy and pharmachotherapy: findings in the NIMH Treatment of Depression Collaborative Research Program. *American Journal of Psychiatry, 148*, 997-1008.

Stern, B. L., Caligor, E., Clarkin, J. F., Critchfield, K. L, Hörz, S., MacCornack, V., Lenzenweger, M., Kernberg, O. F. (2010). Strucutred interview of personality organization (STIPO): Preliminary psychometrics in a clinical sample. *Journal of personality assessment*, *92*, 35-44.

Tasca G. A., Sylvestre J., Balfour L., Chyurlia L., Evans J.Fortin-Langelier B., Wilson B. (2015). What clinical practitioners want: findings from a psychoterapy practice research network survey. *Psychotherapy, 52*(1), 1-11.

Task Force OPD. (2006, tr.it. 2009). *OPD-2 Diagnosi psicodinamica operazionalizzata. Manuale per la diagnosi e la pianificazione del trattamento*. Milano: Franco Angeli.

Vigna-Taglianti, M. (2018). I gruppi di ricerca sulle trasformazioni nel processo analitico. *Rivista di psicoanalisi*, *2*, 225-238.

Von der Lippe, A. L., Monsen, J. T., Rønnestad, M. H., Eilertsen, D.E. (2008). Treatment failure in psychotherapy: The pull of hostility. *Psychotherapy Research*, *18*(4), 420-432.

Wampold, B. E. (1997). Methodological problems in identifying efficacious psychotherapies. *Psychotherapy Research*, *7*, 21-43.
Wampold, B. E., Bolt, D. M. (2007). Appropriate estimation of therapist effects: one more time. *Psychotherapy Research, 17*(2), 256-257.
Wampold, B. E., Imel, Z. (2015). *The great psychotherapy debate* (2nd ed.). Mahwah, NJ: Erlbaum.
Werbart, A., Lavander, S. (2006). Two sets of private theories in analysands and their analysts: Utopian *versus* attainable cures. *Psychoanalytic Psichology*, *23*, 108-127.
Werbart, A., Levander, S. (2005). Understanding the incomprehensible: Private theories of first-episode psychotic patients and their therapists. *Bulletin of the Menninger Clinic, 69*, 103-136.
Zuglian, P., Papini, S.P., Conte, M., Fava, E. D., Ferrari, A. (2011). Diagnosi Psicodinamica Operazionalizzata. Presupposti teorici, descrizione del sistema e applicazioni dello strumento. *Psichiatria di comunità, 10*(2), 69-76.

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