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HARMFUL PSYCHOTHERAPIES? LET'S START WITH MALPRACTICE

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Una vez resuelto el debate eysenckiano sobre la utilidad de la psicoterapia, sobrevino la controversia sobre las eficacias relativas de cada método. Superado parcialmente este último con el traslado de la investigación sobre la eficacia a la de la cualidad de la alianza terapéutica, ha surgido recientemente en España la pregunta sobre la eventual nocividad de algunas psicoterapias. En este texto incluiremos consideraciones tanto en el nivel científico como deontológico como de la práctica profesional de la psicoterapia
Palabras clave: *Psicoterapias nocivas, Ciencia, Deontología, Práctica profesional.*

After the Eysenckian debate on the usefulness of psychotherapy was resolved, professional psychotherapists witnessed seething controversy over the relative efficacy of each method. Having mostly overcome this argument and moved on from the research on efficacy to that on the quality of the therapeutic alliance, once again clinicians in Spain are observing the issue about the potential harmfulness of some therapeutic treatments. In this text, considerations will be developed both at the scientific and the deontological level, from the point of view of the professional practice of psychotherapy.
Key words: *Harmful psychotherapies, Science, Deontology, Professional practice.*

Don't think, look!
Ludwig Wittgenstein

Psychotherapy has always experienced disputes around its greater or lesser scientificity, the greater or lesser proportion between descriptive and prescriptive discourse, the importance of the «human» relationship between patients and therapists, and the placebo. And all the contenders have argued on the basis of some ideal that, once dogmatized, becomes an example of Freudian death drive or fetishist object, according to taste.

With the rise of randomized clinical studies, the balance tipped decisively in favor of biomedical science, and some psychotherapies were declared scientifically better than others. Recently, with the emergence of the contextual model (Wampold & Imel, 2015), new developments are once again calling everything into question. By way of example, we will cite the *Conclusions and Recommendations of the Interdivisional Task Force on Evidence-Based Therapy Relationships* (APA divisions 12 & 29, 2011), which we will discuss in detail below, and the article "Making Science Matter in Clinical Practice: Redefining Psychotherapy" (Beutler, 2009), describing the difficulty that scientists have in proposing a feasible model of science to overcome the hackneyed abyss between science and practice, and in recognizing the weakness of the evidence on which they base some of their beliefs on the empirical basis of treatments. Beutler concludes by calling on scientists to take a much broader approach to research in psychotherapy.

The pendulum has swung to the other extreme, now supporting the professional psychotherapists who, since the establishment of empirically supported treatments, felt that this golden rule surely responded more to the aspiration of «considering psychotherapy as aspirin» (Klerman, 1986), which meant that each form of psychotherapy had to have known ingredients, we had to know what they consisted of, and they had to be able to be trained and replicated between therapists, as well as administered in a uniform way within a given study.

But surely, with both aspirin and psychotherapy, we can expect that they will do some good and some bad at times. This is the objective of this article, to study this topic of the harmfulness of psychotherapies, from the clinical point of view.

Psychotherapy is not a science, if anything it is the application of psychology, a *soft* science if seen based on natural science or extremely *hard* if it is considered as Dilthey (1949) saw it, the border between the *Natur-* and the *Geistwissenschaften*. It is an application that freely draws from any metaphorical field: art, crafts, anthropology, literature, sports, chess, in short, from everything that is convenient to the service of therapeutic efficiency when speaking the client's language, the maximum aspiration of every psychotherapist who does not intend to teach his or her language to the

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patient and who is willing to discover a new word between the two, both being mutually moved.

We could consider it a technique and, in this sense, the mother of science (Charpak & Omnés, 2005; Ridley, 2010). Man has been solving technical problems from the cave days to today, from hunting mammoths to 5G, while science as we define it today was born, let us say, in the 15th or 16th century, with Nicolas de Cusa or Galileo Galilei. Contrary to what it seems, science is not the mother of science but the daughter, science comes after technique, and it explains why some actions have been successful and others not.

SCIENCE IS NOT THE SKY, IT IS THE GROUND

In the fight for efficacy, aspirin believed it had won, achieving some pyrrhic victories, demonstrating local efficacy in return for the extermination of too many variables from the live clinic. Comparisons between psychological treatments showed that psychotherapies do not behave like medicines. This is the position reached by the APA (2011), concluding that the therapeutic relationship generates considerable contributions to the outcome of psychotherapy regardless of the type of treatment employed; and it is responsible for the improvement or worsening of the patient to the same or to a greater extent than any specific ingredient. In this text, the APA outlines a number of corollaries, such as that treatment guidelines should promote therapist behaviors and qualities that generate an enabling therapeutic relationship, excluding which any effort to promulgate evidence-based best practices will be severely incomplete and potentially disorienting. This is a highly recommended text, and its political intention was surely to calm hostilities among the clinical theoretical schools.

Much has happened since common factors theory (Rosensweig, 2010; Frank & Frank, 1993), from the war between theoretical-clinical models (Saltzman & Norcross, 1990) to the movement of integration in psychotherapy (Norcross & Beutler, 2002), the latter born both in the clinic and in research and currently represented by a copious bibliographic production. The famous Dodo bird, imported by Rosensweig from Wonderland, has been declared both alive and dead, to the point that it has now perhaps turned into Schrödinger's cat.

Let's get down to the details. The question is: are there any harmful psychotherapies? And if so, are they due to lacking science or to bad science, or are they cases of bad practice, worthy of ethical and deontological considerations rather than epistemological ones? What is the relationship between good or bad science and good or bad psychotherapy? Can one be a good scientist and a bad psychotherapist, or vice versa? Or perhaps it would be useful to reformulate everything, starting by renouncing the ideal of natural science, so useful for the biomedical model but to date inadequate for assimilating psychotherapy to aspirin.

A work by Lilienfeld (2007) widely cited since its appearance, with an impactful title and a number of disclaimers, has the virtue of laying out all the pieces on the table, and also the courage to point out *a contrario sensu* where the problem lies. Lilienfeld reviews a list of psychological treatments that cause harm and classifies them as Level I, which includes a) debriefing, b) scare treatment, c) facilitated communication, d) rebirthing, e) memory retrieval techniques, f) normal grief counseling, g) experiential/expressive therapies, h) residency in camps for behavioral disorders, i) treatment programs for drug addicts.

In level II, we find: a) peer group interventions for behavioral disorders and b) relaxation for panic prone patients

Level I is characterized as «probably harmful to some individuals» and Level II as «possibly harmful to some individuals». In the first level, one can expect any of these treatments to be harmful to a person, in the second harm is not expected to occur, but an unexpected outcome cannot be denied either in an infinite number of examples.

This classification is based on cases in RCTs, meta-analyses, and in several cases on studies of a priori unlikely events in replicated case reports. It is not the purpose of this article to replicate or review the literature of the Lilienfeld article. A detailed analysis of the references in the Lilienfeld text, pointing out their methodological weaknesses, is available from Wampold and Imel (2015, pp104-112).

As Wampold and Imel say, anyone can see that this list is not homogeneous and that it is difficult to consider some of its elements as psychotherapies. A basic mountain camp can be a formidable modifying experience for a traumatized and violent teenager, and it is also possible that a good scare from a police officer, describing in some detail what happens to a young delinquent in prison, will be sufficient deterrent, but I doubt very much that we would consider these methods psychotherapy.

Rebirthing is considered a harmful therapy based on the case of a patient (sic) who died of suffocation reliving their birth trauma while trying to make their way through a pile of enthusiastic companions in that group experience. Even accepting that rebirthing is a psychotherapy (symptom plus relationship, plus technique with an intelligible foundation), would you consider it harmful because someone once died? In any case it would be an accident, or a case of malpractice, or a murder with a psycho-alibi, a good argument for a psycho-thriller.

To talk about psychotherapy, we first need a symptom, that discomfort that I can't explain, even if I spend the day wondering what I did to make it happen to me. A symptom is an unsatisfactory, transitory solution, but a solution in the end, after all the patient is doing the best he or she can in his or her biographical and mental circumstances. Is that "best he or she can" a symptom? Well, it's the psychotherapist's job to help the patient discover that mystery, and he or she will do so with both behavioral and introspective strategies. As in the previous cases, a preventive program of eventual traumas, such as debriefing or normal grief counseling is expected to

be beneficial or harmful to someone at some point, but strictly speaking it is not psychotherapy. That is why psychotherapy began with neuroses (Freud) and spread as we began to decipher the emotional and relational mysteries and conflicts for which addictions or hallucinations, even organized deliriums, represented solutions. Do efficacy studies focus on anxiety and depression? Not surprisingly, these patients keep wondering how they got that way. But no matter how disturbed some patients are, if they don't ask themselves any questions, perhaps we can treat them in some other way, but let's not talk about *psycho*therapy. And seeing how many first interviews it takes for a patient to question him- or herself symptomatically is the bread-and-butter of many professionals.

But having said all this we can get to the heart of the matter: the therapist's values that inform his or her strategy for change. Lilienfeld is fleetingly clear on this point: «the very definition of a harmful effect may be influenced by value-laden considerations that lie outside the scope of this article». These value-laden considerations are not within the scope of our study, but are we talking about anything other than values when we talk about psychotherapy or more precisely about mental change? «The issues here are again not readily resolved, and hinge on often-unarticulated a priori assumptions regarding what types of change are more or less desirable». Exactly, our values as therapists constitute and inform our desired types of change, just as those of our patient are the basis of and inform us of theirs.

Here we have the real problem, biomedical science does not integrate these values in its reasoning, and if it does, it is to get rid of them as soon as possible, with all the blind trials that are required for this. The object of natural science is indifferent to the values of the scientist who studies it, and the scientist breathes a sigh of relief as he or she sees that. The patients, for their part, are extremely sensitive to the values of their therapist; they will study him or her very carefully and can forgive any error except an insincerity of the heart, especially in the case of psychotic patients, always so sensitive to authenticity. This fact only reflects the importance that values have in the conflicts that are expressed in the symptom (God may have died, but the superego has not) and possibly, although less so, also in the rest of the signs that express and contribute to suffering it. Whether we consider the patient a failed Oedipal hero, a subject cowed by their ontological anxieties, a mistaken intelligence and prey to their biases, or someone who got tangled up in their relational knots until they could not get out of the pit they had dug for themselves—and here I'll stop this list, which could be almost as long as the catalogue of psychotherapies—there are conflicting values throughout. Without values there would be no conflicts, from the survival principle to the debates on the tuning of the first violin, values infiltrate all conflicts, without which we would also not have symptoms.

Psychopathology and its psycho-treatment is housed in the chapter of morality, it is a moral issue, in a broad sense, and surely that is why it does not fit comfortably in the statistics, clinical trials, or meta-analyses. There does not seem to be a non-value-laden psychotherapy, comparable to a pill if you like.

Lilienfeld's list gives us a glaring example of the influence of the therapist's values in the case of facilitated communication, a psychomotor therapy for autistic children, which has generated, according to our author, dozens of charges of sexual abuse allegedly committed by the parents, the vast majority of which are unconfirmed and which Lilienfeld admits were possibly inspired by the causal hypothesis between abuse and autism harbored by the therapists. The same is true for the evocative therapies that very mistakenly confuse history with the past. From psychology, we already know that memories are constructions in the present, the past is not history, and history is always written in the present. This difference, essential to good practice, is often ignored by therapists whose values of justice and rescue often lead them to find abused children in adults who had no memory of being abused at the beginning of therapy (Yapko, 1994) and who collude with the therapist's counter-transference assertions.

And "let alone", the classification of possibly (not probably) harmful for relaxation techniques for anxiety prone patients. As Wampold and Imel say, negative discrimination is suspected here, compared to the risks that unbridled exposure has on these patients. It is of course easier to suspect relaxation techniques than the widely evidenced exposure, although I confess I do not understand why, in either case. It is difficult to criticize relaxation, as well as exposure; all psychotherapies are exposure, from making the unconscious conscious to overcoming spider disgust.

To our consolation, in an article presenting himself as the new editor of *Clinical Psychological Science* (Lilienfeld, 2017), citing his previous work, our author retrieves these considerations, but now with a very broad focus with the intention of bridging «the often yawning gap between basic and applied science in clinical problems» and not of publishing horse race treatment studies.

Even before emphasizing the therapeutic alliance, the Working Group on Evidence-based Practice (APA, 2006) defined evidence-based practice as the integration of the best available research with the clinical expertise of the practitioner, both in the context of patient characteristics, culture, and preferences.

The recent history of this approach has ranged from the best available evidence, through clinical expertise, and more recently to the context of patient values and preferences. It is not a novelty «to speak the language of the patient»; it is since ancient times the greatest aspiration of all therapists, to enter the patient's world, to *speak* like him, to *see how* his eyes see, and to feel as he feels in his body; all this is already an initial and enormous intervention, and the basis of the efficacy of all the following ones. Any psychoeducation will leave only an authoritarian trace without this condition. And it is not just a matter of the hackneyed putting myself in the

other's shoes, but of constantly asking myself in what circumstances—biographical or mental—I would do, feel, or think like my patient, who, by the way, if this happens and we have reached this level of collaboration, is no longer a patient at all.

All these are values, in the most axiological sense, if you'll forgive the redundancy, about the word; about yours and mine; about good and evil; about love, hate, and the meaning of life; about life and death; and so on. If I cannot share yours, even if they are not mine, I will not be of much help to you, and any technique will be welcome, no matter how extravagant it may seem if it operates within this meta-identification.

Evidence-based practice, practice-based evidence, empirically supported treatments, deliberate practice, all these are mutually articulated stages of the reflection on psychotherapy, the relative weight of that triad: best science/expertise/patient context.

Here we are faced with the question: are there harmful therapies, and how does this harm relate to greater, lesser, or worse science?

The easiest and most obvious answer is that we still cannot know. If we shake off the biomedical science model, after having verified its insufficiency to address the complexity of psychotherapies, all we can do is to develop another one. The contextual model (Wampold & Imel, 2015) seems to be the right way; it does not deny the RCTs or meta-analyses at all but it raises them to a higher level, where they are no longer the golden rule, but the value of their contribution is preserved.

However, we also have another option, which neither cancels out nor goes against the preferences of psychologists who follow the biomedical model of a specific disorder/treatment/ingredient.

This other model is that of deontology and professional ethics. Malpractice is a special case of error. Anyone can make a mistake, but there are actions that transgress deontological and ethical principles and if they are reported they are assessed by the deontological commissions of the professional bodies. As psychotherapists we can be as flexible and creative as the demands of our practice and our capacities require, but as psychologists the best available science is an unavoidable requirement, as is permanent training.

The practice of psychotherapy requires a rigorous ethic, and psychotherapists in private practice are exposed to various risks. On the one hand, the temptation of the guru, especially if we are in financial trouble and the loss of a patient makes us nervous, and on the other hand, the temptation of exceptionality, i.e., narcissism. The two temptations coincide to a great extent. In our work it is unethical to enjoy ourselves at the expense of the patient; technical errors may be made by all of us, but what transcends the error and that which we are supposed to have been patients for ourselves is not to make the patient the object of our tendencies, be they sadistic, masochistic, voyeuristic, exhibitionist, or the like, not to vampirize their emotions, not to take advantage of their anguish or inhibitions and thus feel better than them. Perhaps that is why neurotic functioning is the best qualification for being a therapist, because we are so afraid of being perverse that, when we are wrong, we suffer and run to seek supervision or support from colleagues.

We know that there are gurus who prey on despair. Many people have the capacity, the disposition and even the vocation to enter into perverse, toxic relationships, to be victims of a psychopath disguised as a therapist, with or without a degree qualification. Childhood attachment disorders leave a bottomless pit of longing for a love never received and leave us vulnerable and sometimes willing to put our lives in the hands of a seductive therapist's charisma. These temptations also lurk in the public practice, of course, but since the market is different, as we are not competing for clients but for jobs, it is not exactly the same. This difference in the market surely produces a difference in the clinical practice.

Let us recap. We began by asking ourselves if harmful psychotherapies exist. The answer is no, or in any case we do not yet have a sufficiently complex system of evaluation to elucidate this on a scientific level. This is because psychotherapy rides between technique and ethics, between procedures of psychological help and the values that infiltrate both the patient's symptomatic conflicts and those of the therapist's position and methods. A good confluence between patient and professional will require reciprocal recognition, a good fit between individuals and methods; perhaps there is no such thing as psychotherapy composed only of common factors, some specific ingredient will be necessary, but without the relationship and its therapeutic alliance it will not have the necessary momentum for change. For Norcross and Beutler (2002), the success of a therapy rests on several factors in the following order: the patient, the helping relationship, the therapist, and the particular method of treatment. In more abstract terms: the symptom, the relationship, the countertransference, and finally the method. The what and the how of each treatment are difficult to distinguish. Each of us will prefer a method or will elaborate our own formula and the therapeutic relationship each individual proposes will be coherent with that choice. Or it will not be, as in the case of those professionals who fervently wish to be faithful to a certain school or teacher, without accepting that this longed-for and guilty faithfulness is the main source of their own resistance and a foreseeable brake on their natural talents.

We cannot affirm that bad psychotherapies exist, but we do frequently verify our bad practices, in ourselves to begin with. We supervise our cases, that is to say ourselves, and return to therapy with some frequency. In this way we can see that our successes and failures are based on our ability to welcome the other as someone else, and to listen well so that the patient can speak better.

CONFLICT OF INTEREST

There is no conflict of interest.

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