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## Towards a Person-Oriented Approach to Psychotherapy Research

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**Abstract:** Common conclusions from traditional psychotherapy research are that we still do not know how or why even our most well-studied interventions produce change, and that there is little evidence that any form of psychotherapy is generally more effective than any other. This has led some researchers to the so-called Dodo Bird Verdict, that all forms of psychotherapy are equally effective, and to the conclusion that what is at work are “common factors” that have little to do with treatment method. An alternative explanation, however, is that the traditional research paradigm is insufficiently sensitive to provide us with the required kind of knowledge. First, the outcome in typical RCTs is averaged across individuals, and at best complemented by a search for predictors in the form of stable individual differences. This means that this research stays at a group level of analysis and is insensitive to variation and change in individual patients. Second, the independent variable in RCTs does not consist in any well-controlled psychological intervention, but in large-scale treatment packages that contain a large number of interventions over a considerable time period. In other words, this research is insensitive to the effects of specific treatment interventions. Third, traditional psychotherapy research is insensitive to the therapist and patient as individual persons, and their specific interaction. It is argued that a person-oriented approach to psychotherapy, which is idiographic, holistic and interactional, may be able to overcome some of these problems by being more sensitive to (1) the treatment course of individual patients, and patterns during that course; (2) the effects of the specific interventions that are implemented over time, and (3) the personal characteristics of patient and therapist, and nuances of their interaction.

**Keywords:** Psychotherapy research, Person-oriented, Idiographic, Holism, Interactionism, Common factors, Therapeutic skills

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Psychotherapy research during the last decades has focused on demonstrating empirical evidence for treatments of specific forms of psychopathology by means of randomized controlled trials (RCTs). After some decades of such research, a number of treatments have been identified as evidence-based and included in officially sanctioned guidelines for how to treat various psychiatric conditions. It has also led to the general conclusion that psychotherapy works. But one main problem is that it has not led to any real breakthrough in the understanding of *what* makes psychotherapy work. Despite the fact that a large number of psychological treatments are now seen as effective, our knowledge about what causes these effects is still quite

limited. As summarized by Kazdin (2007), “after decades of psychotherapy research we cannot provide an evidence-based explanation for how or why even our most well-studied interventions produce change, that is, the mechanism(s) through which they operate” (Kazdin, 2007, p. 1).

Although RCTs may tell us *that* a treatment works, they have not been able to contribute to knowledge about the mechanisms involved, or the therapist skills needed to conduct successful psychotherapy. Although RCTs have showed that different forms of psychotherapy produce better results than various control conditions, it has been difficult to find evidence that any one form of psychotherapy is more effective than any other. As argued by

Wampold and his associates (Wampold & Imel, 2015; Wampold, Mondin, Moody, Stich, Benson, & Ahn, 1997), when two or more forms of *bona fide* psychotherapy (i.e., “real” therapies described in books and manuals and delivered by trained therapists) are directly compared in an RCT, there is no strong evidence that any one of them is more effective than any other. Similarly, on the basis of around 500 RCTs that examined the effects of psychological treatments of adult depression during four decades, Cuijpers (2017, p. 7) concluded that all psychotherapies that have been tested (i.e., various forms of CBT, short-term psychodynamic therapy, interpersonal therapy, and nondirective supportive therapy) “are effective and there are no significant differences between treatments” (p. 7).

Why should different forms of psychotherapy, based on widely different theories and involving widely different techniques, produce equivalent effects? This is a conundrum in present-day psychotherapy research. How are these results to be explained? Two broad kinds of explanations can be distinguished:

(1) The different forms of psychotherapy are in fact equally effective; this is referred to as the Dodo Bird Verdict (Rosenzweig, 1936).

(2) Different forms of psychotherapy lead to different effects, but we are not able to detect this because our research methods are insufficiently sensitive.

The purpose of the present paper is to explore this second possibility. Although it is difficult to find significant differences in efficacy between different forms of therapy this need not mean that there are no such differences. It might be that different forms of therapy actually have quite different effects, but that the dominant research paradigm (with its focus on RCTs and linear correlations) is too insensitive to detect these differences. A possible reason for this is the heavy bias for studying effects of large treatment packages at a group level of analysis, while ignoring the patterns of change at the level of the individual, as well as the effects of specific interventions, and the interaction between the therapist and patient as two persons. One possibility is that in order to increase our knowledge about how psychotherapy works we need to change to a more person-oriented approach that focuses on what occurs in the treatment over time, in order to identify lawful regularities and patterns of change at the level of the individual.

The present paper takes its starting-point in the person-oriented approach as developed by Bergman and Magnusson (Bergman & Andersson, 2010; Bergman & Magnusson, 1997; Magnusson, 1999, 2001), based on a holistic-interactionistic perspective on the person as an integrated whole that develops and functions as an intentional agent in interaction with the environment (Magnusson, 1999). This holistic-interactionistic approach is here seen as an overarching paradigm that is able to integrate a number of methodological innovations and ways of rethinking methodological issues, such as those found, for example, in the work of Peter Molenaar (2004), Ellen

Hamaker (2012), and the increased use of experience sampling and ecological momentary assessment (e.g., Aarseth, Rot, et al., 2012; Csikszentmihalyi & Larson, 1987; Myin-Germeys, Oorschot, Collip, Lataster, Delespaul, & van Os, 2009), and the potential of single-subject designs (Kazdin, 2011).

An important implication of this framework is that developmental processes are by necessity idiosyncratic, and must be studied at the individual level. This, however, does not mean that we should abstain from searching for general regularities. On the contrary, the search for regularities may preferably start at the level of the individual, and then continue by formulating hypotheses about such regularities that may be tested in additional individuals. As pointed out by Lamiell (1998), Hamaker (2012) and others, general laws by definition should apply *at the level of the individual*, and this is something quite different from the statistical regularities *at the aggregate level* that are studied in traditional psychotherapy research. An additional important aspect of Bergman and Magnusson’s person-oriented approach is that it is not only idiographic (i.e., focusing on individuals rather than aggregates) but also holistic (focusing on the person as a complex system) and interactional (focusing on the person in interaction with the environment). As applied to psychotherapy research, this implies the following:

1. An *idiographic* focus on processes, and the relationship between processes, over time (variation, change, development) for the purpose of identifying *regularities* and *patterns of change* in a specific patient, and in a specific treatment. This is in contrast to a group approach where the focus is on comparisons *between* patients, and between *groups* of patients, and on *individual differences* associated with treatment outcome. For example, multi-level modeling does not represent a person-oriented approach if it is about modeling means and variation across individuals and does not focus on changes within individuals.
2. A *nomothetic* ambition to find lawful regularities in how effective psychotherapy works. A person-oriented approach *starts* by seeking lawful regularities at the level of the individual, but it does not stay there. It also aims to generalize these findings by a categorization of similar patterns into a more general theory. With regard to psychotherapy this involves an ambition to formulate general hypotheses about what leads to psychotherapeutic change in various contexts.
3. A *holistic* focus on patient and therapist as *two persons in interaction*. In other words an idiographic approach is not sufficient, even if it is taken as the starting-point for an attempt to arrive at generalizations about lawful regularities. As formulated by Bergman and Andersson (2010, p. 162), “just be-

cause the individual is focused on and the results apply at a disaggregated level do not suffice for an approach to be called fully person-oriented... To a reasonable extent, the integrity of the system under study must also be retained.”

This paper is divided into three main sections, which focus on three different kinds of insensitivity that characterize the dominant paradigm in present-day psychotherapy research, and a discussion of how they may be overcome by a more person-oriented approach. The first section focuses on the “dependent variable” in psychotherapy research, i.e., the patient, and the dominant paradigm’s *insensitivity to variation and change in the individual patient*, and to the relationship between within-patient mechanisms of change and outcome at the level of the individual. It is suggested that a person-oriented approach requires an increased use of intensive longitudinal data, time-series analysis, and experience sampling methods (ESM) to study processes of change at the level of the individual.

The second section focuses on the “independent variable” in psychotherapy research, i.e., the treatment, and the traditional paradigm’s *insensitivity to the effects of specific interventions*. In RCTs generally, the experimental condition is not any well-controlled psychological intervention but a big treatment package that contains a large number of interventions over a considerable time period. A person-oriented approach here means an increased focus on the effects of specific therapeutic interventions, by means of single-subjects designs.

The third section contains a discussion of the dominant paradigm’s *insensitivity to the therapist and patient as individual persons, and their interaction*. A person-oriented alternative here means an improved conceptualization of patient and therapist as intentional agents that both contribute actively to the treatment, and an increased focus on the nuances of their interaction.

## Insensitivity to variation and change in individual patients

In a typical RCT, patients are randomized to two or more treatment conditions, and the effects are compared in terms of average outcomes on measures of some targeted problem (e.g., depression). Such comparisons of averages belong to a group level of analysis, and are insensitive to what occurs at the level of individual patients during treatment. This insensitivity to the individual patient can be illustrated by comparing graphs which show average change at the group level with graphs that show change at the level of the individual. Figure 1 shows the average scores session by session on the Beck Depression Inventory (BDI-II) in a study where depressed patients were randomized either to Cognitive-Behavior Therapy (CBT) or Interpersonal Therapy (IPT) (Ekeblad, Falkenström, Andersson, Vestberg, & Holmqvist, 2016).

Figure 2 shows, from the same study, the plotting of each

individual patient’s scores at a disaggregated level, session by session, and shows widely different patterns of variation and change during the course of treatment. Obviously, a lot of information is lost when these individual patterns over time are aggregated into average scores of patients within each treatment condition.

## Individual differences versus intra-individual variation

The traditional research paradigm is not insensitive to *individual differences*. Quite to the contrary, there is much research on individual differences within the traditional research paradigm, for the purpose of identifying predictors, moderators, and mediators of treatment outcome. But most of this research focuses on *between-person* variation, and thereby stays at a group level of analysis.

One example is the aptitude-by-treatment interaction paradigm (Snow, 1991) which is designed to take individual differences into account in treatment evaluation, to see if treatments differ in effectiveness depending upon the patients’ personal characteristics. For example, Tasca et al. (2006) randomized patients with binge eating disorder to group CBT, group IPT, or a control condition and found that, although both treatments worked equally well, individual outcomes differed across treatments due to level of attachment anxiety. Whereas higher attachment anxiety was associated with more improvement in IPT, lower attachment anxiety was associated with more improvement in CBT. Although this represents an interesting finding at the group level, it does not increase our understanding of how therapeutic change takes place over time.

As argued by Molenaar (2004), all developmental processes, learning processes and adaptive processes are non-ergodic. What this means is that findings on *inter-individual* (i.e., between-person) variation and covariation (contemporary or lagged) cannot be generalized to the level of *intra-individual* variation and co-variation over time (see also Hamaker, 2012). The latter processes therefore need to be studied in themselves by means of intensive longitudinal data that are subjected to time-series analysis of intra-individual variation and change. Despite this, however, the focus in traditional psychological research “is almost exclusively restricted to variation *between* individuals (interindividual variation [IEV]), to the neglect of time-dependent variation within a single participant’s time series (intraindividual variation [IAV])” (Molenaar, 2004, p. 202). This seems to be as true in psychotherapy research as in other psychological research, which is somewhat of a paradox since the main focus for a practicing psychotherapist naturally seems to be what works in each specific case of psychological treatment. Molenaar’s call for “bringing the person back into scientific psychology” (p. 201) by a more idiographic research seems to be as relevant for psychotherapy as for psychological science in general:

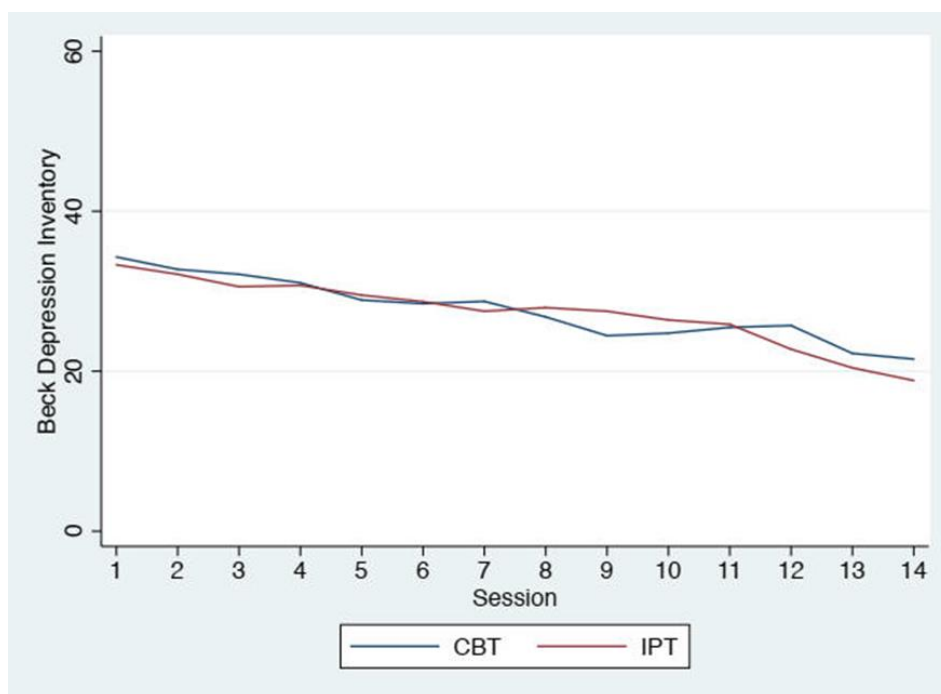


Figure 1. The average scores session by session on the Beck Depression Inventory (BDI-II) in a study by Ekeblad et al. (2016), where depressed patients were randomized either to Cognitive-Behavior Therapy (KBT) or Interpersonal Therapy (IPT).

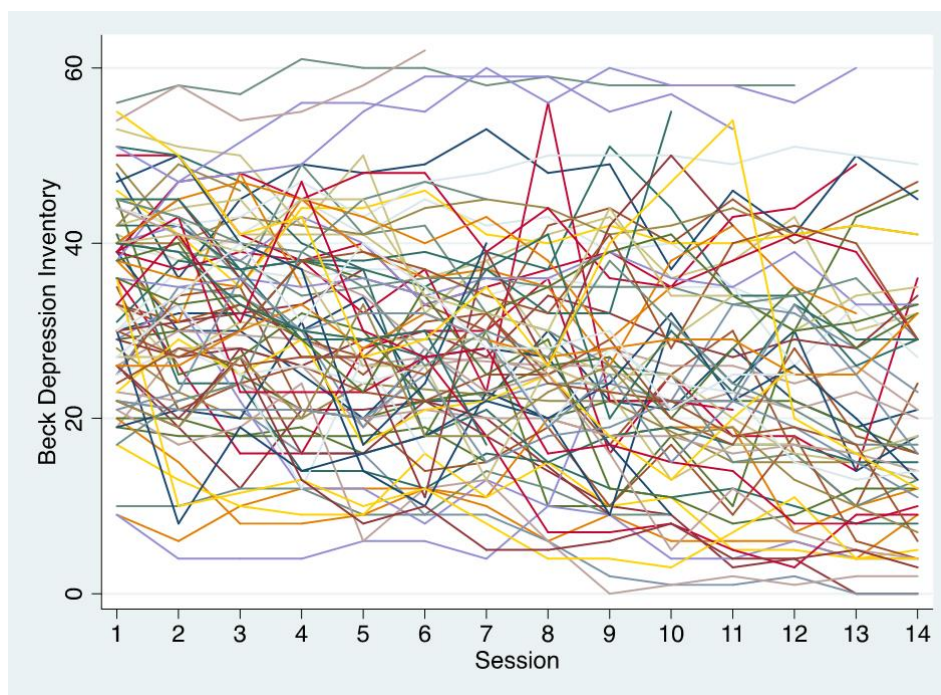


Figure 2. The plotting of each individual patient's scores on the Beck Depression Inventory (BDI-II) session by session in a study by Ekeblad et al. (2016)

...psychology as an idiographic science restores the balance by focusing on the neglected time-dependent variation within a single individual (IAV). It brings back into scientific psychology the dedicated study of the individual, prior to pooling across other individuals. Each person is initially conceived of as a possibly unique system of interacting dynamic processes, the unfolding of which gives rise to an individual life trajectory in a high-dimensional psychological space. (Molenaar, 2004, p. 202)

If each person is to be seen as a potentially unique system of dynamic processes that unfolds in an individual life trajectory, this should apply to both patient and therapist, which means that we need to conceptualize the dimensions that are relevant to this analysis for them both. That is, to optimize sensitivity to the individual person in psychotherapy research we need (1) to collect intensive longitudinal data that can be analyzed by time-series analysis, and (2) to conceptualize the relevant dimensions of the therapist and patient as persons. We will return to the latter in the third main section of the paper; in the present section we will focus primarily on how intensive longitudinal data can be collected and analyzed

### Global outcome measures versus experiential sampling

Psychotherapy outcome is often assessed by means of global measures of symptoms, severity or distress administered at single time-points. In the case of self-assessment this procedure relies on the patients' retrieval of information from memory and their way of averaging their own functioning over time. This research is relatively insensitive to specific aspects of the patient's actual functioning and experiencing. One step in the direction of an increased sensitivity might be to use such global measures on repeated occasions, to collect intensive longitudinal data. However, as Stiles (2013) points out, there is a problem with global indexes of severity or distress as such, as they "substitute evaluation for specific information" (p. 34) and are quite insensitive to "the theoretically specific conceptualizations that scientific research is meant to test" (p. 34).

A more advanced method is to use experience sampling (e.g., Conner, Tennen, Fleeson, & Feldman Barrett, 2009) or ecological momentary assessment (Stone & Shiffman, 2008). Common to these methods is that data are collected on individuals' experiences (contexts or behaviors) in natural settings, close to the time when the person had these experiences, and on repeated occasions. In this way, multiple snapshots are obtained of people's daily experiences, which make it possible to identify patterns of experiences and behaviors *within* the individual, and to test hypotheses about a single person. These kinds of studies use various time spans, from a few days to several months, and can employ a range of designs (e.g., event-based designs, fixed

time-based designs, and variable time-based designs) and technologies (including paper-and-pencil questionnaires, electronic diaries, and mobile phones).

### Time-series analysis

Intensive longitudinal data can be used in various ways. First of all, it is important to distinguish between using these data (1) for analyses of intra-individual variation and change and their use (2) for the purpose of analyses at the group level. For example, mean scores over time on some variable (e.g., sadness or happiness) that has been assessed repeatedly can be used to compute a trait measure that may be more reliable than traditional trait measures (which are usually based on self-assessment at one single time-point on the basis of the individual's memory), and that might therefore improve analyses at the group level. Similarly, standard deviations that quantify the degree of variability around a person's mean (e.g., the degree of variability in a person's moods) may provide valuable information for analyses at a group level. The same is true for within-person correlations, or any other indexes computed on the basis of intensive longitudinal data: if they are *aggregated across individuals* they can provide variables for analyses at a group level.

One example is Parrish, Cohen, Gunthert, Butler, Laurenceau and Beck's (2009) computation of within-person indexes of affective reactivity on the basis of patients' daily ratings of negative events and daily affect. Among other things they found that patients showed a decrease in their daily negative affect reactivity to negative events after six weeks of cognitive therapy. This illustrates how new indexes can be computed on the basis of intensive longitudinal data, and used as variables at a group level of analysis, but this does not represent a person-oriented approach.

A person-oriented approach requires that intensive longitudinal data are analyzed at the level of the individual. To take an example, Boswell, Anderson and Barlow (2014) carried out an idiographic analysis of change processes in a patient with depression and anxiety who underwent unified transdiagnostic CBT treatment. The results showed, among other things, that changes in mindfulness preceded changes in both depression and anxiety at a lag<sup>1</sup> of 3-4 days, whereas changes in depression and anxiety showed no significant time-lagged associations with ensuing changes in mindfulness. As Boswell et al. (2014) concluded, this indicates that the relationships between changes in mindfulness and symptom change "were largely unidirectional. Changes in mindfulness appeared to drive changes in depression and anxiety" (p. 9).

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<sup>1</sup> In time series analysis, the term *lag* is used to describe time periods between two observations.

For purposes of generalization it is, of course, essential to replicate such findings. Using a replicated single-subject time-series design, Snippe, Bos, van der Ploeg, Sanderman, Fleer, and Schroevers (2015) found that changes in mindfulness preceded changes in depressive symptoms the next day in only one of six participants. This does not only indicate that psychological change processes differ across individuals, but also suggests the importance of trying to establish under which conditions these kinds of processes occur.

To take a simple example, one possibility is that processes differ between patients with high and low symptom severity. For example, Stroe-Kunold, Friederich, Stadnitski, Wesche, Herzog, Schwab, & Wild (2016) compared the longitudinal interaction between emotional intolerance (as assessed by the item “today I could not tolerate unpleasant emotions”) and symptoms of anorexia over the course of inpatient treatment in patients with high and low symptom severity. Their results showed that the diaries of almost 70% of the high severity patients showed increased anorectic symptoms after having reported an inability to tolerate unpleasant emotions, whereas this was the case for only one patient with low symptom severity.

**Contemporaneous and time-lagged associations.** Time series analysis of intensive longitudinal data allows for the analysis of both contemporaneous and time-lagged associations. Here it should be noted that, just as between-person correlations need not be mirrored by within-person correlations, time-lagged within-person associations need not mirror contemporaneous within-person associations. Fisher and Boswell (2016), for example, describes a patient who showed significant positive contemporaneous correlations between anxiety and depression ( $r = .39$ ), but significant negative cross-lagged associations from depression to anxiety ( $\beta = -.28$ ). That is, although the co-occurrence of depression and anxiety was positively correlated at any given moment, their dynamic relationship was such that if the level of depression had increased at one time point, the level of anxiety was likely to decrease after that. The important point for the present purposes is that this kind of dynamic within-person associations must be assessed empirically in each individual case, and cannot be inferred from between-person correlations, or from contemporaneous within-person correlations.

Here it is important to remember that what is considered as contemporary association within this kind of analysis depends on the temporal resolution of the experience sampling. As noted, for example, by Epskamp, van Borkulo, van der Veen, Servaas, Isvoranu, Riese, and Cramer, 2018, the time between consecutive measurements in an ESM study typically is a few hours. This means that causal effects that take place over time *within* such a few hours window are coded as contemporary; moreover, it is likely that many causal relationships relevant to psychological functioning occur within such a time frame.

## Person-specific dynamic assessment for the purpose of personalizing the treatment

One approach towards a personalized approach to psychotherapy is illustrated by the development of network models of psychopathology (Borsboom, 2017; Epskamp et al., 2018) which can be used for assessment. Fisher, for example, described such an approach to person-specific dynamic assessment (Fisher, 2015; Fisher & Boswell, 2016), where the purpose is to identify the latent dimensions of each person's specific psychopathology, and the dynamic organization of those dimensions in time, in order to formulate personalized treatment plans. For this purpose, they used ecological momentary assessment to collect intensive longitudinal data (e.g., by completing smartphone-enabled, web-based surveys four times per day for a minimum of 30 days), which were subjected to a person-specific factor analysis (P-technique; Cattell, Cattell, & Rhymer, 1947) so as to identify latent dimensions across symptoms of anxiety and depression. Dynamic factor modeling (Molenaar, 1985) was then used to examine underlying predictive relationships between symptoms over time. Fisher and Boswell (2016) argue for a personalization of psychotherapy by means of this kind of person-specific dynamic assessment “in order to select optimal treatment protocols on a person-by person basis” (p. 496).

One possibility is also to use the information from such network analyses as personalized feedback to patients. Kroeze et al. (2017), for example, describe such a procedure with a patient who suffered from treatment resistant anxious and depressive symptoms, and who participated in ecological momentary assessment of mood and context related items during two weeks. Network graphs showing the interplay between symptoms were discussed with the patient, which led to increased insights about stress caused by somatic symptoms, and an increased readiness to engage in interoceptive exposure exercises that this patient had previously refused repeatedly.

Network models need not be limited to symptoms of psychopathology. Kaiser and Laireiter (2018) expanded the focus from symptoms of psychopathology by including measures also of patients' intersession experiences, such as thoughts about past and present sessions, imagined dialogues with the therapist, and positive and negative treatment-related emotions, into the network model. Their results showed a substantial interpersonal variation in how symptom stress interacted with various kinds of such intersession experiences.

Although this kind of research is often referred to as *idiographic*, it may also be referred to as *nomothetic research at the level of the individual*, because it involves a search for lawful pattern within the individual. The patterns that are found in one patient may then serve to formulate hypotheses to test in other patients – or alternatively as a starting-point for the exploration under which conditions one type of pattern is found (cf. Hamaker, 2012).



It should be noted that all the examples given so far are only about the variation and change in individual patients, and says nothing about how this variation and change is related to what occurs in the psychological treatment. An increased use of experience sampling and time series analysis may benefit psychotherapy research by introducing an increased sensitivity to the ongoing *outcome* of the treatment. But in order to qualify as research on how psychotherapy works it must also focus on how this ongoing outcome is associated with specific interventions or interactions during treatment.

### Insensitivity to the effects of specific interventions

One important difference between psychotherapy and many forms of medical treatment is that what is evaluated in RCTs in psychotherapy research are large *treatment packages* which contain numerous technical procedures and personal interactions, usually in the form of weekly treatment sessions during a considerable period of time (from around 12-20 sessions in short-term therapies up to 1 year or more in long-term treatments). This is quite different, for example, from testing the efficacy of a tricyclic antidepressant versus placebo in patients with depression; here the experimental condition contains one specific component, which makes it easier to know where to attribute the effects. However, in psychotherapy research, if two treatment packages are found to produce equivalent results, there are a large number of possible alternative explanations. Among these are, for example: (1) that the effects were due to some factors that were *common* to both conditions; (2) that *different* treatment components were effective in the two treatment conditions, but were equally effective at an *average* in the two conditions; (3) that different treatment components were effective for different patients even *within* each treatment condition, but that the effect was to produce equal average change in the two treatment conditions; and (4) that different techniques may have activated similar change mechanisms resulting in similar effects.

RCTs in psychotherapy research are classified as *experimental* designs, and experimental designs are generally considered to be optimal to establish causality, because they prioritize *control* over all possible variables that are involved. This ideally should involve a rigorous control both of (1) the experimental manipulation (the independent variable), and (2) other possible variables that may have an effect (by the use of control groups and random assignment). The ideal is that the experimental group and control group should differ in only one way: the experimental group receives a rigorously controlled experimental manipulation, whereas the control group does not receive it.

### Pseudo-experimental research

RCT designs in psychotherapy research, however, in general suffer from a *very low degree of control* over the

experimental manipulation – that is, what actually takes place in the treatment. The therapies that are tested in RCTs are not described in terms of actual situations and behaviors but in terms of certain *constructs* that are used to label entire treatment packages (e.g., cognitive behavior therapy, short-term psychodynamic therapy, interpersonal therapy, etc.), the principles and procedures of which are outlined in manuals. The extent to which a treatment package is implemented as intended is called *treatment integrity* (Perepletchikova, Treat, & Kazdin, 2007) and defined in terms of (a) therapist adherence (i.e., the degree to which the therapist utilizes prescribed procedures and avoids proscribed procedures); (b) therapist specific competence (i.e., the level of the therapist's skill and judgment in carrying out this particular treatment); (c) and treatment differentiation (i.e., whether the treatments that are compared differ from each other along critical dimensions). To ensure an acceptable treatment integrity, treatment sessions are recorded and trained observers are recruited to observe these sessions and judge the therapist's adherence and competence.

Treatment integrity is an example of *construct validity*. For example, if a treatment that is implemented under the name of cognitive therapy really fits the construct of cognitive therapy as defined in the manual, and if it is also sufficiently differentiated from other therapy constructs (e.g., psychodynamic therapy), then this speaks in favor of the construct validity of the conclusions that can be drawn from the results of this particular study (cf. Shadish, Cook, & Campbell, 2002).

High construct validity, however, involves more than just treatment integrity. It also involves the ability to *exclude alternative explanations* of the results of treatment – for example, explanations in terms of the therapist's warmth, genuineness, empathy, validation, supportive interventions, persuasiveness, responsiveness, and other kinds of relational skills. Although these potential factors are also, in principle, possible to rate by trained observers, this is almost never done. In a systematic review of comparative RCTs of treatments for Borderline Personality Disorder, Lundh, Petersson and Wolgast (2016) found that existing studies generally included little data that would make it possible to rule out such alternative explanations of the effects. Most of the RCTs even failed to control the actual dosage of the treatment (number of sessions, length of sessions, etc.), the amount of supervision, the use of medication in addition to psychological treatment, the therapist's competence, and the quality of the therapeutic relationship.

It may be argued that RCTs in psychotherapy research represent a kind of *pseudo-experimental* research. Pseudo-experimental<sup>2</sup> research is here defined as research that conform to all the formal requirements of an experimental design (i.e., control groups, randomization, etc.) but where

<sup>2</sup> *Pseudo-experimental* research in this sense is different from *quasi-experimental* research, where there is no randomization.



the experimental condition (the independent variable) suffers from a low degree of experimental control. Given this low degree of experimental control of the treatment intervention, one possible explanation of the difficulty of finding significant differences between different forms of psychotherapy could be that each of these different forms of psychotherapy involve a sufficiently large number of different treatment interventions and interactions, each of which are effective in a sufficiently large number of patients so that their *aggregate* effect is equally large at an *average* in the groups that are compared.

Even if most RCTs in psychotherapy research are to be seen as pseudo-experimental, the experimental method as such may still have an important role in psychotherapy research. For example, the effect of well-defined and well-controlled treatment interventions may be studied in the form of experimental single session studies, or by means of experimental single-subjects designs. A methodological advantage of experimental single session studies (e.g., Kim, Lundh, & Harvey, 2002; Nilsson & Lundh, 2016; Nilsson, Lundh, Faghihi, & Roth, 2011) is that there can be more control over the independent variable than in RCTs that compare large treatment packages. They do not, however, constitute a form of person-oriented research, because they still operate by comparing average effects on a group level. A more obvious step in the direction of a person-oriented approach is taken by the use of single subject designs.

### Single-subject designs

In a single-subject design (e.g., Kazdin, 2011) no control group is used, but the subjects serve as their own controls. This kind of design (which is also known as the  $N = 1$  design) is therefore sensitive to the treatment process in individual patients in a way that traditional RCTs are not. A large number of subjects may be used in this kind of research, but because the subjects serve as their own controls it still remains a single-subject design.

Single-subject designs can make use of a series of baseline assessments before a treatment is implemented, and then use repeated observations over the course of the treatment. This makes possible not only a comparison between treatment and baseline periods, but also an identification of trends both during the baseline phase and the treatment phase. Because the individual is assessed repeatedly during treatment, the design also allows the researcher to see how consistent changes are over time. Single-subject designs can use different ways for establishing experimental control (e.g., reversal, or multiple baselines), to increase the internal validity of the conclusions that can be drawn from the results, and to study the interaction between different treatment interventions (e.g., if it matters whether one kind of intervention precedes another). They can also make use of time series analysis to study time-lagged associations between treatment interventions and symptom change.

For example, Town, Salvadori, Falkenström, Bradley and Hardy (2017) used a case series design to analyze time-lagged correlations between in-session affective experiencing and degree of distress across 20 sessions in four depressed clients who were treated by intensive short-term dynamic psychotherapy. This is a form of treatment where “the aim of every session is to put the patient in touch with as much of his true feelings as he can bear” (Malan, 2001, p. 84). Town et al. (2017) compared two clients who were considered recovered after 20 sessions with two others who showed no change based upon posttreatment outcomes. Their analysis indicated that higher in-session affective experiencing (as rated by independent judges) was significantly associated with reduced distress 7 days later in the recovered clients, but not in the no change cases.

One limitation of this study is that it used symptom measures that were completed by the patients at only three occasions during the baseline period (before the start of treatment) and then regularly before the start of each session during treatment. It might be argued that more sensitive measures of the variation and change in patients’ symptoms might have been obtained by means of experience sampling in their daily life. In terms of the argument of the present paper, combining single subject designs with experience sampling would represent an increased sensitivity to *both* treatment processes and treatment outcome.

As argued in the introduction, a *fully* person-oriented approach to psychotherapy research, however, also requires good sensitivity to the person’s functioning as a whole (i.e., not only with a focus on symptoms) and to important aspects of his or her interaction with the environment. As applied to psychotherapy research, this holistic and interactional approach in particular requires a theoretically adequate conceptualization of the interaction between therapist and patient.

### Insensitivity to the interpersonal interaction between therapist and patient

Psychotherapy by definition is a *form of interpersonal interaction* where one person (the therapist) has the task to help another person (the patient) to move towards some kind of goal (e.g., improved health, well-being, personal development, insight, learning, or behavioral change). Traditional psychotherapy research, as exemplified by RCTs and process-outcome research, however, is insensitive to the interpersonal interaction between patient and therapist. The purpose of the present section is to discuss some aspects of this insensitivity, and how a person-oriented approach may possibly overcome these problems.

Importantly, a *fully* person-oriented approach means to see both patient and therapist as intentional agents in interaction (Magnusson, 1999). To focus ideographically just on events and processes at a disaggregated level does not suffice, but “the integrity of the system under study must also be retained” (Bergman & Andersson, 2010, p. 162). In this

interaction both therapist and patient *act* and *respond* in relation to each other, and this acting and responding can be more or less *skillful* in relation to the goals and subgoals of the treatment. One basic aspect of this interaction, which often tends to be forgotten, is that patients are not merely respondents to treatment interventions, but intentional agents that actively contribute to the process (e.g., Bohart, 2000). Another basic aspect of the interaction is that therapists adapt their behavior to what their patients say and do; Stiles (2009, 2013) refers to this as *responsiveness*. The present section starts by discussing therapist responsiveness, then goes on to a critical discussion of traditional research on the therapeutic alliance, and ends with a discussion of the kinds of skills that are relevant in conceptualizing therapist and patient as two persons in more or less skillful interaction.

### Therapist responsiveness

Responsiveness, as defined by Stiles (2009, 2013) is a general term that is applicable to all kinds of interpersonal interactions. Simple examples of responsiveness are that people normally answer each other's questions, stay on related topics, and take turns when speaking. More specific to psychotherapy, therapists are likely to adjust their interventions as a function of how the patient responds to them. In other words, the therapist does not just *deliver* an intervention, but responds to the client's behavior on a wide range of time scales. Here psychotherapy differs clearly from medical treatments, which can often be carried out more as one-way *interventions*. Importantly, this is a problem not only for experimental designs, but also for so-called process-outcome research.

To take an example: a basic assumption in psychodynamic therapy is that the therapist should use interpretations that lead the patient to new insights and therapeutic change; in terms of process-outcome research this would seem to imply the hypothesis that the frequency of interpretations should correlate positively with treatment outcome. But here the phenomenon of responsiveness might actually lead to *negative* correlations between interpretations and outcome, *even when* interpretations are effective. As pointed out by Kramer and Stiles (2015), in the treatment of clients with low insight capacities therapists may need to repeat and rephrase interpretations more frequently than in the treatment of clients with high insight capacities, and yet the latter may have better outcomes than the former. This means that correlations between the frequency of therapist interpretations and symptom change may be negative even *if* interpretations are an effective ingredient in the treatment process.

A person-oriented approach to psychotherapy research needs to take this kind of therapist responsiveness into account. To the extent that responsiveness is involved in a therapeutic intervention, this intervention "is not a coherent entity but a fluid, adaptive process" (Kramer & Stiles, 2015,

p. 289) and cannot be seen in isolation, but has to be seen as an intrinsic part of an interaction sequence. Moreover, what is of interest in psychotherapy is skillful responsiveness, or as Stiles, Honos-Webb and Surko (1998) call it, *appropriate responsiveness*, defined as the therapist's ability to achieve optimal benefit for the client by adjusting his/her responses to the patient's current state.

### The working alliance

Much of traditional psychotherapy research has focused on the alliance between therapist and patient. According to Bordin's (1979) conceptualization, the working alliance is defined as agreement on the goals and tasks of therapy in the context of a positive affective bond between patient and therapist. It seems reasonable to assume that a good working alliance will facilitate the treatment, and should therefore be associated with a positive treatment outcome. Much research has been devoted to test this hypothesis by means of correlational designs, and meta-analyses in this area have found a weak-to-moderate correlation ( $r = .22$  to  $r = .28$ ) between degree of working alliance and treatment outcome (Flückiger, Del Re, Wampold, & Horvath, 2018; Horvath, Del Re, Flückiger, & Symonds, 2018; Martin, Garske, & Davis, 2000).

Most of these studies, however, measure the alliance only at one single time-point early in treatment. The finding that patients with a higher degree of working alliance tend to show a better outcome than patients with a lower degree of alliance (a between-persons analysis) can say nothing about whether improvements of the alliance lead to symptom improvement at the level of the individual (a within-persons analysis). To test whether changes in the alliance affects symptom level, it is important to have a series of repeated measurements of both alliance and outcome during treatment, that makes it possible to study temporal associations between these variables on a session-to-session basis (Kazdin, 2007).

Falkenström, Granström and Holmqvist (2013) used longitudinal multilevel methods with analyses of both between- and within-person effects and found evidence for a reciprocal causal model in a primary care sample. The alliance was found to predict subsequent change in symptoms from session to session, while prior symptom change also predicted the alliance on a session-to-session basis. In addition, they found that the alliance effect varied considerably between patients. This variation was partly explained by patients with personality problems showing stronger alliance effects. In the subgroup of patients with personality problems, the effect of the alliance on subsequent change in symptom level was six times larger than in the group without personality problems. The latter finding points to the potential importance of identifying subgroups of patients with different within-person patterns over time. This finding also suggests that it may be extra important to monitor the level of the alliance in subgroups of patients who re-

spond stronger to variations in the strength of the alliance.

Similar reciprocal associations between alliance and symptom improvement were found in psychiatric patients with depression (Falkenström, Ekeblad, & Holmqvist, 2016) and also in a Kenyan psychiatric outpatient sample (Falkenström, Kuria, Othieno, & Kumar, 2019). One limitation of this kind of studies, however, is that the within-person patterns are aggregated and analyzed at a group level. A person-oriented approach to the study of within-person associations between the alliance and symptom improvement would require idiographic analyses at the level of the individual, to identify patients with different types of alliance-symptom patterns. One possibility would also be to integrate alliance-related items into the experience sampling of intersession experiences (e.g., asking about experiences of feeling understood by the therapist, looking forward to future collaboration with the therapist, etc.), in a similar way to that done by Kaiser and Laireiter (2018).

On the other hand, it is unclear what associations between alliance and symptom level really mean, even at the level of the individual. An important limitation with most research on the alliance is that the very notion of the *strength of the alliance* is static, and therefore can hardly be regarded as a potential cause of anything. Barber (2009) suggested that an alternative perspective is to see the measurement of the alliance in psychotherapy as a “thermometer” (p. 3): “If alliance is not causally related to outcome, perhaps it could be associated with good outcome in the sense that if the alliance is high, then the therapy is going well” (Barber, 2009, p. 3). As pointed out by Stiles (2013), to measure the alliance is to measure an *achievement*, rather than the conditions or actions which *lead* to this achievement. What may be causally active in the treatment is rather what the therapist *does* to establish a good working alliance, and to maintain it and repair it when it is subject to ruptures or impairments (e.g., Safran, Muran, & Eubanks-Carter, 2011). More generally:

The actual attitudes and behaviors that yield high ratings on alliance... differ across cases and times, as therapists do the right thing in response to clients' emerging needs and circumstances. It is plausible that such achievements predict global outcome, but they do not show which specific activities predict which of therapy's specific effects. (Stiles, 2013, p. 35)

In other words, what is needed is a much more specific analysis of the interaction between therapist and patient.

As pointed out by Hougaard (1994), “the therapeutic alliance is not a theoretically well-developed concept” (p. 67). Hougaard suggested that we should differentiate between the *collaborative* relationship (agreement on goals and tasks) and the *personal* relationship (mutual liking, mutual understanding, agreement on degree of intimacy, and agreement on degree of directiveness), as well as *the therapist's and patient's respective contributions* to these two aspects

of the alliance. In terms of Hougaard's model, a more penetrating research on the alliance would require the measurement of the therapist's expertness, engagement, and efforts to strengthen the patient's expectations (therapist contributions to the collaborative relationship) and authenticity, warmth and acceptance, unconditionality and empathy (therapist contributions to the personal relationship), as well as the patient's working capacity, motivation, and positive expectations (patient contributions to the collaborative relationship) and confidence, friendliness, compliance, and receptivity of empathy (patient contributions to the personal relationship).

Hougaard's analysis, as well as Stiles' focus on appropriate responsiveness, point to the importance of developing better ways of conceptualizing and measuring *skillful* action in the therapist's way of interacting with the patient. Hougaard's analysis, in addition, point to the importance of focusing not only on therapists' but also patients' contributions to the development of an effective working alliance.

### **The conceptualization of patient and therapist as persons in interaction**

A person-oriented approach needs to conceptualize therapist and patient as individual persons, and to specify the therapeutic relationship in terms of patterns of their interaction over time. First of all, this requires a theoretical framework for understanding the *dimensions of personal functioning* that are of relevance during the treatment process, and reliable procedures for their measurement.

Second, this also has to take into account the basic fact that, although an important part of the therapeutic relationship (defined as a relationship where the therapist's role is to help the patient to reach some kind of goal, as for example improved well-being, insight, or personal development) involves the use of *technique* (defined as intentional methodological action undertaken for this therapeutic purpose), there are also highly important *non-technical* aspects of the therapeutic relationship (Lundh, 2017). Whereas technical action by definition involves *skills*, non-technical interaction involves the therapists' and patients' emotional responses to each other as well as actions undertaken for other than explicitly therapeutic reasons.

With regard to technical action in psychotherapy, Lundh (2017) suggested a basic distinction between two kinds of techniques: (a) relational techniques which the therapist *uses* in the interaction with the patient, and (b) self-techniques which the therapist *teaches* the patient to use. Whereas psychodynamic therapy and person-centered therapy contain a large variety of relational techniques for listening and communicating with the patient (and relatively little of self-techniques explicitly taught to patients), cognitive-behavior therapy is much more focused on the teaching of self-techniques to the patient (and is relatively less focused on relational techniques).

**The need for a taxonomy of therapeutic skills.** The

importance of conceptualizing the therapist as a person is seen, among other things, in evidence that there may be large variation in outcome between different therapists (e.g., Hill & Castonguay, 2017). A concept that has figured long in the discussion of the therapist as person is the concept of *therapeutic skills* (e.g., Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Hatcher, 2015; Lambert, DeJulio, & Stein, 1978). From this perspective, we would need a comprehensive *taxonomy* of therapeutic skills that could be used to code therapists' actions during psychotherapy sessions.

On the basis of a preliminary review of the psychotherapy literature, Lundh (2017) suggested the following provisional categories of therapeutic skills: (1) the ability to take a benevolent attitude to the patient, and to keep it and communicate it even under pressure due to problematic interactions with "difficult" patients; (2) rhetoric, educational, motivational and supportive skills, for educating patients about various self-techniques and engaging patients in the use of these; (3) empathic-listening skills; (4) empathic communication skills; (5) observing-analyzing skills; (6) exposing-containing skills, defined as the ability to expose the patient gradually to anxiety-related experiences in a safe context; (7) the ability to take a mentalizing stance in the interaction with the patient; (8) "balancing" skills, defined as the ability to balance seemingly opposing attitudes, such as acceptance and change, warmth and control, and being both centered and flexible; (9) a capacity for non-defensive exploration and reparation of the relationship; and (10) the capacity for a disciplined form of genuineness (i.e., a selective use of the therapist's genuine feelings to the benefit of the patient).

In traditional psychotherapy research some therapeutic skills have been studied at a group level, by correlating measures of these skills with treatment outcome. For example, meta-analyses show a moderately strong association (mean  $r = .31$ ) between therapist empathy and treatment outcome (Elliott, Bohart, Watson, & Greenberg, 2011). Although these findings with regard to empathy in general stay at a group level, and have nothing to say about how empathy works during treatment, they suggest that we need more idiographic research on how empathy is experienced and expressed by therapists during actual treatment, and how patients respond to these expressions in real time.

But it is important to note that a person-oriented approach to therapeutic skills must also be holistic – that is, it is not meaningful to focus only on isolated skills (cf. Hatcher, 2015). As pointed out by Hill and Castonguay (2017), we need to study both how therapists adapt "the choice, dose, manner of implementation, and timing of their interventions to fit clients' moment-to-moment needs" (p. 333), and their ability to integrate these skills holistically. As they suggest, rather than single skills, "the integration of skills and other variables may provide a better explanation of therapist effects" (p. 333).

The point here is not to argue for any specific conceptu-

alization of therapeutic skills, but to illustrate that *some* kind of meta-theoretical framework that includes a taxonomy of relevant skills is needed as a common ground for conceptualizing aspects of the therapist's skillful action during the treatment process. If consensus could be achieved around such a conceptual framework it would facilitate the coding of relevant aspects of the therapist behavior as part of a person-oriented approach to psychotherapy research.

**Patients' goals and skills.** Although dynamic network models may represent a move towards a more personalized approach to the patient's symptoms, it does not take account of the patient as an intentional agent, with goals and skills and other personal characteristics that may have an impact on the treatment process. As emphasized by Bohart (2000), the patient's active contribution to the treatment process is often forgotten in psychotherapy research. An analysis of patients' narratives (Adler & MacAdams, 2007) indicates that patients may use psychotherapy in very different ways: for example, whereas some patients actively use therapy to solve personal problems and to reassert personal agency, others rely much more on the therapist and the therapeutic relationship as a mechanism of change.

To the extent that the treatment essentially involves patients' use of self-techniques, patient skills may also be of the utmost importance. As a highly preliminary step to the development of a taxonomy of the skills involved in the patient's use of self-techniques, Lundh (2017) suggested the following categories: (1) exposure skills, defined as a willingness and ability to substitute approach for avoidance; (2) attentional awareness skills, defined as an ability to attend to ongoing experience; (3) the ability to take a non-judgmental or non-defensive attitude to experience; and (4) observing-analyzing skills, defined as an ability to take a scientific attitude to the exploration of mental life. These are skills that may exist to various degrees in patients even before entering therapy, and that possibly may grow as the result of an effective treatment. There is little research on these kinds of patient skills in traditional psychotherapy research; what would be needed is methods to measure these skills during treatment, and to analyze their role in the therapeutic process. Moreover, just as a therapist may act and respond more or less skillfully during treatment, this also applies to the patient; this therefore requires an idiographic approach to the measurement of these skills which is sensitive to their variation and change over time.

## Conclusion

The research paradigm that has dominated psychotherapy research during the last decades has focused on analyses at a group level, by means of randomized controlled trials (RCTs) to provide evidence for the effects of various forms of psychotherapy, and correlational studies to find variables (e.g., therapeutic alliance) that can predict treatment out-

come at a group level. Although RCTs have probably played an important role in defending the place of psychotherapy in the medical care system, this kind of research has not been able to provide an understanding of what makes psychotherapy work. The primary argument of the present paper is that there is a fundamental mismatch between the traditional research methods and the subject matter of psychotherapy, as seen in a basic insensitivity to (1) variation and change within the individual patient, (2) the effects of specific treatment interventions, and (3) the patient and therapist as individual persons, and nuances of their interaction.

A second argument of the present paper is that further progress in this area may require the systematic development of a person-oriented approach to psychotherapy research, which is (1) *idiographic* in the sense that it focuses on within-patient variation and change (by means of intensive longitudinal data) in relation to specific treatment interventions and interactions (by the use of single-subject designs), (2) *nomothetic* in the sense that it strives to generalize from findings at the idiographic level to the formulation of general hypotheses about what makes psychotherapy work under various conditions; and (3) *holistic and interactional* in the sense that it focuses on patient and therapist as two persons (intentional agents with goals, beliefs, etc.) in more or less skillful interaction during treatment, and the variation and change in various aspects of this interaction.

If a person-oriented approach is defined as idiographic with nomothetic ambitions, and as holistic and interactional, we may conclude that at least a partial movement in that direction is seen in some varieties of psychotherapy research. Most obviously, there are examples of psychotherapy research that are clearly idiographic (or at least include idiographic moments) by focusing on within-person changes at the level of the individual, and in relation to various therapeutic interventions, but without being holistic or interactional. This is true, for example, of idiographic research that makes use of intensive longitudinal data to analyze changes in the patient during treatment, the temporal order of different kinds of changes in the patient, and how these changes are associated over time with various treatment interventions, and also in the use of single-subject designs.

Although this research represents a move towards a more person-oriented approach, it tends to focus on individual events and processes rather than more holistic aspects of the patient as a person. That is, the patient is analyzed primarily in terms of single variables (e.g., anxiety, depression, mindfulness, emotion regulation), or at best in terms of networks that may involve a conceptualization of dynamic associations over time, but still primarily as a passive respondent rather than as an active intentional agent. Moreover, the only individual that tends to be focused here is the patient (i.e., the person of the psychotherapist is generally missing from the analysis). Although this kind of research

is clearly idiographic, it is not fully person-oriented in Magnusson's (1999) sense because it lacks a holistic approach to therapists and patients as persons, and does not take account of their specific interpersonal interaction.

There are at least three more moves that are needed to develop a person-oriented approach to psychotherapy: (1) The patient needs to be conceptualized as a whole person, including his/her problems, personal skills and other patterns of personal functioning. (2) The therapist needs to be conceptualized as a whole person, with a special focus on patterns of professional and relational skills, but also including the therapist's more personal ways of functioning. (3) The relationship between therapist and patient over the course of treatment needs to be conceptualized in terms of specific forms of interpersonal interaction.

Finally, a major limitation of the present paper is that little specific advice has been offered as how to realize a fully person-oriented approach. Given the vast topic that is involved, however, nothing more than a broad outline is possible within the limed space available. Still, it may be argued that a discussion of these issues at a meta-theoretical level is a necessary prerequisite for the development of more specific empirical approaches. If this paper can contribute to a discussion of how to reorient psychotherapy research along more productive lines, it will have served its purpose.

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## Author contributions

LGL wrote the first draft of this paper. FF contributed by revising and adding text, and with empirical data from his own research. Both authors read and approved the final version of the manuscript.

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