Revived call for consensus in the future of psychotherapy

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ABSTRACT
The emblem of success in psychotherapy research and practice has long been innovation. Although such ingenuity is commendable, it has nonetheless perpetuated fragmentation across the field. At least four decades ago, it was suggested that achieving consensus on what constitutes psychotherapy’s theoretical, empirical, and practical ‘core’ might allow the discipline to evolve beyond its siloed state, as is reflective of mature science. Yet, division remains the rule versus exception, owing in large part to power struggles among disparate schools of therapy and quarrels over whether theory-specific or theory-common factors most account for therapeutic change. We outline here a vision for psychotherapy’s future that is defined by consensus rather than disintegration. Namely, we reiterate the need for the field to invest in clinical strategies that transcend ostensibly incompatible theoretical models. We also argue that psychotherapy research should build on the growing evidence for such clinical strategies in an effort to establish core, evidence-based principles of therapeutic change. We then discuss how establishing consensus will require reconciliation among the mounting evidence for flexible, principle-informed practice with the current realities of training, dissemination, and implementation paradigms. Finally, we articulate ways in which practicing clinicians will serve a vital role in carrying out, and amending as needed, actionable efforts toward psychotherapy consensus.

When invited to contribute to this issue, we were struck by its title, the Future of Psychotherapies. To us, the plurality, while an admirable mark of expansion in one sense, also emphasises the discipline’s stubbornly fragmented nature, with its extensive list of ostensibly disparate psychotherapy models, orientations, approaches, and interests. We argue that the future of this field should weight toward psychotherapy (singular) rather than psychotherapies (plural), a reality that can only be realised after achieving a notable level of consensus—the mark of a mature science.

Despite consensus being identified as a goal for the psychotherapy discipline at least 40 years ago,1 the prevailing rhetoric has remained that of a power struggle between dual therapy schools (of different names) and the falsely dichotomised theory-specific versus theory-common factor camps. Reflecting this, the nature of psychotherapy training remains largely dictated by the theoretical orientation of one’s clinical supervisor or graduate programme,2 with an emphasis placed on employing theory-specific interventions, often in a manualised or otherwise scripted sequence, despite a dearth of evidence to support doing so.3 Put differently, we would speculate that there is no element of a clinical training curriculum that all programmes agree is essential—another striking example of limited consensus. (In fact, even for a construct like the therapeutic alliance, which is perhaps the field’s biggest achievement in consensual thinking, few programmes formally train on evidence-based alliance practices.)4 Moreover, even with many clinicians identifying as ‘integrative’,4 the heterogeneity of integrative approaches leaves us with little agreement on what comprises the core knowledge of psychotherapy. Thus, integrative models add to the aforementioned dizzying list of ways to practice (with even more names/labels!). Consequently, the defining feature of our discipline arguably remains disintegration. Such an impasse necessitates that we begin to metacommunicate about that on which we can agree. We attempt here to start (or revive) this conversation.

Perhaps what psychotherapists and clinical scientists would agree on most is that people are complex, and therefore so too is psychotherapy and therapeutic change. If this tenant is accepted, then it follows with psychotherapy that one size does not fit all. We suspect that many would also agree, at least to some extent, that there are some therapeutic change principles that transcend the seemingly incongruent overarching theoretical models (at the highest level of theoretical abstraction) and their specific theory-based techniques (at the lowest level of theoretical abstraction).5 Accordingly, rapprochement across divided camps may be possible by divesting from particular theories and techniques and instead investing in core, transtheoretical change strategies (at a middle level of theoretical abstraction) that can be responsively tailored to individual patients. It is at this middle level of abstraction that we have the greatest likelihood of finding commonality to unify our discipline. Working here, with acceptable levels of empirical support for such change principles, therapists can be freed from theoretical loyalties that may inadvertently steer them toward rigidity and away from the evidence base, as well as any cognitive dissonance stemming from ‘not knowing enough about this’ or having ‘not trained on that’ to use such principles effectively.

As we further argue below, shifting toward consensus will require a multipronged approach that includes (a) investigating the nature of, and acquiring further empirical support for, transtheoretical clinical strategies to elevate them to
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RESEARCH
In one laudable movement toward consensus, several authors
have compiled largely correlational evidence for transtheoretical
and transdiagnostic clinical strategies that may comprise the
psychotherapy core (eg, the latest volumes of Psychotherapy Rela-
tionships That Work 9 10 and Principles of Change: How Psycho-
 therapists Implement Research in Practice 11). To expand on the
preliminary support for these principles, we believe that future
research will need to experimentally test their causal influences
on patient improvement. Consistent with our assertion that one
size does not fit all, this work should embrace (rather than disre-
gard) the intertwining complexities of patient, therapist, dyadic
(or group) and moment-to-moment contextual factors. To better elucidate what works best for whom, we will need to test how best to flexibly deploy transtheoretical strategies in response to
particular clinical contexts.9 10 Further, and adding layers of who
works for whom when ... and how, we can draw on the
actions of those therapists who are empirically most effective in
using these clinical strategies to therapeutic benefit.9 10 Of course,
all of this work will require thorough replication in order for
such strategies to earn the distinction of ‘core, consensual prin-
ciples’ and to warrant adoption into training and practice.

For the research literature to take meaningful steps in this
direction, we will need to divorce ourselves from the archetyp-
ical, theory-directed approach in which followers of a particular
school seek to tip the scale in favour of their own faction by
amassing support for full treatment packages (assumed to bring
about change through theory-specific mechanisms). Instead, we
believe the discipline will need to set aside our deeply rooted
rivalries and place greater value on creating a knowledge base
that can be shared by all. This may demand a culture shift, as
much as a shift in specific aims, given that academic careers are
more often thought to be made through innovation than repli-
cation. In service of our patients, we may need to demonstrate
greater allegiance to our science as a whole than to our own
insulated professional subcommunities.

TRAINING, DISSEMINATION, AND IMPLEMENTATION
As we accumulate evidence for transtheoretical principles, the
field will also need to consider how best to introduce them into
the clinical vernacular and strategic repertoire of those engaged
in psychotherapy practice. Capitalising on existing dissemination
and implementation (D&I) efforts is one way to target licensed
practitioners, though graduate programmes may be the key
means through which research-informed training innovations
can take the strongest hold with the next generation of psycho-
therapists.11 12 However, to make use of such avenues, we will
need to grapple with the present state of D&I practices (which
remain largely concerned with facilitating the adoption of, and
promoting fidelity to, school-specific treatment manuals13) and
training practices (which have sparse empirical support
behind them14). If our D&I and training practices are to reflect
the current state of the science—a literature that increasingly
supports the utility of therapist flexibility15 over strict model
adherence—the challenging conversation, and associated para-
digm shift, are long overdue.

One promising means for bringing training practices in line
with the evidence is to engage modular trainings that empha-
sise the importance of identifying key moments in session and
responsively using core clinical strategies to personalise psycho-
therapy to a given patient and therapeutic context.8 9 Within
this training approach, a consensually effective therapist would
be one who, when faced with a specific clinical scenario, could
astutely select and deploy the optimal evidence-based strategy
at the appropriate time,8 16 regardless of their main therapeutic
orientation. In addition, as the D&I field widens its scope to
consider rolling out more than just treatment manuals (eg, prog-
ress monitoring17), we believe that accessible, modular trainings
on the responsive use of core, consensual principles will need to
be added to the docket. Notably, such principle-based trainings
would better align with clinician-reported preferences.12

CLINICAL PRACTICE
All of the efforts outlined here will need to be reinforced by input
from practicing therapists through a reciprocated dialogue, or
two-way bridge.17 After all, the ultimate goal of psychotherapy
research is clinical actionability, and it is practicing clinicians
who are best equipped to provide feedback on the responsive
use of core clinical strategies in real-world settings through trial
and error. In the spirit of practice-oriented research,18 we believe
clinicians can serve in integral roles throughout the process by
helping researchers to design empirical studies that most closely
resemble how clinical strategies would be deployed in routine
clinical practice, identifying additional transtheoretical strate-
gies worthy of further empirical investigation, and guiding the
creation of feasible and acceptable training modules that can
feed into D&I efforts and graduate-level training programmes.

CONCLUSION
We feel that the future of psychotherapy must be rooted in
consensus across orientations, roles, and professional commu-
nities. Put plainly, the accumulating evidence for commonalities
across approaches8 9 and the role of patient, therapist, and contex-
tual factors5 6 9 calls for us to question the long fragmented and
immature state of our science and practice. If we continue to focus
solely on promoting our own interests, our contributions will
inevitably fade into the background, leaving little lasting impact.19
To achieve meaningful consensus, we will need to learn how to
work across the aisle rather than compete against one another.
Indeed, this will require that we address our longstanding issues
with professional (mis)communication by facilitating discourse
across traditionally insulated areas of the literature. With such
collaboration, we may begin to shape future research, training,
and practice to be more in line with the current evidence base, and
one that will continue to reveal and reshape the discipline’s ‘core’.

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