Chapter 12
The Relevance of Dispositionalism for Psychotherapy and Psychotherapy Research

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12.1 Introductory Preface

Being educated as a clinical psychologist, I am grateful for having had the opportunity to work with unforgettable patients and colleagues. Yet, having worked within both secondary and primary mental health care services for the last 16 years, something has persistently felt wrong with my working conditions. Having shaken off my worry that this feeling is a symptom of something being wrong with me, I have become convinced that a significant part of the problem is the scientific paradigm of psychology, which does not only set the conditions for psychotherapy research, but also for clinical perspectives of relevance for any health professional working in mental health care.

Through the history of psychology, psychologists have sought to legitimize their discipline as a science by differentiating it from the humanities. However, as such, they have unfortunately put more faith in the processing of computers working inductively on accumulations of empirical data, than to their natural abilities to scrutinize their assertions via thorough reflection and in critical dialogue. One particularly detrimental aspect of this paradigm has been the predominant presumption that statistically supported empirical experiments in the form of randomized controlled trials (RCTs) are needed for clarifying the causal effects of psychotherapy. However, this idea is not so scientific as it is bad philosophy. Not only does it imply questionable conceptions of causality, but it also neglects many natural characteristics of being a person.

Moreover, it does not help much that results of RCTs have been used as a bureaucratic remote control by governmental health authorities wanting to assure the quality of health services from the outside (that is, without taking part in the process of providing the service). On the contrary, this has made clinicians walk around on

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their tiptoes needlessly worrying about whether they conform sufficiently to standardized procedures thought to have had results on an average level. This runs the risk of dehumanizing mental health care services by not taking sufficiently into account the context-bound complexities of clinical encounters and by being an obstacle for a sufficient focus on the unique needs of individual patients.

Accordingly, though this book promotes an account of causality relevant for all health sciences and professions, the focus of this chapter is on how dispositionalism may improve upon the foundations of clinical psychology, psychotherapy research and mental health care services. This is important not only for psychologists, but for all clinicians providing psychotherapy or related services (nurses, physiotherapists, psychiatrists, physicians, social workers etc). Not only will the recent advancements of dispositionalism (see Anjum, Chap. 2, this book) provide resources for a refreshingly new foundation for psychological science and psychotherapy research, but also for more humane mental health care services.

12.2 Misleading Statement on Evidence Based Psychological Practice

Philosophers have often considered it a virtue to be informed by psychology. Psychologists, however, though they may admit philosophical inspiration, have only rarely declared philosophy as relevant for improving psychological science and practice. Accordingly, the widely acknowledged statement on evidence based psychological practice provided by the American Psychological Association (APA 2006: 273–4) puts a one-sided emphasis on empirical research and neglects the relevance of philosophical reflection. As such it simply upholds that statistically supported empirical experiments in form of RCTs are the standard for drawing causal inferences about the effects of psychotherapy. However, as the APA-statement is a significant supplier of terms for evidence based mental healthcare services in general, this emphasis of the statement is beset with difficulties. Not only is the prevailing presumption that RCTs is the standard for clarifying causal relations part of a questionable Medical Model of psychotherapy (not to be confused with the biomedical model discussed in Chap. 5 of this book), but it also hinges on dubious conceptions of causality inherited from Hume and is therefore not something one should take uncritically for granted (see Anjum, Chap. 2, this book).

To be fair, to some extent the APA-statement also seems to have relevantly rectified the medical model. Not only does it provide a broader definition of evidence based psychological practice as the integration of the best available research evidence with clinical expertise in the context of patient characteristics, but it also approves of multiple types of empirical research evidence, not only RCTs. However, though these are important steps in the right direction, the understanding of evidence based mental health care must be broadened so as to include philosophical and theoretical reflection, and moreover, and accordingly, the predominant idea that

RCTs are the best way of drawing causal inferences for the single patient must be abandoned.

Notice, that though my call for change is critical, it does not have destructive aims. Rather, it is part of a constructive counter-reaction that seeks to liberate the health sciences from the detrimental impacts of Humean conceptions of causality and to pave the way for more apt alternatives. Fortunately, the Humean regularity view, along with its descendent counterfactual and difference-making accounts, are not the only accounts of causality available. As such, the recent philosophical advancements of dispositionalism (e.g. Mumford and Anjum 2011; Anjum and Mumford 2018a) do not only provide relevant resources for bringing psychology out of its dead ends, but they may also breathe new life into pertinent alternatives that have been unheeded. What is at stake is nothing less than the understanding of what relevant psychotherapeutic competency is, how it may develop, and how the quality of mental health care services may be assured.

12.3 Questioning the Medical Model

Despite attempts to overthrow its predominance (Wampold and Imel 2015; Duncan et al. 2010) the Medical model still thrives as the following tripartite set of presumptions:

(i) RCTs are the best way to clarify causal effects.
(ii) Evidence based psychotherapy depends upon the clarification of causal effects of *specific* treatment interventions and methods (often derived from *specific* psychotherapy-models) on *specific* disorders categorized according to *specific* symptoms frequently observed together.
(iii) The implementation of such empirically supported treatment methods (so-called ESTs) is what evidence based psychotherapy should amount to (cf. Chambless and Hollon 1998).

As medical research and practice are more varied than what these claims amount to, the Medical model could perhaps be better called "the Pill Model". This fits the idea in question that psychotherapy should be studied and understood in the same way as drugs. Though this model has never been generally accepted, the idea it represents has been very much alive among influential scholars. E.g. Kennair et al. (2002: 9) have claimed that "the major conclusion after years of research into the effects of psychotherapy is that certain interventions work for specific disorders", and that though "there are variations between humans, … there also is a relatively uniform human nature [which] means that interventions that work on large groups of humans will probably work for random individuals". Accordingly, proponents of the Medical model have not only argued that psychological treatments require theories of causal relations and mechanisms of change, but they have also misconstrued psychotherapy as the systematic use of psychological knowledge in such a way that it leads to expected change with statistical probability. Accordingly,

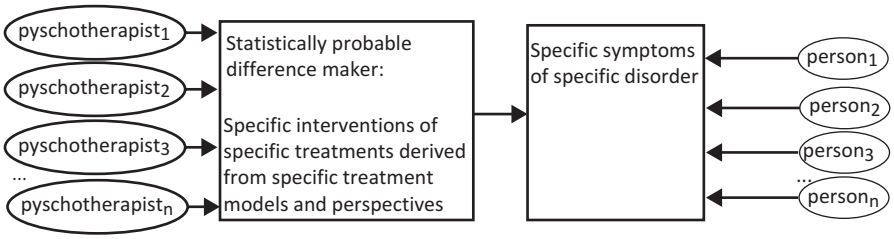

Fig. 12.1 The Medical model

Fig. 12.1 illustrates how the predominant Medical model portrays any psychotherapist as complying with one or more empirically supported treatments which purportedly makes a statistically probable difference on specific symptoms of a specific disorder that are allegedly shared by various patients.

12.4 The Challenge from Dodo-Birds and Meaning-Makers

As mentioned, however, the Medical model has not remained unchallenged, and roughly put, seminal critiques have come from two partly overlapping groups of scholars; to keep them apart I will henceforth call them the *Dodo-birds* and the *Meanings-makers.* The Dodo-birds have long argued that "psychotherapy does not work in the same way as medicine" (Duncan et al. 2010: 28), and that RCT-research has "failed to find a scintilla of evidence that any specific ingredient is necessary for therapeutic change" (ibid. 33). Moreover, they have claimed that the empirical research originally conducted in accordance with the Medical model actually produces evidence that supports an alternative contextual model on which the methodological and technical aspects of therapy processes cannot be studied as isolated from the relational context in which they are part (Wampold and Imel 2015). Thus, rather than continuing the search for the one and only miracle cure, the Dodo-birds have emphasized the so-called Dodo-bird-verdict first uttered by the fabulous dodo-bird in Lewis Carroll's tale of Alice in Wonderland: "Everybody has won, and everyone must have prizes". Accordingly, the Dodo-birds have claimed that there are no evidential statistical differences between treatment models and have stressed the importance of common factors purportedly transcending any specific treatment method, such as client-, therapist- and alliance factors, as well as factors external to the therapy, and that psychotherapy processes must be "evidence based one client at a time" (Duncan et al. 2010: 39–40).

Several Meaning-makers have agreed with these conclusions. However, their arguments have also cut more deeply by pointing out that the research-design of RCTs ignores fundamental aspects of human beings, such as responsiveness and irreversible uniqueness (e.g. Stiles 2009; Smedslund 2009). So far, so good. However, often inspired by phenomenology or Wittgenstein, the Meaning-makers

have taken the even more radical step of rejecting any psychological relevance of causal explanation as they think the notions of causality and human meaning-making belong to different explanatory domains (Brinkmann 2011; Harré 2002; Smedslund 2012a). I principally agree with both groups of critics. However, I also argue that they have not taken the bull by its horns, and that acknowledging the relevance of dispositionalism will provide the relevant improvement on their arguments. What is wrong is not to emphasize causation, but rather the Humean ideas about causality that nourish the Medical model.

12.5 The Philosophical Bias of the Medical Model

Whenever one emphasizes some research methods rather than others, one takes for granted that the phenomena one wants to study may have properties that make one's choice appropriate. As such presumptions might be wrong, it ought to be considered a scientific virtue to make one's presumptions about what one studies available for scrutiny. As such, the abovementioned claim of Kennair et al. (2002: 9) admirably illustrates that the critics of the Medical model have not been attacking a strawman. The claim of Kennair et al. that "there … is a relatively uniform human nature [which] means that interventions that work on large groups of humans will probably work for random individuals" does not only rest on ill-founded Humean presumptions about causality, but it also errs seriously on behalf of human nature.

However, as argued by several Meaning-makers (e.g. Smedslund 2009; Stiles, 2009), physiological research is not needed to demonstrate the relevant variability. There is more to human beings than mere measurable existence: Unless we are in a coma, we are compulsively meaning-making persons for whom something exists, and once something has been experienced, this is irreversibly so. As we also unavoidably attach meanings to the world from never identical contexts, the complete sets of our experiences become inevitably unique. And moreover, we are continuously susceptible to change by attaching new meanings to our experiences. Thus, the ways we make sense of things are bound to evolve in unique ways within unique contexts. Hence, though this does not prevent similar experiences, we cannot take for granted that persons will react in the same or similar ways to the same event or similar events.

Most textbooks on psychological research methods have acknowledged that persons have characteristics that make them difficult to experiment with. Nevertheless, apparently because it is held that these difficulties can be circumvented via statistics, the view still prevails that RCTs are the best way to uncover causal relationships (e.g. Hollon 2006). Thus, regular causal effects are standardly not sought for on an individual level, but rather on an average level (APA 2006). By randomly assigning a high number of persons to groups subjected to different conditions – for instance, offering some persons psychotherapy while others not – and estimating subsequent statistically significant differences between the average scores of the groups, one may conclude that the differences have been caused by the

psychotherapy. The viability of this conclusion depends on the two groups being similar in all other relevant respects, and it is held that this is taken care of by the randomization procedure. However, though characteristics that are possible for people to share (e.g. height) may spread evenly in large-sized random groups, unique characteristics (e.g. memories) cannot. Thus, as no randomization procedure can prevent unique experiences (e.g. memories) from being influential, we cannot take for granted that groups are relevantly similar without having thoroughly considered the unique experiences of the individuals involved. Also, simply increasing the number of persons in the hope that the statistical law of large numbers will apply will not help, as increasing the number of unique aspects does not necessarily make the groups any more similar, but would rather increase the numbers of influential factors that ought to be taken into account for understanding why the results occur. In other words, if we do not get a sufficiently thick understanding of the unique experiences of the individuals involved, information about aspects that inevitably influence the results are missed (Smedslund 2009; Stiles 2009). Hence, RCTs risk throwing the baby out with the bathwater. RCTs can only tell us *that* psychotherapy has had such and such results on a mean level, but neither *why* these results occurred, nor *how* and *whether* similar results are attainable now or in the future.

12.6 Dodo-Birds Must Take the Bull by Its Horns

Unfortunately, the above critique of the Medical model has been largely unheeded. Admittedly, the APA-statement does offer related rectifications by providing the somewhat broader definition of evidence based psychological practice mentioned above, as well as by approving of other empirical research designs than RCTs, such as the process-outcome studies often emphasized by the Dodo-birds (Orlinsky et al. 2004). However, by upholding RCT's as the standard for drawing causal inferences about the effects of psychotherapy and even declaring that barriers to this kind of research should be identified and addressed (APA 2006: 274), the statement uncritically makes the same ontological commitment to a regularity view of causality as do proponents of the Medical model. As such, rather than explicitly acknowledging the contextual model as an apt meta-understanding to replace the Medical model, the APA-statement does not only contribute to maintain the flawed idea that replicated RCTs are the best research design that we have, but at worst it inspires proponents of the Medical model to uphold the contextual model as just another specific form of treatment that must be evaluated by RCTs (e.g. Crits-Christoph et al. 2014).

However, if the prevailing emphasis on RCTs relies upon a faulty understanding of causality, the argument of the Dodo-birds that evidence from RCTs does not support the Medical model does not cut deep enough, as it has not explained why this is so. That is, pointing out that the statistical evidence indicates that the presumption of the Medical model that specific treatments work for specific disorders is wrong, does not explain why it is wrong. However, as the arguments of the

Dodo-birds wave in the relevant direction, it is to be hoped that they are also prone to open their eyes and take the bull by its horns. Indeed, the reason Duncan et al. (2010: 36) are right that "clients are not dependent variables on which independent variables operate [but] agentive beings who are effective forces in the complex of causal events", is that the Humean conception of causality is wrong and dispositionalism right.

12.7 Meaning-Makers Must Target the Right Enemy

Where the Dodo-birds have not yet taken the bull by its horns, the Meaning makers have overshot their target. If there was no alternative to the prevailing Humean conceptions of causality, the Meaning-makers would have been right to deem causal explanation as relevant only for the natural sciences while inapt for psychology (Smedslund 2012a; Harré 2002; Brinkmann 2011). However, as alternative accounts of causality do exist, their rejection of the relevance of causal explanation amounts to no less than overkill.

It should be noticed, however, that this rejection stands in a long tradition of scholars inspired by Dilthey's distinction between explaining via causal covering laws (*Erklärung*) and understanding agents' points of view (*Verstehen*) (Harré 1999; Smedslund 2009). This distinction is indeed relevant, as the very point of RCTs – to compare the outcome of therapy with no therapy – is clearly related to the so-called covering law model, at least in Hempel's version inspired by Hume. According to this model, scientific explanations should reveal the regular antecedent conditions without which something would not happen by appealing to empirical correlations of one type of event (outcome) with another type of event cited as its cause (intervention). However, that this kind of explanation by referring to empirical correlations (covering laws) is inadequate for understanding human meaning-making, entails neither that meaning-making and causality belong to mutually exclusive explanatory domains (cf. Smedslund 2012a; Harré 2002; Brinkmann 2011) nor that it is required to think about human action in ways that go beyond models of causality (Valsiner 2014). Thus, though Valsiner is right that sticking to search for linear causality has led psychology to ignore the possibility of alternative accounts of causality, Valsiner and Brinkmann (2016) are wrong that any human sign-regulatory system is a catalysed, *rather than* a causal system (my italics). Rather, in line with Valsiner's (2017) more recent statement, talk about causality must take *a new form*, and as such, the recent advancements of dispositionalism (Mumford and Anjum 2011; Anjum and Mumford 2018a) seem related to Valsiner's suggestions to emphasize catalytic conditions and mutually beneficial relations rather than relations between independent and dependent variables.

To sum up: both Dodo-birds and Meaning-makers have compellingly argued against the second and the third presumption of the Medical model described in Sect. 12.2, but to no avail. However, as an apt dispositionalist alternative to Humeanism exists, also the first presumption of the Medical model must be

abandoned: Not only is it wrong that evidence based psychotherapy is equal to empirically supported treatments, and senseless that specific kinds of outcomes must be repeatedly found to follow from specific kinds of interventions, but more fundamentally, it is also wrong that RCT's are always needed for drawing causal conclusions.

12.8 Humeanism Must Be Replaced by Dispositionalism

The recent advancements of dispositionalism relate to the resurgent philosophical interest in understanding the relevance of dispositional properties for causality (e.g. Groff and Greco 2013). As such properties are also often called causal powers, dispositionalism has often been presented as influenced by Rom Harré's seminal efforts (with Madden 1975) to replace the Humean regularity theory of causality with an account that revivifies the notion of causal powers. However, though Harré's contributions to discursive psychology (e.g. with Gillett 1994) are relatively well known to psychologists, his contributions to the philosophy of causality have been largely unheeded. Probably, this is not so much because Harré (2002) was reluctant about the relevance of causal explanation for psychology, but because psychologists are rarely encouraged to be philosophically informed. Yet, the relevance of causal powers has long been discussed in relation to the social sciences (Groff 2008), and with the recent advancements of dispositionalism their pertinence for medicine (Anjum 2016) have been demonstrated. However, pace Harré, these advancements are no less relevant for psychology. The problem is not that psychologists have wanted to discover causal relations, but that their Humean conceptions have been misleading.

A growing number of philosophers now regard the long prevailing Humean regularity theory as no more than a standard against which to contrast and develop more refined accounts. Though the extent to which Hume himself really held the view is controversial, there is no doubt that he put both it and the related counterfactual difference-making account on the table. On the first view, causal relations (infamously exemplified by colliding billiard balls) consist in no more than that events of one kind can be observed as regularly conjoining or following events of another kind. On the latter view, causes are events without which their effects would not happen. However, on both views, causal relations are neither governed by any necessities nor by any dispositional properties, or if they were, we could simply not know. Notice, that as these Humean conceptions imply that causal links must either be demonstrated by statistical evidence of correlation and/or by comparing the average outcome of exposure by stimuli with the average outcome of no exposure, they fit with the Medical model's emphasis on RCTs like a glove. Probably, the Medical model's predominance is also due to the continued influence of Hempel's covering law model, in which scientific explanations should reveal the regular antecedent conditions, as well as the empirically observed general laws, without which something would not happen (Groff 2011).

However, as pointed out by prominent advocates of dispositionalism, scientific observations of regularities that cannot be prevented by any means hardly exist (Mumford and Anjum 2011). Probably, this is why the number of citations of general laws in the scientific psychological literature have decreased (Teigen 2002). Yet, the predominant scientific paradigm of psychology still emphasizes research methods developed for the empirical discovery of regular causal relations and statistical differences. However, in line with dispositionalism it should be noted that methodological questions of how to discover causal links should not be confused with ontological questions of what causality is (Anjum and Mumford 2018b). Thus, though differences between group averages may indicate that relevant causal relations exist, causality is not in itself a statistical phenomenon. Without further argument we therefore cannot take for granted that causal effects is something that ought to be clarified by demonstrating statistical differences via RCTs. Moreover, RCTs are not necessarily the best way to clarify causal relations as they can only provide sparse information about what the relevant causal connections consist in, how they may come about, and how similar effects might be attainable in the future.

Notice that this argument is related to the arguments made by many Meaning-makers that the results of RCTs cannot tell us *why* any psychotherapy process has had this or that effect, nor *how*. However, though dispositionalists would wholeheartedly agree with the Meaning-makers that the relevant information cannot be gained by trying to establish knowledge of causal covering laws (Erklärung), pace the Meaning-makers, dispositionalism implies emphasizing an alternative account of causal explanation rather than to deny its relevance. Thus, though the Meaning-makers have put apposite emphasis on understanding agents' unique points of view (Verstehen), causality is not the enemy. Rather than to construe Verstehen as about non-causal phenomena, understanding what something means for someone is more often than not to get to know about their causally powerful dispositional properties.

In line with a Humean perspective, both the Medical model and APA's statement on evidence based psychological practice treat causal effects as something that must be clarified by RCTs. At best, this understanding is incomplete. For one thing, it ignores that there can be regular succession of events that are not causally related, and moreover, we must account for the possibility of causal processes that happen only once (the kind of result an RCT would purposely elide). To deal with these features, dispositionalism revives a realist view of causality, in which causal relations rest upon the powers of dispositional properties to produce changes. And on the view developed by Mumford and Anjum (2011), causal relations are constituted by properties that only dispose towards other properties as their effects. Causes may thus only tend towards their effects, and these effects might never be manifested in any observable regularity (Anjum and Mumford 2018a).

Thus, contra the Humean conceptions, isolating variables in the hope of measuring regular relations between them is no royal road to know about causal relations. Not only do we need more thorough inquiries that explain how and why causal effects emerge, but knowledge about relevant causal links and mechanisms can even be gained without having recorded any correlations, for instance, when the possible interplay between dispositional properties can be understood before any causal

changes emerge. Statistical evidence is thus not needed if we already understand the mechanisms involved, and causal claims are best supported by theory that explains how and why causal effects are brought about (Anjum and Mumford 2018a, b). Nor is statistical evidence needed if we can come to understand how and why causal effects may emerge by reflecting on the possible interplay between the dispositional properties of persons and their surroundings. Importantly, these advancements of causal dispositionalism do not only bring support to the arguments of both Dodo-birds and Meaning-makers, but as such they demonstrate the relevance of dispositionalism both for psychotherapy research and psychotherapy.

12.9 Implications for Psychotherapy Research

Of the many relevant implications of dispositionalism for psychotherapy research only five will be delved into here. That is, (i) *methodological pluralism* and (ii) *causal singularism*, and the related potentials for (iii) *advancing theoretical reflection*, (iv) *avoiding pseudo-empirical research* and advancing the (v) *theoretical integration of psychotherapy perspectives*. These interrelated aspects are picked out both because they have profound potential for changing the field of psychotherapy research for the better and because they are relevant for the implications of dispositionalism for psychotherapy discussed in the next section.

As mentioned, the statement of APA (2006) approves of a multitude of evidential resources, but from a dispositionalist perspective it is still too narrow. By upholding RCT's as the standard for drawing conclusions about the effect of psychotherapy one treats causal relations as something that must be discovered through RCTs. However, questions of how to clarify causal relations must not be conflated with ontological questions of what causality is. Thus, though RCTs can indicate the possibility of relevant causal links by demonstrating difference making and regularity on an average level, there are also other, and often better, ways to get in touch with causality. For instance, by understanding what was experienced by someone; say, when we wonder why a child suddenly got anxious when playing with his dad, and get to know that playing with toy-soldiers with his dad suddenly made the child remember that his dad could not only act unpredictably, but also just as aggressively as the toy-soldiers. Accordingly, we must emphasize *methodological pluralism* which is also related to *causal singularism*: Causality is manifested in concrete particular instances because of the dispositional properties involved (Anjum and Mumford 2018b). Whether a child becomes anxious when experiencing a parent as unpredictable, depends upon the properties of the child, the parent, and their surroundings, not on whether a statistically significant number of children experiencing their parents as unpredictable become anxious when together with their parents.

This brings us to the third implication of dispositionalism: Singularism means not only that the priority traditionally given to quantitative research rather than qualitative research is untenable, but also that we should emphasize the primacy of causal theory over statistical data. Thus, methodological pluralism does not only

mean that there are many ways to get in touch with causality, but also that psychologists must put more emphasis on *theoretical reflection*. Agreeing with APA (2006: 274) that one should recognize the strengths and limitations of evidence from different types of research, we should notice that where Hume's covering law model suggests collecting more and more data of the same type from repeated instances, dispositionalism encourages us to collect more data about singular instances. What matters is that we can understand the causal processes involved in actual singular cases. What happens elsewhere and at different times is not only ontologically irrelevant but may also be epistemologically extraneous. Not only do we need more thorough inquiries that explain how and why causal effects emerge here and now, but we can also clarify possible interplay between dispositional properties before any causal changes have emerged (Anjum and Mumford 2018b).

This leads us to the fourth implication of dispositionalism, that is, the potential for *avoiding pseudo-empirical* research. The notion of pseudo-empiricism, acknowledged by most Meaning-makers (e.g. Brinkmann 2011; Valsiner 2012; Harré and Moghaddam 2012), that we should not mindlessly put assertions to empirical test if they can be evaluated by other means, was first introduced by Smedslund (1995). Notice, however, that acknowledging the relevance of this notion does not mean that we ought to follow Smedslund's arguments all the way towards concluding that psychology cannot be an empirical science. On the contrary, not only is it probably more coherent to think of theoretical reflection as comprising kinds of inquiries in which experience plays a significant role (cf. Casullo and Thurow 2013), but in line with methodological pluralism, RCTs and other kinds of empirical research do have their areas of application. Thus, acknowledging the relevance of avoiding pseudo-empirical research only means that an emphasis on empirical research must not exclude the relevance of theoretical reflection and that the relevance of advancing theories of causal tendencies is often more relevant than statistical data.

For instance, collecting more empirical data to test the hypothesis that people tend to attempt to do what they think they are able to do when they also want it, or whether people tend to get anxious when together with unpredictable people, will be pseudo-empirical. Thus, if we already have relevant and sufficient amount of information about the relevant dispositional properties, we can know this by reflecting on the possible interplay between them without further empirical inquiry. For instance, if we know that someone (say, Caesar) has come to think that he is vulnerable, and if we also know that he thinks that someone else (Brutus) may come to do something (stab with a knife) that might kill or hurt him, and he also thinks that he cannot know whether this may be done at a time when he is able to prevent it, then we know that he is disposed to become anxious when together with Brutus. Moreover, we can also know by reflecting on possible preventing circumstances, that these are only tendencies. For instance, though Brutus thinks that he is able to stab Caesar and wants it, he might not attempt to do it because he thinks that Caesar's guards may be able to protect Caesar, and Caesar may feel safe with Brutus when his guards are around. Similarly, there are no unpreventable laws to be found that children having unpredictable parents will become anxious when together with their parents. They may feel safe in context of their grandparents, by believing they are

stronger and/or more competent than their parents, etc. Nevertheless, knowing about such tendencies is practically relevant, and we should avoid being unpredictable with regards to potentially harmful actions if we want to become worthy of anyone's trust, our children included.

Though these examples may sound trivial, the point itself is not. Though it is a matter of controversy how much psychological research has been pseudo-empirical, a growing number of psychologists have recognized the relevance of the notion. Indeed, the point does not only extend to many psychological theories, many of which are clinically relevant, but also to psychotherapy research. A striking example is the aforementioned Dodo-bird-claim that the great mass of empirical data actually produces evidence that falsifies the Medical model. There is nothing wrong with this conclusion, except that it is *pseudo-empirical*. In other words, that the practical relevance of psychotherapy perspectives must be tested on an average level by RCTs – as if psychotherapy was some kind of context-transcending pill with regular and replicable effects working independently of the unique properties of the persons involved – is simply nonsense. This is adeptly demonstrated by the above-mentioned Meaning-maker-argument that RCTs cannot ever pay due respect to the fact that existing persons are someone for whom something exists: As none of us will ever make sense of things from the exact same perspective as any other, and no experience can ever be undone, and moreover, that we are continuously open for change by attaching new meanings to things, implies that we cannot take for granted that persons will react in the same or similar ways to neither the same nor similar events. Hence, there is no other option than to qualify our services one psychotherapy process at a time.

This also brings us to the fourth potential of dispositionalism for psychotherapy research mentioned above. Alas, the prevailing emphasis on RCTs has thrown a plethora of psychotherapy perspectives, models and theories[1] into pointless rivalry, needlessly competing for the best results on an average level. This has been at the expense of theoretical work to clarify the extent to which these perspectives may be integrated. However, the idea of psychotherapy perspectives as consisting of competing empirical hypotheses of regular causal relations between isolated variables is misleading, and the many various perspectives, models and theories are better characterized as compatible and/or overlapping attempts to put possible relations between the clinically relevant dispositional properties of persons into words. This also makes it relevant to consider the extent to which the perspectives can and ought to be theoretically integrated. The further upshot is that such integrative work will

[1] A far from complete list would include Narrative Therapy, Cognitive Behavioural Therapy, Schema Therapy, Meta-cognitive Therapy, Acceptance and Commitment therapy, Emotion-focused Therapy, Gestalt Therapy, Client- and Person Centred Therapy (not to be confused with person-centred medicine), Compassion-focused Therapy, Existential- and Humanistic Therapy, Mindfulness, Rational Emotive Therapy, as well as various psychoanalytically oriented and psychodynamic perspectives such as Intensive Short Term Psychodynamic Therapy, Self-Psychology, Mentalization Based Therapy, Object Relations Therapy, Traditional Psychoanalysis, Relational Psychodynamic Therapy, and many more.

highlight the relevance of a capacity that is not only pivotal for psychological research, but also vital for any psychotherapy process: To study and take part in the ever-evolving unique and vastly complex contexts of psychotherapy processes requires that we take advantage of our capacity for thorough theoretical reflection, so as to critically calibrate our knowledge of possible and impossible relations between the dispositional properties that persons may have.

Notice that philosophers sometimes speak of dispositional properties by using the shorter term "dispositions". However, to avoid confusion it should be noticed that psychologists have often used the latter term in another sense, that is, to refer to character traits by which one can purportedly predict behaviour by referring to the frequency of past behaviour. For instance, one may think of one's father as dangerous now or in the future simply because he has often done hurtful things in the past. By contrast, dispositionalism emphasizes a notion of dispositions (causal powers) as constituted by intrinsic properties, or propensities (see Rocca, Chap. 3, this book). Thus, whether a father is dangerous or trustworthy here and now, depends upon his properties here and now not on how often he has had these properties before. For instance, whether he comes to do something that hurts his child or not does not depend upon whether he has been violent in the past, but on whether he actually cares for and understands his child, on whether he currently has the relevant amount of self-control, on whether he is currently able to act autonomously, etc. Accordingly, developing relevant clinical competency depends not so much on being able to attribute statistically based character traits, as on being able to calibrate one's notions of possible and impossible relations between the dispositional properties that persons may have in various singular cases here and now.

12.10 Implications for Psychotherapy

Thus, where the Humean commitments of the Medical model lead to a narrow emphasis on empirical research and a one-sided compliance to empirically supported treatments, dispositionalism implies pluralism with respect to both research methodology and practice. In significant respects, this pluralist stance of dispositionalism is related to the proposals of a so-called *bricoleur-model* of psychotherapy (Smedslund 2012b). On this view, practitioners should not let an emphasis on specific pre-construed models and interventions stand in the way for focusing on the needs of the unique patient, but should rather be prepared to use *whatever is at hand* that might contribute to solve the problems encountered.

Alas, the need for emphasizing a practice where one strives to meet persons as openly and unprejudiced as possible so as to ensure a sufficiently flexible adjustment to the unique case, is not only different from the Medical model, but it has been disregarded by governmental authorities aiming to ensure the quality of the therapy process from the outside. The implementation of the so-called "Quick Psychological Health Services" in Norway (Norwegian: Rask psykisk helsehjelp) inspired by the "Improving Access to Psychological Therapies Programme" in

England, may serve to illustrate this. The primary aim of this programme, to provide people with free, low threshold, professional aid when suffering from depression and anxiety, is impeccable and I'm proud to have contributed to fulfilling this aim for 5 years. However, the programme has also suffered from one great mistake dictated by the dogmas of the Medical model, that is, it has exclusively emphasized cognitive behavioural therapy (CBT). Presumably, this is because it has been maintained that it has been demonstrated by RCTs that CBT *is* effective for relieving depression and anxiety. In line with the Medical model this understanding accounts for CBT as an empirically supported treatment, that is, a kind of "miracle drug" comprising statistically proven effective specific interventions. However, though the principles of the CBT-models undoubtedly contribute to understanding psychological phenomena in ways that *may* be practically relevant, this picture is seriously flawed. First, CBT is not the only perspective providing relevant assertions, neither for low threshold services, nor for dealing with depression in general. Second, it may not always be the most relevant one, and third, if it is relevant, it may be so in combination with other perspectives.

However, though cognitive-behavioural-therapists have often been eager to promote CBT as an empirically supported treatment they have also often described matters as being more complicated than as construed by the Medical model. Rather than picturing persons attending psychotherapy as patients who passively receive some kind of miracle drug, one has not only emphasized the relevance of establishing a trusting relationship, but also of motivating clients to contribute as active agents towards reaching their goals. However, how various dispositional properties of patients, therapists and their surroundings may combine and intertwine towards establishing a trusting relationship are not described by CBT-models, but more extensively by other psychotherapy-perspectives (e.g. various psychoanalytically oriented and psychodynamic perspectives). Also, though one actively encourages patients to take active part in the process, this is normally done by "socializing the patients" towards proceeding within the frame of specific CBT-models, and this way of proceeding puts us right back into the linear scheme of the Medical model; as if all patients always suffer in ways to be treated by the same treatment procedures.

Yet, that one size does not fit all, is also well known among cognitive-behavioural therapists. E.g. it has been recognized that it is not always sufficient to deal with the *content of cognitions* triggered in specific situations to counteract various problems. For instance, realizing that your first thought that someone did not like you actually was wrong – and that it was more likely that the reason this person avoided you was that he was shy – may not be enough to overcome social anxiety. Rather, or additionally, more *fundamental and context-transcending assertions* (often called schemas) may have to be dealt with. For instance, being convinced that no one will ever really like you if you fail at something, and thus, that you have to make sure not to fail in any kind of situation. To take such more fundamental assertions into account so-called Schema-focused models of psychotherapy was construed by integrating aspects from CBT and psychodynamic perspectives. More recently, the fact that it is not always sufficient, sometimes not necessary, and perhaps not even desirable, to alter the content of cognitions has been incorporated

into the therapy-models. For instance, we may not want to change our minds about it being both true and sad that someone we love is no longer alive. Thus, one has acknowledged the relevance of working with how to deal with having thoughts without altering their content by integrating Mindfulness exercises, for instance, practicing on recognizing one's thoughts as a natural and harmless aspects of the fluctuating moment, or by bringing in the principles of Meta-cognitive therapy, for instance, by recognizing that scary thoughts about something are actually not dangerous in themselves.

From the perspective of dispositionalism, this picture could not only easily, but also ought to, be expanded by aspects of further therapy models and perspectives not traditionally thought of as part of the cognitive paradigm. For instance, one may take into account the aspect emphasized by models of Emotion-focused therapies that simply work on how to think differently without making sure that this actually creates emotional change, may not be sufficient, or one may aptly integrate aspects traditionally emphasized by various psychodynamic perspectives such as Object-relations therapy and Self-psychology. For instance, validating the experiences of patients (making their thoughts understandable without necessarily agreeing with their content) so as to foster self-esteem by the recognition of the value and intelligibility of being who they are (this may have been prevented by inhospitable circumstances when growing up, insensitive or violent parents and/or by bullying at school). Or one may inquire into whether inhospitable growing up conditions have made persons prone to satisfying other people's needs rather than their own, perhaps even to the extent of having become unable to recognize their own real wants and needs, eventually leading to depression or anger. Such inquiries may have the aim of providing the patients with the relevant understanding of themselves both to prevent feeling ashamed about one's suffering and to foster opportunities for exploring how to flourish in one's life on one's own premises.

However, as aptly pointed out by Wampold (2019) there is a risk that the idea of integrating various approaches will be taken to be a specific approach in its own right, so that one simply adds to the expanding number of specific therapies that purportedly must be evaluated by RCTs. Fortunately, dispositionalism offers a viable solution to overcome this risk. Thus, the aim of clarifying the extent to which various perspectives are overlapping or may be fruitfully combined is not to construct yet another empirically supported treatment, but to get a hold on how the various perspectives describe possible causal links between the possible dispositions of persons that *might* be relevant in possible singular and unique cases. The aim of integration is not to construct yet another miracle drug suitable for all, but to widen one's scope, so as to be more flexible and able to deal with the immensely complex ways in which the various dispositional properties of unique persons may interact both with each other and the properties of the surroundings. As such, theoretical integration is no aim in itself, but may serve the more general bricoleurious aim of being prepared to use *whatever is at hand* that might contribute to solve the problems encountered. Thus, this overall aim does not only include taking various psychotherapy perspectives into account, but also perspectives and ideas suggested by professionals primarily working with other kinds of services than psychotherapy,

such as social workers and physiotherapists, as well as anything else that might be beneficial. For instance, making a phone call to a social worker to get help solving financial problems, may be no less relieving than psychotherapy. Or by taking into account how moods may change by altering body-posture, helping patients to recognize that though their traumatic experiences may have made them more prone to strain their muscles (e.g., as part of being angry or terrified), become restless or agitated (e.g. as part of being worried or more alert) or collapsed (e.g. as part of being depressed or shameful) as part of a bodily defence against perceived threat, their inborn ability to create a more balanced and harmonious posture is not destroyed.

Thus, where the Medical model portrays clinical competency as the ability to use psychological knowledge in such a way that it leads to statistically probable change, dispositionalism emphasises our abilities to critically calibrate our knowledge of the vast amount of possible and impossible relations between the dispositional properties that persons may have in various circumstances. In other words, though we should not deny ourselves the possibility of looking to RCTs for inspiration, making it obligatory to look to this kind of research for evidence runs the risk of distracting focus away from what matters, which is to deal with the properties and processes involved in actual singular cases. Just as one does not necessarily get wiser simply from having had more experience, we cannot know whether relying on RCTs conducted elsewhere and with other patients at another time is relevant here and now. Accordingly, just as clinical competency cannot be assured through inductions from the unavoidably limited and biased experience of individual therapists, neither can it be built on inductive generalisations from accumulations of empirical data from RCTs or other correlational studies alone. Rather, the clinical competency relevant for psychotherapy has to do with having gained the relevant *degrees of interpretational freedom* for dealing with possible tendencies. The extent to which humans really differ from other animals with respect to the capability for building such competency might be discussed. What is clear however, is that human beings are normally able to recognize more opportunities, say, with a nut than eating it raw (e.g. baking a cake). Similarly, we not only can but should be more flexible than simply complying with empirically supported treatments. By working to clarify the possible and impossible relations between the dispositional properties that persons may have in various contexts, one might not only get a reflective overview of various possibilities that may be actualized in concrete situations, but one might also gain relevant resources for avoiding overgeneralizations and avoiding jumping to unwarranted conclusions. Thus, clarifying possible links between the dispositions of persons may not only strengthen an apposite sensitivity for more possibilities than one's immediate first impressions, but it might also provide resources for understanding and dealing with actualized feelings, thoughts and behaviour.

12.11 As Statistics Don't Get It, Try Getting the Vectors Right

To the extent that the above discussions are up to something, dispositionalism does not only improve earlier critique of the Medical model, but may as such also have profound consequences for psychotherapy research and mental healthcare services. Dispositionalism provides an account of causality that implies pluralism with respect to both research methododology and practice, all toward the aim of dealing sufficiently with the complex interplay between the unique properties of persons, their circumstances, and clinical practitioners. This can be illustrated by the vector model suggested by Mumford and Anjum (2011) and introduced in Chap. 2 in this book.

Thus, where the Medical model portrays all psychotherapists as complying with the same empirically supported treatments purportedly making a statistically probable difference on specific symptoms of specific disorders purportedly shared by various patients (see Fig. 12.1 above), the vector model (see Figs. 12.2 and 12.3) provides a way to emphasize and clarify aspects of a vastly more complex reality consisting of both catalysing and preventing dispositional properties of patients, therapists, and their circumstances.

The broken line T on top in the picture represents a threshold that has to be met for the experience of improvement and/or wellbeing to occur for some patient P, while the broken line at the bottom of the picture represents some threshold condition for the experience of suffering or of having some kind of problem. The horizontal lines P and S represent some points in time where the various properties of the patient and various conditions of his/her current situation, respectively, push and

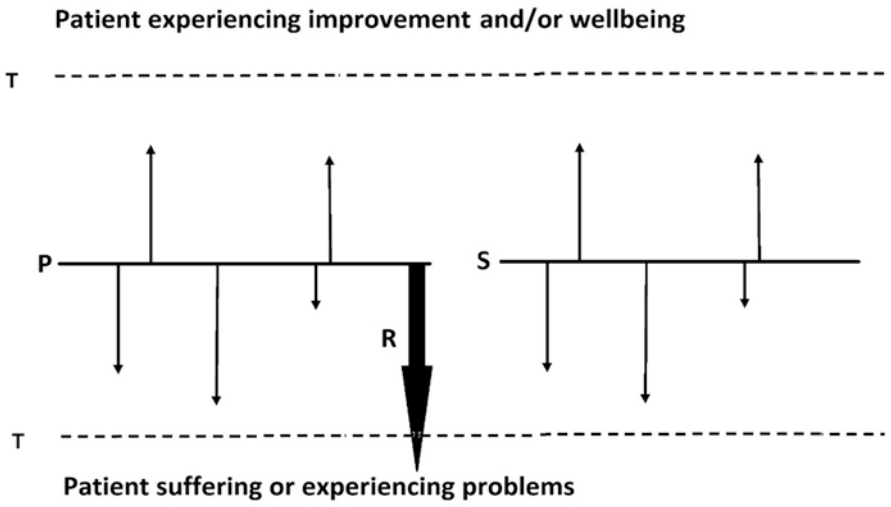

Fig. 12.2 The vector model part 1: patient and his/her situational circumstances

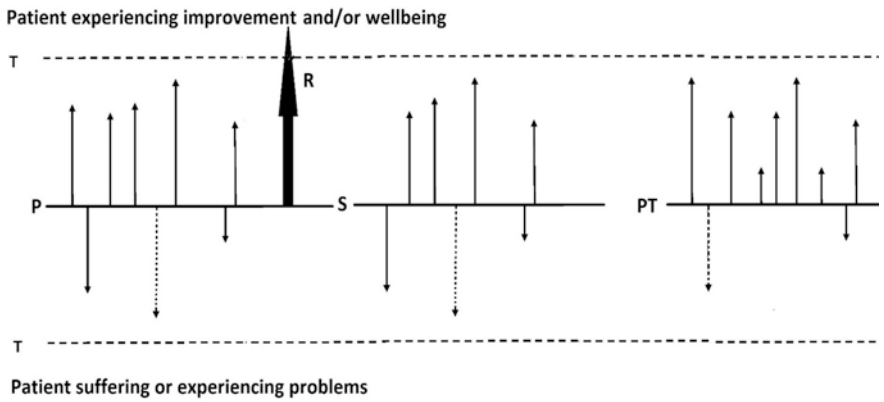

Fig. 12.3 The vector model part 1: patient, situational circumstances and psychotherapist

pull towards the thresholds for experiencing wellbeing or suffering. The arrows pointing upwards from the horizontal line P represent the properties of the patient that dispose towards wellbeing, while the arrows pointing downwards represent the properties of the patient that dispose towards suffering. The thicker arrow R represents the overall result of all the vector-dispositions; alas, at this point in time, crossing the line for suffering to emerge. Hopefully, however, there are some potentials for helping the patient. First, there are already some dispositions still pointing upwards, and if it could be possible either to strengthen these or to add some vectors pointing in the upwards direction, the overall resultant vector R might turn in the other direction, and hopefully dispose as far as reaching not only improvement, but also well-being. Alternatively, or additionally, the vectors pointing downwards could be removed or at least weakened, so as to bring the overall result less in the direction of suffering and more in the direction of wellbeing. However, at this point in time, the properties of the patient and his/her surroundings leave the patient stuck in suffering.

Say, however, that one of the properties of the situation involves a friend who encourages the patient to consult a psychotherapist, and even better, one of the properties of the patient is that he/she thinks of the friend as trustworthy. Fig. 12.3 illustrates what could ideally have happened if the patient and the psychotherapist met. Now that the psychotherapist has become part of the complex situation, the horizontal line PT represents the period in the patient's life when consulting the therapist, and the arrows pointing upwards from PT represent properties of the psychotherapist that dispose towards the wellbeing of the patient. The arrows pointing downwards, however, represent the properties of the psychotherapist that dispose towards worsening the suffering of the patient. For instance, the therapist may be prone to misunderstand, or act in ways that the patient experiences as too challenging.

Fortunately, however, though there are arrows pointing downwards, the downward arrow in the far right of the figure is rather weak compared to the other vectors, and moreover, the vectors pointing upwards represent properties of the therapist that dispose towards helping the patient. For instance, the therapist cares for the patient, dares to call a social worker for relevant financial advice or aid, knows about the various ways that actions, thoughts, and emotions may relate to various experiences, does not let statistical considerations take focus away from the actual patient, has sufficient amount of self-control, and so on.

Moreover, the other arrow pointing downwards from PT is dotted, which represents that the therapist has had the ability to prevent some property of him- or herself from contributing negatively to the therapy process, for instance, his disagreement with the patient's political views, being hungry, or prone to think about his/her own family-problems. Notice also, that during the therapy process captured by Fig. 12.3, the number of patient- and situation- vectors pointing upwards has increased compared to Fig. 12.2, and although this could possibly have happened independently of the psychotherapy process, it might also be the result of, or perhaps even dependent upon, the therapy-process. Moreover, one of the vectors pointing downwards from P, as well as one from S, are now dotted. Again, this represents that they are removed from the complete set of properties relevant for the mental health of the patient. For instance, in line with the examples described in the former section, some financial problems may be gone, weakened or prevented by making contact with a helpful social worker. Or the patient has become able to recognize that he/she has tended to take more care of others than him/herself, and has additionally managed to forgive him/herself for this by having worked with the therapist to understand these actions as having had an understandable rationale. Moreover, this may have contributed to release potential for working towards being able to act more autonomously, flexibly and in tune with one's own desires. Thus, the overall result R is now different from in Fig. 12.2, pointing upwards.

There is clearly much more work to do in order to clarify the implications of dispositionalism for psychotherapy research and mental health care. However, the take-home message so far is that nothing (except from ethical concerns) should stop us from doing *whatever it takes* to find out about and to deal with the relevant dispositional properties involved. Statistics may help to indicate the existence of relevant causes in larger groups and on an average level. And if we are lucky, these causal tendencies are relevantly similar to what happens when encountering unique individuals here and now. However, beyond that, statistics don't help us much. Thus, we are rather in need of thicker explanations, a deeper understanding of the properties and experiences of persons and their contexts that dispose towards well-being and suffering. If statistics don't get it, try getting the vectors right.

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