

A Blueprint for the Future Development of Psychotherapy

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A dispassionate view of psychotherapy, leaving aside allegiances to particular schools, reveals it is extremely uncommon to find clear differences in efficacy between diverse treatment approaches (Luborsky et al., 2002). Even worse, when active treatments are compared to structurally equivalent placebos, only negligible effects are obtained in comparison to former treatments (Baskin, Tierney, Minami & Wampold, 2003). A plausible explanation for the apparent similarity in efficacy of different treatments is the existence of underlying common factors shared by all treatments which is ultimately responsible for the purported equivalence attained by different therapeutic approaches (Frank & Frank, 1993). This shared equivalence has been recently reinforced by the literature on placebo, and particularly research using neuroimaging techniques showing how patients' expectancies interact with the clinical setting stimulating the rewarding brain circuitry (Benedetti, 2008; 2010).

Bearing in mind that what is tested on patients are therapeutic procedures (the ritual component), not their theoretical foundations (the rationale), and taken for granted that the remaining two components in Frank's common factors theory are present (i.e., a therapeutic relationship and a helping context), we advance the hypothesis concerning the shared mechanism underlying the ritual component of all therapeutic techniques i.e., every therapeutic technique ritual conveys an implicit change in the focus of attention. By suggesting topics to talk about, or actions and tasks to perform, therapists tacitly demand, direct, focus, distract, and, on the whole, they call the patient's attention away from the cognitive, behavioral, emotional, temporal, spatial coordinates and interpersonal awareness that anchor the patient's complaints.

Whereas informed psychodynamic therapies direct the patients' attention toward unconscious material, cognitive therapies focus on mental schemas and family therapy in interaction patterns. Accordingly, the different emphases of each theoretical alternative is designed to tackle the supposed particularity of symptoms, while at a formal level all share a demand for the patient to change the focus of attention, i.e., to see the problem through different lenses. However, this perspective has not yielded much consensus regarding best treatments for specific disorders.

An alternative perspective involves developing new treatments that would address the formal cognitive processes that allow the maintenance of symptoms in the consciousness. The experience of "having a problem" equals the experience of its continued awareness at the expense of a great deal of attentional resources. However, attentional resources are finite whilst inner and outer stimulus, thoughts and life events compete for them. Thus, having a symptom, as occurs in depression and anxiety disorders usually conveys that short-term memory is overwhelmed by inner worrying and rumination (Wells, 2011). To exacerbate matters, attempts to get rid of these unpleasant experiences may ironically backfire (Wegner, 1994), which may further aggravate the awareness of "having a problem". Thus, symptoms draw lots of attention not only from the symptom-bearer but also from relatives, friends, and others who become

trapped in this negative feedback loop. Consequently, disengaging attention to the symptom/problem becomes an insurmountable task, regardless as to whether it has been generated through voluntary and controlled attentional processes or has been generated by an involuntary process, as in the case of automatic attentional bias towards threatening cues. From this perspective, the efficacy of any therapeutic technique may depend on its success in helping patients to disengage attention from the object-problem. Hence, the distraction away from recurrent thoughts embodying the distressing experience by means of the employment of attentional competitors and distractors would entail an automatic relief from worrying, rumination and distress. However, this disengagement of attention is not the explicit target of conventional therapeutic approaches whose main goals are inextricably linked to different assumptions about the nature and maintenance of abnormal behaviour and psychopathology.

It is well established that attention cannot be divided among several perceptual objects without any cost in performance (Duncan, 1984), in the same vein, paying attention to a distracting task would convey a cost in the performance of worrying and rumination (Oliver & Page, 2008). Just as magicians and illusionists employ different techniques for making their effects follow the rules for the management of attention, new treatments are trying to restore patient homeostasis by correcting the allocation of attentional resources (Hakamata et al., 2010), and fascinating new perspectives are just beginning to unfold with research on memory reconsolidation (Nader & Hardt, 2009). However, in contrast to magic where normal people come to enjoy the altered states of consciousness guided by the magician's tricks, in psychotherapy patients come with a distressed state of mind and are in search of help to recover a less painful life.

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