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Implementing evidence-based practice while embracing uncertainty in psychotherapy – a practical guide

O wdrażaniu praktyki opartej na dowodach i tolerowaniu niepewności w psychoterapii – praktyczny przewodnik

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Abstract

Introduction and objective: In recent decades, research has generated a substantial body of clinically relevant knowledge about the effectiveness of psychotherapy and the role of both specific and common therapeutic factors in facilitating change. This article is intended for practicing psychotherapists seeking to assess the effectiveness of their clinical work in light of current research. We reflect on what is empirically supported, what remains uncertain, and how to avoid overinterpreting findings when evaluating therapeutic outcomes. **Materials and methods:** We highlight the need to consider the ontological and epistemological assumptions underlying different research methodologies. We also examine how therapeutic change is defined and measured, emphasizing that psychotherapy research is diverse and different studies illuminate various aspects of change in patients with different disorders. We advocate integrating scientific knowledge with clinical judgment and patient preferences, while warning against the uncritical application of guidelines based solely on empirical data. **Results:** Despite substantial progress, many questions remain open. Hopes are placed in the treatment personalisation and advancement of methods for studying psychotherapy, which – in our view – should always be accompanied by a reflective approach to areas of uncertainty that constitute an inherent element of therapeutic practice. **Conclusions:** We argue that research provides necessary support for clinical practice, but should be interpreted in light of its methodological limitations, patient characteristics, and the therapist's personal qualities, which are best understood through self-reflection, personal therapy, and supervision. The capacity to tolerate uncertainty emerges as a key therapeutic competence.

Keywords: psychotherapy outcomes, change in psychotherapy, efficacy research, effectiveness research, evidence-based psychotherapy

Streszczenie

Wprowadzenie i cel: W ostatnich dekadach badania dostarczyły wielu użytecznych dla praktyki klinicznej i terapeutycznej informacji na temat efektywności różnych modalności psychoterapii oraz znaczenia swoistych i wspólnych czynników leczących w osiąganej zmianie. Artykuł jest adresowany głównie do praktykujących psychoterapeutów, zastanawiających się nad efektywnością własnej pracy terapeutycznej w kontekście wyników badań. Autorki dzielą się w nim wiedzą i refleksjami nad tym, co rzeczywiście wiadomo na podstawie badań, a co pozostaje w obszarze niepewności, a także jak unikać nadinterpretacji w ocenie skuteczności terapii. **Materiał i metody:** Przedstawiono znaczenie refleksji nad założeniami ontologicznymi i epistemologicznymi leżącymi u podstaw metodologii badań nad psychoterapią, omówiono definicje i wskaźniki zmiany terapeutycznej, a także pokazano, że badania nad psychoterapią są zróżnicowane i każde z nich odsłania inne aspekty oraz procesy zmiany zachodzące u pacjentów z różnymi zaburzeniami psychicznymi. **Wyniki:** Podkreślono konieczność integrowania wyników badań z oceną kliniczną i preferencjami pacjenta oraz wskazano ryzyko wynikające z mechanicznego stosowania zaleceń opartych wyłącznie na danych empirycznych. Pomimo ogromnych wysiłków badawczych i klinicznych badacze oraz terapeuci wciąż poszukują nowych rozwiązań. Nadzieje pokłada się w personalizacji leczenia oraz w równolegle udoskonalanych metodach badania psychoterapii, którym – w przekonaniu autorek – powinno

zawsze towarzyszyć refleksyjne podejście do obszarów niepewności, stanowiących nieodłączny element praktyki terapeutycznej. **Wnioski:** Autorki stoją na stanowisku, że badania stanowią niezbędne wsparcie dla praktyki klinicznej, ale powinny być interpretowane w zakresie ich trafności, z uwzględnieniem ograniczeń wynikających z właściwości pacjenta oraz osobistych cech terapeuty, które poznaje poprzez autoanalizę, własną terapię i superwizję. Tolerowanie niepewności okazuje się kluczową kompetencją w praktyce psychoterapeuty.

Słowa kluczowe: skuteczność psychoterapii, zmiana w psychoterapii, badania *efficacy*, badania *effectiveness*, psychoterapia oparta na dowodach

INTRODUCTION

In recent decades, a vast body of knowledge has been accumulated regarding the effectiveness of psychotherapy in relation to various therapeutic approaches. Such research encompasses not only specific and common therapeutic factors, but also those characteristics and attributes of therapists and patients that may strengthen or weaken the effectiveness of therapeutic interventions. This knowledge is used in the service of improving the quality and effectiveness of psychotherapy, although it is also sometimes used in a simplified or superficial manner – not so much to better tailor the therapy to the problem reported by the individual, but rather to limit the possibility of dialogue between specialists and to declare the victory of one school over others (see, e.g., Leichsenring et al., 2018). While it seemed that the era of races for supremacy between psychotherapeutic modalities ended with the Dodo bird verdict: "everyone has won, and all must have prizes" (Luborsky et al., 1975; Westra, 2023), in practice, its echoes still clearly resonate.

This article is educational in nature. As its authors, we wish to invite Readers – primarily practising psychotherapists – to a collective reflection on what is actually known based on research, what is only beginning to emerge from the data, and what still remains in the realm of uncertainty. In this article, we analyse several key issues that, we assume, will help readers better understand current research findings, the contradictions between some of them, and the ways to recognise unjustified overinterpretations or generalisations present in certain publications. Psychotherapists have reliable grounds for an increasing sense of certainty regarding the sources and factors influencing the effectiveness of psychotherapy. However, at the same time, they confront various areas of uncertainty that foster the emergence of tendencies toward simplification or the denial of these ambiguities. The sense of certainty is largely influenced by knowledge derived from numerous studies on the effectiveness of psychotherapy, which creates a credible foundation for evidence-based therapeutic practice.

At the same time, among clinicians and therapists there is a reduced tolerance for ambiguity and to undervalue reflexivity in diagnostic and therapeutic procedures, which leads to erroneous decisions and to proposing ineffective therapeutic procedures to the person seeking help (Spring and Neville, 2016; Willig, 2019). There is no form of psychotherapy (nor any therapist) that is effective in treating all mental and behavioural disorders. Developing a well-founded and responsible position on the effectiveness of therapeutic interventions requires asking oneself several important questions and formulating sound answers grounded in contemporary theoretical and empirical knowledge – answers that may help confirm or revise one's beliefs and illuminate the inevitable areas of uncertainty.

WHAT IS THE USEFULNESS OF SCIENTIFIC KNOWLEDGE FOR THE PRACTITIONER?

In professional practice, practitioners should draw on scientific research findings, but always in a reflective manner

Evidence-based practice (EBP) is an approach that allows the integration of the best available scientific results with clinical experience, taking into account the context of the patient's individual characteristics, culture, and personal preferences (Levant and Hasan, 2008). Using knowledge derived from EBP is an essential component of a therapist's clinical work, bringing benefits to both the patient and the therapist. This makes it possible to increase the effectiveness of therapy, minimise risk, and optimise the process of achieving change and treatment outcomes. In the practical application of research findings, the question of their clinical usefulness becomes particularly important. This concerns whether the therapist will be sufficiently diligent in seeking appropriate knowledge about effective procedures and therapeutic strategies that would, on the one hand, take into account their own skills and professional capacities, and, on the other, the characteristics of the patient. In specific studies on the effectiveness of psychotherapy, both statistical significance (e.g. differences in self-reported questionnaire measures of depressive symptoms at the beginning and at the end of psychotherapy) and clinical significance (e.g. patient-perceived changes in social relationships) should be assessed on the basis of selected criteria and their indicators (Cuijpers, 2019; Lambert and Ogles, 2009). Criteria and indicators of clinically significant change derived from psychopathology include a reduction in symptom severity or their remission, along with the alleviation of associated suffering. Within specific modalities of psychotherapy, these criteria are also defined through intrapsychic markers of mental health. Many researchers emphasise that the utility of research on change in therapy is determined primarily by clinically significant improvement –

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both in terms of symptom reduction and at the level of the underlying intrapsychic mechanisms. Symptom reduction alone therefore cannot serve as the sole criterion of therapeutic effectiveness (cf. e.g. the Marburg Declaration – Rief et al., 2024 or the recommendations of the International Consortium for Health Outcomes Measurement – Prevolnik Rupel et al., 2021). Equally important are studies on mechanisms of change, improvements in quality of life, long-term treatment effects, and contextual determinants. Knowledge about the effectiveness of an intervention that has only statistical value – yet cannot be applied to a particular person in the context of uniqueness, uncertainty, or value conflict (Willemsen, 2022), or proves inadequate due to the influence of socio-cultural factors – loses, at least at its current stage of conceptualisation, its practical relevance. In this sense, isolated knowledge about treatment effectiveness is of little use for practice as long as it does not translate into clinical change.

There are many reasons why psychotherapeutic practice should be linked not only with theory but also with knowledge derived from scientific research. Using research findings creates opportunities for reliable and accurate clinical decision-making and enables the use of procedures and interventions based not on the therapist's personal preferences but on a broad view of effective and available treatment options. Such knowledge constitutes an essential complement to the therapist's clinical experience, supporting sound decision-making and enabling the provision of care at the highest possible level (Cook et al., 2017). Under ideal conditions, drawing on research findings saves time, money, and resources, and minimises risk by protecting against the use of ineffective (and at times even harmful) treatments. Reflective use of knowledge derived from empirical research is a complex skill that requires learning, but one that is worth the effort. From the perspective of a therapist seeking empirical scientific literature to better address a difficulty arising in the psychotherapy of a particular patient, it is worth considering the perspectives that are outlined in the following sections of this article as a conceptual map containing reflections and guidelines that may be useful when navigating research on psychotherapy effectiveness.

WHAT ONTOLOGICAL AND EPISTEMOLOGICAL ASSUMPTIONS UNDERLIE RESEARCH ON PSYCHOTHERAPY EFFECTIVENESS?

The way human nature is conceived and knowledge about the world is acquired shape both the conduct and interpretation of psychotherapy research

Once psychotherapy came to be viewed not as an art but as an applied interdisciplinary science, and the therapist not as an artist but as a professional whose work requires specific training and practice, various models of competencies for psychologists, clinicians, and therapists began to emerge. These models include not only the knowledge and skills required for conducting sound diagnostic procedures and formulating different types of psychological diagnoses (APA Presidential Task Force on Evidence-Based Practice, 2006; Blais and Hopwood, 2017; Handler and Meyer, 1998; Sugarman, 1991), but also competencies related to providing help in the form of counselling and therapy. Competency models for psychotherapists emphasise the need for trainees to possess broad knowledge of mental health, the ability to use therapeutic procedures and strategies, interpersonal skills, and a readiness for reflection and for monitoring their own psychological states as they arise in the relationship with the patient (France et al., 2008). Willig (2019) argues that being an effective therapist involves not only expanding therapeutic knowledge and skills, but also developing awareness and reflection – both regarding personal practice and its outcomes, and regarding the influence that an adopted ontological and epistemological stance exerts on therapeutic work. Just as researchers do, therapists should, on the one hand, develop awareness of their own assumptions about human nature and the world, and become familiar with the patient's beliefs in this regard (ontology). On the other hand, they should be aware of both their own and the patient's beliefs about what counts as genuine knowledge and how it can be acquired, that is, how to communicate about suffering and the change expected in the therapeutic process (epistemology). Ontological assumptions about human nature, and epistemological assumptions about how it is possible to understand, acquire knowledge about, and explain human functioning, form the core of every therapeutic modality with which a therapist identifies during training – often without being fully aware of how these assumptions shape understanding and perception, as well as the diagnostic and therapeutic decisions that follow.

The methodology and interpretation of research on the effectiveness of psychotherapy and changes occurring in patients are deeply intertwined with ontological assumptions about human nature, including the conceptualisation of health and mental disorders

When a patient's functioning is conceptualised within a positivist and empirically realist framework, the therapist is guided by principles of objectivity and deductive logic. In contrast, when the guiding framework is constructivist or social constructionist, which, in its extreme formulation, holds that individuals do not have direct access to reality but instead construct it, the therapist attends to the mental processes through which the patient generates their reality across different social contexts (Raskin, 2002; Richert, 2003; Zwierżdżyński, 2012). While empirical realism and certain constructivist tenets are present in positivist psychology and psychopathology, social and linguistic constructionism are most prominent in systemic and feminist therapies, gender

studies (Cierpiałkowska, 2006; Józefik, 2016) and narrative therapies (Richert, 2003; Soroko, 2008). In general, these concepts assume that constructs such as health and mental illness are products of either the mental processes generated within the nervous system or social discourse. Here, reality is not only experienced through language but is constructed by it, with the mind shaping reality into narratives, descriptions, and interpretations (Józefik, 2016; McAdams and Janis, 2004; Soroko, 2008). Consequently, from a social constructivist perspective, mental health is a socio-mental construct – a narrative formed under the influence (or pressure) of society and culture, then internalised by the individual. In contrast, from the perspective of positivism and empirical pragmatism, health is a "mental entity" (Guyon et al., 2018), identified through empirical research and indicators of an individual's biological, psychological, and social functioning. Predictably, these two approaches differ fundamentally in their research questions and methodologies, making the results of psychotherapy effectiveness studies difficult to compare. In the positivist approach, which appeals to empirical realism, mental health is treated as a real entity. Research questions focus, for example, on the objective determinants of health and the relationships between risk factors and individual or environmental resources that protect health or increase the risk of its loss. Furthermore, such studies are typically quantitative, involve large groups of participants, and rely on statistical analysis, emphasising the importance of replicability. The constructivist approach, however, poses broader questions about the lived experience of health and the impact of social pressures and constraints (e.g. 'What does health mean to you?' or 'How do you experience it?'). This research is primarily qualitative, and the resulting material (narratives) undergoes phenomenological analysis to uncover individual and socially negotiated symbols and meanings (Anderson and Goolishian, 1992; Carr, 1998). In narrative therapy, the patient or client is encouraged to challenge (deconstruct) internalised constructs of mental health and to construct definitions of self and health that feel more authentic to them (Carr, 1998). Ultimately, the choice of ontological assumptions dictates the methodological framework and determines which conclusions are deemed valid for understanding the effectiveness of psychotherapy.

HOW IS CHANGE DEFINED IN PSYCHOTHERAPY?

Change in psychotherapy is defined in many ways, which reflects both the theoretical and practical assumptions of a given therapeutic modality and the methodology of research – particularly the types of questions posed and the ways in which indicators of change are operationalised

The aim of every psychotherapy is to achieve a change, agreed upon by the patient and the therapist, in the intrapsychic domain or in behaviour – one that leads to improved psychological functioning and greater well-being compared to the period before therapy began. Therapeutic change is a construct with multiple meanings, which becomes particularly evident depending on whether it is described as a process occurring in the interaction between therapist and patient – based on a specific mechanism of change – or as a partial or final outcome of therapy. It may therefore refer both to the very process of change within the therapeutic relationship, activated through particular techniques, strategies, or procedures, and to the results of these interventions, manifested in intrapsychic or behavioural changes. Research focused on describing the process of change (including studies on mediators that allow the identification of mechanisms underlying observed effects) addresses different research questions than studies examining therapy outcomes understood as the effects of specific interventions. Current research on the process of change most often explores questions concerning the dynamics of the therapist–patient relationship, especially the determinants of the strength of the therapeutic alliance and its influence on the changes achieved by the patient (e.g. Cierpiałkowska, 2023; Kazdin, 2009). Studies that are relatively difficult to conduct, yet more promising for understanding the course of change in therapy, are undertaken less frequently. These focus on micro-analyses of sequences – that is, the chronological chain of the patient's reactions to successive therapeutic interventions. Identified "intervention–patient reaction" sequences and their effects, expressed as the presence or absence of observable change in the patient, explain how change unfolds in the therapeutic process and what constitutes its essence. Unfortunately, "intervention–outcome" studies still dominate, leaving the process and nature of change inside a "black box" (Clarkin et al., 2015; Elliott, 2010).

A review of research on change as an outcome of therapeutic interventions shows that it is a highly complex construct, analysed and defined depending on the adopted perspective and criteria. In psychotherapy modalities grounded in positivist and empirical-realist assumptions, change is defined in various ways, using both single indicators and sets of indicators referring to the following levels of change in the domain of mental health:

- A positive or negative definition of health – within health psychology and positive psychology, the focus is on happiness and life satisfaction, whereas in clinical psychology and psychiatry, the emphasis is on the absence of mental disorder symptoms and associated suffering.
- Change in behaviour and individual functioning across various life spheres and social roles, which are characteristic of specific developmental stages within the life cycle.
- Change on an intrapsychic level, encompassing three distinct dimensions: structural (involving changes in personality traits or core aspects of the personality), functional (relating to the mutual dependencies and interactions between these traits or aspects), and dynamic (concerning the stability or fluidity of various personality

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aspects activated by internal or external factors as manifestations of health).
- Change: (a) at the biological level and in brain functioning (e.g. the tendency to activate different neurotransmitter pathways, the frequency of high-amplitude delta waves occurring at 1–4 Hz, or changes in temperamental traits); (b) at the environmental level in which the individual has functioned since childhood (e.g. leaving an abusive family); (c) at the intrapsychic level – involving mental-affective representations or personality aspects (e.g. a shift in the hierarchy of attachment representations activated in relationships from an insecure to a secure attachment).

Beyond the question of the nature of change and its various forms, it is also crucial to consider that several individual and social entities may be involved in its definition; change may be understood differently depending on who is evaluating it. In the tripartite model of mental health and psychotherapy effectiveness (Stricker, 2012; Strupp and Hadley, 1977), the necessity of incorporating three perspectives is emphasised: the patient, the therapist, and society (including the family as well as institutions and insurance companies). Each of these groups relies on distinct criteria and indicators for mental health and treatment outcomes. Furthermore, questions have arisen regarding which criteria should guide the evaluation of treatment outcomes – and what it signifies when research results indicate contradictions or alignment between these three parties in their assessment of achieved changes. Patients expected change in the form of a sense of well-being and stability in fulfilling social roles. Families and insurance companies sought greater adaptation, more efficient social functioning, and the predictability of behaviour. Meanwhile, professionals employ both objective indicators, such as changes at the personality level, and subjective ones, such as improved mood. It follows that the evaluation of psychotherapy outcomes must account for a multiplicity of perspectives and criteria, and the very concept of "change" necessitates interpretation in relation to the party performing the assessment (cf. Cuijpers, 2019).

Therapeutic change can be investigated as a single aspect – such as a personality trait or a specific symptom – as well as a set of interrelated symptomatic and structural indicators

The effects of psychotherapy conceptualised within positivist approaches – namely cognitive behavioural therapy (CBT), psychodynamic psychotherapy, humanistic therapy, and various integrative therapies – focus on measuring highly diverse indicators. Each of these approaches is characterised by its own epistemology of health and disorder, and each describes and explains them differently, both at the level of observable manifestations in individual functioning and at the structural-dynamic and epigenetic levels. For example, in CBT, descriptive assessment often focuses on estimating an individual's adaptive capacities in a changing environment, whereas in transference-focused psychotherapy (TFP), the emphasis is on evaluating the capacity for love (including sexual intimacy) as well as the capacity for work and rest. At the structural-dynamic level, the CBT approach examines changes in maladaptive beliefs and cognitive distortions in information processing. In contrast, TFP focuses on various aspects of personality, such as the sense of identity, the capacity for reality testing, and the control of aggressive and sexual impulses. Investigating changes at the intrapsychic level, particularly the structural dimension, is more challenging and sophisticated than assessing mere symptomatic improvement. Nevertheless, when evaluating therapy effectiveness, improvements from both perspectives – symptomatic and structural – must be taken into account. It has been observed, for example, that patients with anxiety and depressive disorders who receive only symptomatic treatment tend to have shorter periods of remission and more frequent relapses (cf. Leichsering et al., 2018). If research is limited solely to assessing changes in the intensity or occurrence of symptoms, there is a higher probability that the results will be overestimated due to systematic procedural errors and bias in interpretation – a point corroborated by meta-analyses of therapies focused on symptom reduction (Cuijpers, 2019).

Treatment outcomes are analysed not only through individual indicators but also via sets of complex measures observed at various stages of the therapeutic process. A single change resulting from psychotherapy represents only a fragment of the broader landscape of shifts that may be captured or overlooked in any given study. Placing such a change within the wider context of other desired outcomes prevents cognitive distortions when evaluating the overall effectiveness of psychotherapy. For example, the International Consortium for Health Outcomes Measurement (ICHOM) (Prevolnik Rupel et al., 2021) has outlined a standard set of treatment outcomes for patients with personality disorders. This set encompasses four broad categories of criteria including mental health (e.g. suicidal ideation, emotional dysregulation), behaviour: (e.g. self-harm, impulsivity), functioning: (e.g. interpersonal relations, self-care), and recovery: (e.g. quality of life, sense of belonging).

Empirical verifications of psychotherapy outcomes currently focus primarily on: (1) the analysis of the change process across various modalities, with a particular emphasis on the interaction between specific and common factors, and their influence on the emergence of desired phenomena at successive stages, as well as on the final therapeutic outcome (Crits-Christoph and Gibbons, 2021; Wampold and Imel, 2015); (2) the effectiveness of strategies and procedures within a given therapeutic modality when working with new patient groups (distinct from those for whom the therapy was originally developed) in terms of age, gender, socio-cultural background, or diagnosis (e.g. research into applying dialectical behaviour therapy to issues other than borderline personality disorder) (cf. Dubose et al., 2019); (3) changes in the effectiveness of a known and partially verified therapeutic modality after introducing new therapeutic interventions into standard strategies and procedures (e.g. in CBT, examining the impact of incorporating mindfulness-based stress reduction techniques

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for individuals with anxiety or depressive disorders) (MacKenzie and Kocovski, 2016); (4) the effectiveness of selected configurations of therapeutic strategies and interventions derived from different modalities and applied within various integrative therapies (e.g. Zarbo et al., 2016).

The patient perspective confirms the need to think of therapeutic outcomes as complex and multidimensional. Zavlis et al. (2025), drawing on a meta-analysis of 177 qualitative studies regarding patient experiences (Ladmanová et al., 2025), categorised distinct types of change into three overarching domains. According to the researchers, these domains correspond to the three fundamental goals of psychotherapy: the capacity for love (understood as an improvement in relationships with oneself and others, characteristic of psychodynamic and systemic approaches), work (the development of coping skills typical of CBT), and meaning (associated with emotional stability and the search for significance, emphasised in humanistic and mindfulness-based approaches). According to the authors, this indicates an alignment between the goals of psychotherapy and what patients consider the most important treatment outcomes, which may serve as a starting point for an integrated, comprehensive understanding of change in psychotherapy. It must be emphasised, however, that from the perspective of an individual patient, the ultimate measure of therapeutic effectiveness is whether the treatment helped them achieve the change they sought. If a change is observed only by the therapist and not corroborated by the patient, it is likely the result of a discrepancy between the therapeutic goals pursued by each party. It is not uncommon for a discrepancy to arise between the therapist's conviction that they have applied an optimal, protocol-consistent intervention or procedure and the unsatisfactory results obtained, such as a lack of improvement or even the patient's decision to discontinue therapy. When there are insufficient resources to reflect on the source of such failures, disappointment and a reluctance to examine the issue further can set in. Yet it is precisely a reflective stance – and the capacity to tolerate uncertainty at critical moments in psychotherapy – that allow difficulties to be treated as a natural part of the process. They become signals that call for reconceptualisation and the creative adaptation of techniques to the specific patient and the dynamics of the therapeutic relationship (e.g. Constantino et al., 2013, 2020; Owen and Hilsenroth, 2014).

WHAT KNOWLEDGE ABOUT THE EFFECTIVENESS OF PSYCHOTHERAPY DO RESEARCH FINDINGS PROVIDE, AND WHAT COMPETENCIES ARE NEEDED TO MAKE USE OF THEM?

EBP encompasses three distinct components and the relationships between them, rather than a single one – namely, research findings on the effectiveness of a given method

Following the pathways established in medicine, the American Psychological Association formulated a definition of evidence-based psychological practice that consists of three elements. According to this definition, EBP is the integration of the best available research findings (element 1) with the clinical competencies of the practitioner (element 2), in the context of the individual characteristics of the patient, their preferences, cultural background, and the circumstances that brought them to seek help (element 3).

Research findings span multiple domains that bear on the effectiveness of psychotherapy, including method (the application of a specific intervention), the therapeutic relationship (e.g. the significance of the therapeutic alliance), characteristics of patient (e.g. the level of mentalisation), and the therapist (e.g. the capacity to engage in conversations about alliance ruptures or resistance). Research is conducted across each of these domains, most often independently, by different research teams that rarely combine several of them (e.g. Keefe et al., 2021; Wibbelink et al., 2022), and full integration of this vast body of knowledge remains a distant goal. As a result, clear guidance and a coherent conceptualisation of how to effectively integrate the three core components of EBP are lacking. Moreover, in public discourse it is typically empirical data on method that takes centre stage as the primary marker of scientific rigour and of an intervention's credibility (American Psychological Association, 2021; Berg, 2019; Willemsen, 2022). As a result, "research findings" are often reduced to evidence of method efficacy, while findings on common factors – including the characteristics and competencies of the psychotherapist, as well as the preferences and qualities of the patient – are left aside.

From the perspective of the psychotherapist and their competencies, research focuses, on the one hand, on estimating the importance for treatment effectiveness of specific competencies resulting from training in a chosen modality, as well as interpersonal and communication skills. On the other hand, research aims to determine the impact of the interaction between the therapist's competencies and the patient's traits and attributes, and their significance for the course of the relationship and the therapeutic alliance. Examples include meta-analyses examining the associations between the therapeutic alliance and treatment outcomes (Flückiger et al., 2018), as well as studies demonstrating the benefits of repairing alliance ruptures (Eubanks et al., 2018). Despite solid evidence, routine assessment of the alliance is still uncommon both in clinical training programs and in everyday therapeutic practice. Training focused directly on working with the therapeutic alliance is similarly rare.

From the perspective of the patient and their individual characteristics, research findings encompass an extensive body of knowledge on the effectiveness of psychotherapy for individuals presenting with a wide range of psychological problems, mental disorders, or behavioural difficulties. Considerable knowledge exists regarding the impact of sociodemographic and socio-cultural variables on psychotherapy effectiveness, as well as the role of personality traits and characteristics (e.g. attachment style). This also extends to the course of treatment and the history of presenting

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difficulties, such as medical history, age of onset, the presence of comorbidities beyond the currently dominant or patient-identified disorder, recurrence frequency, and the history of prior treatments or premature terminations (e.g. Constantino et al., 2018; Piper et al., 2011).

A crucial task for a psychotherapist conducting a specific process is to identify these various domains of research findings and verify which of them should be considered and applied, at what point in the therapeutic relationship, and for which particular patient.

Diverse types of research are necessary to address various clinical questions, and a comprehensive picture can only be achieved by integrating multiple perspectives

Evaluating and applying research findings is one of the key competencies of a clinician. However, this task is far from simple given the diversity of study types, their varying levels of credibility and methodological complexity, as well as the frequent inconsistencies – or even contradictions – found in their conclusions. Developing this competency is supported by an understanding of the status of different kinds of studies, their limitations, and their potential applicability within a specific therapeutic relationship. In scientific research, a hierarchy of evidence is used as an attempt to answer the question of which type of study should be considered the most reliable for assessing psychotherapy effectiveness. Although such a system has organisational value, it also has serious limitations. At the top of the hierarchy are randomised controlled trials (RCTs) and their syntheses, that is, meta-analyses and meta-analyses of meta-analyses (umbrella reviews). Lower in the hierarchy are other types of studies, including observational studies, qualitative studies, and case studies. One of the myths about psychotherapy research that is increasingly being challenged is the belief that RCTs constitute the sole and definitive method for measuring the effectiveness of psychotherapy. This myth originates from Cochrane's publication (1972), in which a new standard for medical practice was proposed: making clinical decisions on the basis of RCT results. These studies were regarded as a method free from systematic errors and biases that could distort clinical inference. The aim of randomisation is to compare two (or more) groups that are as similar as possible with respect to all relevant variables, with one group receiving the intervention and the remaining groups serving as controls. This design makes it possible to attribute observed differences in outcomes specifically to the studied intervention. Over time, however, it became clear that efficacy (explanatory) studies conducted under strictly controlled conditions are not sufficient for achieving the broader goal of formulating practical recommendations about which psychotherapy should be offered to a particular patient in a specific clinical context (Cierpiałkowska, 2016). This is due to the limited generalisability of such studies, as the conditions of RCTs often differed substantially from the realities of everyday therapeutic practice and therefore exhibited low external validity. Although in theory many approaches may be effective when applied under favourable conditions, in practice the details matter most – the differences not only between patients but also between therapists. It is well known that therapist effectiveness varies both inter-individually (i.e. therapists differ from one another) and intra-individually (the same therapist may achieve varying effectiveness when working with different patients) (Werbart *et al.*, 2018) – yet efficacy-type studies have rarely accounted for this variability. In response to these limitations, researchers began to develop pragmatic (effectiveness) studies conducted in naturalistic settings, which consider not only the success of an intervention but also its cost-effectiveness, the availability of human resources, and the real possibilities of implementing research findings across diverse clinical contexts. The distinction between efficacy and effectiveness highlights the important difference between studies conducted under strictly controlled conditions and their application in clinical practice. While the deliberate simplification of complexity is methodologically justified in efficacy research, transferring such simplifications into everyday therapeutic work may lead to a deterioration in the quality of care. In other words, interventions deemed "effective" within the efficacy model may display varying levels of effectiveness depending on the context in which they are implemented. In line with recommendations emerging from the field (Kramer et al., 2022; Rief et al., 2024), the most recent RCTs are increasingly moving away from the older, simplified model and now encompass not only considerably more diverse patient populations but also progressively more complex methodological strategies (e.g. Abeditehrani et al., 2025; Briganti et al., 2024). Growing emphasis is also being placed on transdiagnostic and process-based approaches (Dalgleish et al., 2020; Hayes et al., 2017), which means that new generations of RCTs do not merely test the efficacy of interventions but also allow for the investigation of mechanisms of change and contextual factors. Although this line of development is promising, the evidence base is still emerging, and existing studies – grounded in earlier, simplified models – provide only limited guidance for practical clinical recommendations.

Another important element in the discussion of the weight of different forms of evidence in psychotherapy research is the shift from a nomothetic approach (based on generalisations derived from studying large groups) to an idiographic one (focused on the individual patient and their trajectory of change). While large-sample studies yield knowledge about average effects, every clinician makes decisions in relation to a specific patient, not an averaged "statistical case". Therefore, group-level findings cannot be mechanically transferred to the individual without risking inferential errors (so-called ecological fallacies) (Schwarzbach et al., 2025). It is the individual histories of patients (with their unique genetic, temperamental, personality-related, somatic, and environmental conditions) that reveal the

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complexity of the therapeutic process. For this reason, there is a growing body of research tracking the individual course of change in single patients and identifying subgroups of individuals following different recovery trajectories, including within the context of randomised trials (e.g. Abeditehrani et al., 2025; Baelemans et al., 2025). In response to these needs, newer and more complex research methods are being employed, such as diary studies and case studies, as well as idiographic and network-based approaches (for example personal-social-network analysis) (e.g. Cain et al., 2025; Meehan et al., 2023). This shift also relates to a growing awareness of the limitations stemming from the dominance of quantitative methods over qualitative ones in psychotherapy research. Historically, this trend emerged from mimicking the medical science model, which reinforced a narrow understanding of scientific research, focusing primarily on prediction, control, and statistical testing – in line with the assumptions of empirical realism. Currently, the need to integrate quantitative and qualitative methods is increasingly emphasised in order to obtain a fuller picture of therapeutic outcomes, including from the perspective of patients' subjective experiences (Levitt et al., 2025). A debate is ongoing within the research community about what the hierarchy of evidence in psychotherapy research should look like today. For example, Levitt et al. (2025) propose moving away from a hierarchical model in favour of a pluralistic, circular conception of knowledge in which qualitative research does not merely "illustrates" but also initiates the process of scientific inquiry into the effectiveness of psychotherapy. Within this framework, qualitative research is treated as equal in standing and indispensable to the interpretation of efficacy findings, since it provides data on processes and meanings that cannot be captured through quantitative methods.

In sum, the practising clinician cannot rely solely on the findings of efficacy-type studies. Although their newer versions (enriched with more complex methodological strategies and with transdiagnostic and process-oriented approaches) now offer valuable insights into psychotherapy effectiveness and mechanisms of change, these approaches are still relatively new, and the accumulation of this type of evidence has only just begun, limiting the possibility of drawing definitive conclusions for clinical practice. To obtain a complete picture, it is therefore necessary to consider effectiveness studies conducted in naturalistic settings, as well as qualitative research and case studies. The hierarchy of evidence, which for years has served as the basis for EBP recommendations, now requires some degree of reconceptualisation – or at least more cautious use, accompanied by awareness of its limitations.

We continue to struggle with the lack of integration between science and practice

In practice, the science-to-practice gap (i.e. the unsatisfactory transfer between research and clinical practice) continues to pose a significant challenge, limiting the realisation of EBP's full potential (Lilienfeld, 2019; Schwarzbach et al., 2025; Willemsen, 2022). The shift from the concept of empirically supported treatments to EBP was intended as a step towards a more inclusive model of best clinical practice. Yet many of the problems surrounding the integration of research and practice have remained unresolved (Berg, 2019). A further transition – from EBP to evidence-informed practice – may perhaps offer a way forward. Ultimately, the distance between science as defined within EBP and therapeutic practice remains considerable. At the current stage of development, research can support therapists in their day-to-day work, but rarely provides a clear answer to the question "what should I do now with this patient?" (cf. Leibovich and McCarthy, 2025). In this context, participatory approaches are gaining increasing prominence – those that involve close collaboration between researchers and practitioners and that engage individuals with lived experience as experts (e.g. Chevance et al., 2020). This allows research questions to be better aligned with the real needs of patients and the therapeutic community, and more firmly grounded in actual clinical conditions (e.g. Renneberg et al., 2024). Such initiatives support the development of knowledge that is useful to both science and practice, with the overarching goal of improving the quality and fit of treatment methods. Involving practitioners and patients in the research process enhances the validity and clinical utility of findings, facilitates implementation, and strengthens the broader social impact of the research conducted. This involvement is increasingly regarded as a component of the standard of high-quality research into the efficacy and mechanisms of psychotherapy (Rief et al., 2024).

Research findings can only be of use when thoughtfully applied by a psychotherapist drawing on continuously developing clinical competencies

Due to the lack of integration at the research level, combining findings with patient characteristics and therapist competencies can only be performed by a specialist. Therefore, every practitioner must step into the role of an expert and independently assess these three aspects when planning an intervention. If this internal integration within the psychotherapist's mind is omitted, there is a risk of a simplified application of EBP, limited to the mechanical implementation of research results, without considering the specific patient's context or reflecting on one's own clinical competencies. Consequently, expert judgement becomes essential for translating the best available evidence into therapeutic practice. Science formulates generalised statements describing effects, whereas the practitioner interprets and applies these results within a specific clinical context, drawing upon other competencies as well. Moreover, as the definition of EBP makes clear, the values and preferences of the patient must be taken into account in the treatment process,

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and the patient should be actively involved in decisions concerning treatment and the setting of therapeutic goals. This requirement further underscores the distinction between the efficacy of methods and their clinical utility in individual cases, since the applicability of a given intervention may be limited in patients with a complex clinical presentation or where expectations cannot be reconciled (e.g. treating symptoms of emotional disorders without addressing a co-occurring addiction).

TOWARDS PERSONALISATION

The question is no longer which modality is more effective, but what works for whom* – and why?

Expressions of dissatisfaction among therapists regarding the practical usefulness of available research findings prompted researchers to seek solutions that would better meet practitioners' expectations. Various concepts and research models focused on personalisation (also referred to as patient-centred research) are emerging, attempting to move beyond the tension between standardised therapy models and the individual needs of the patient. Treatment personalisation involves tailoring interventions to the unique characteristics and social context of a specific individual, rather than applying a 'one-size-fits-all' model. Generally, depending on the area of interest and methodology, two research directions aimed at optimising the outcomes and treatment process for individual patients can be distinguished.

The first direction attempts to identify moderators and mediators that may influence the results of therapies with proven effectiveness. Moderators are variables present prior to the start of treatment that influence its final outcome and allow for the identification of patients who are highly likely to benefit from, or fail to respond to, a specific type of therapy. Mediators, in turn, explain how an intervention leads to change – they form the basis for identifying the mechanisms of change and key elements of the therapeutic process. Research is currently being conducted and new models are being developed to answer questions about the impact of moderators on effectiveness and how mediators modify the therapy process (Huibers et al., 2021; Spielmans and Flückiger, 2018). Nevertheless, knowledge about the moderators and mechanisms of change underlying successful psychotherapeutic interventions remains limited. In response to these limitations, research methodology is being modified to better address these key questions. Among the proposals are: (a) determining the influence of sociodemographic factors (such as age, gender, ethnic background, and disability) on the effectiveness and implementation of interventions, and identifying the conditions under which given interventions produce positive or limited outcomes (the question of moderators); (b) investigating transdiagnostic mechanisms of change (the question of mediators); (c) developing an evidence base to support therapeutic decisions tailored to the individual characteristics of the patient; and (d) developing methods that enable analysis of the interaction between social context and the course of therapy (Kramer et al., 2022). Although the findings to date appear promising, the number of studies of this kind remains limited, owing to their high methodological demands, conceptual complexity, and cost (Fuertes and Nutt Williams, 2017). Study samples need to be sufficiently large to allow moderators and mediators of change to be analysed with adequate statistical power. Achieving this requires large-scale, multicentre research designs, which frequently entail substantial costs, posing a significant financial and organisational barrier. At the same time, increasingly sophisticated research designs are being employed – for example, studies investigating mechanisms of change from an integrative perspective that encompasses both the psychological and biological correlates of the treatment process, alongside the use of complex methodologies for measuring therapeutic outcomes. These include longitudinal measurement approaches such as ecological momentary assessment and experience sampling methodology, detailed personal-social-network measurements (Stadel et al., 2024), methods targeting specific difficulties arising in therapy, and case studies capable of capturing the complex dynamics of individual therapeutic processes.

A second line of research focuses on the analysis of significant positive or negative events in the therapeutic process (where an "event" is understood as a specific intervention or occurrence within the therapeutic relationship), as identified by patients, therapists, and observers. Such studies are typically qualitative or mixed-methods in nature (Elliott, 2010; Hill and Norcross, 2023) and draw on participatory research methodology. Once positive or negative events have been identified, the sequences of patient responses to therapist interventions are analysed, most often in an interpersonal context linked to fluctuations in the therapeutic alliance. Analysis of intervention-response sequences and their desired and undesired effects reveals which chronological patterns of intervention, and in which patient groups, contribute to alliance repair, and which lead to further alliance disruption – including, in some cases, complete rupture and premature dropout (Eubanks et al., 2018, 2019).

Both lines of research allow for a richer description and explanation of the complexity of therapeutic processes, thereby increasing the likelihood of achieving lasting, meaningful, and desired changes. In line with the rationale behind personalisation, every psychotherapy works, but it produces different outcomes in patients who differ in their mental-health status (e.g. those with a single diagnosis versus those with comorbid conditions) or who live in different socio-cultural contexts. There remains a long road ahead to

* *What Works for Whom?* is the title of a book by Peter Fonagy and Anthony Roth, published in 2005.

a full understanding of what works in psychotherapy, how it works, for whom, and why. Our knowledge of these processes remains fragmentary and calls for further, complex research.

Research findings serve as a guide for reflective application within a specific patient–therapist dyad, rather than a guarantee of therapeutic success

Findings from research on therapeutic change (to the extent that they can be generalised) provide overall guidance for maximising the likelihood of successful psychotherapy but do not guarantee an effective therapeutic process within a given patient–therapist dyad. Placing research findings above careful observation of the scope of change (or its absence) in the patient, which falls within the domain of the therapist's clinical competencies, increases the risk of failure due to the therapist's cognitive biases (APA Presidential Task Force on Evidence-Based Practice, 2006). Research findings provide a basis for planning interventions but do not guarantee the outcome of any given intervention. For this reason, it is important that they are processed reflectively by the therapist rather than taken literally and concretely. Such an approach presupposes working with the patient in a way that requires tolerating uncertainty.

Methodological and statistical competencies are sometimes insufficient when gaps in research are encountered. In such cases, reflexivity and tolerance of uncertainty prove essential

EBP assumes that a specialist, understanding the value of various research findings, uses the best available scientific evidence as a starting point rather than the sole determinant for intervention planning. Evidence-based psychotherapies should be viewed as a "map" of potential treatment paths, from which the therapist selects the appropriate one, taking into account the patient's individual dispositions and circumstances. At the same time, rigid adherence to protocols can produce adverse effects. Consequently, the "flexibility within fidelity" model is recommended: therapists maintain commitment to core therapeutic principles while adapting techniques to the needs of the specific case. This is particularly vital in situations where data are insufficient to formulate clear recommendations. For example, if efficacy studies exclude patients with comorbidities, physical illnesses, or those from minority groups – as well as patients in precarious life situations or those struggling with severe stressors – the effectiveness of the intervention within these populations is undermined. This underscores the continued importance of fundamental EBP training and the systematic updating of clinical knowledge. In the education of psychotherapists, it is worthwhile to include not only a robust introduction to scientific research and methodology but also the active promotion of collaboration between researchers and practitioners. Such cooperation facilitates an exchange of experience, mutual learning, and the cross-pollination of clinical and scientific knowledge. It also fosters a dialogue that respects the realities of day-to-day therapeutic work while helping to formulate research questions that are both relevant and practically useful. Above all, however, the key competence that research training should support is the capacity to tolerate uncertainty as an inherent and inseparable element of therapeutic work.

FINAL CONCLUSIONS

The aim of this article was to demonstrate how a practitioner should and can consciously, critically, and reflectively draw on research findings in their day-to-day clinical work. The most important elements of such a reflective analysis of research are presented in Tab. 1. Central to this process is clarifying what question the therapist wishes to answer in the context of a given patient's treatment, as this determines which aspects of a study deserve particular attention. We propose first identifying the theoretical assumptions underpinning the study. Next, it is important to determine whether the study examined final outcomes or rather step-by-step changes in the therapeutic process, how therapeutic outcomes (that is, change) were defined, and what research methodology and statistical procedures were used. While we have not provided definitive answers to many of the questions raised, we have described our way of thinking about psychotherapy research, which we believe reflects the current state of knowledge in the field. We have shown that a major weakness lies in the lack of an answer to the question of how to integrate knowledge drawn from the best available research with an assessment of the therapist's competencies and the patient's individual characteristics. We feel it is vital to emphasise that fostering reflexivity and the capacity to tolerate uncertainty are core competencies for any therapist striving to reconcile scientific evidence with the realities of everyday clinical practice. We hope to have made a convincing case for this perspective. Our position is that research constitutes an indispensable support for clinical practice, but it must be interpreted in terms of its validity. This requires taking into account the limitations arising from the patient's specific characteristics and the therapist's personal qualities, which the therapist comes to understand through analysing their own work, personal therapy, and supervision. Even the findings of the most rigorous studies are worth approaching with openness and reflection, bearing in mind that there will always be areas that lie beyond their reach. As Leibovich and McCarthy (2025) aptly put it, *the room inside is bigger than it looks from without* – because the process of psychotherapy is richer and broader than what can be measured, and research findings illuminate only a fragment of this complex whole.

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Key areas of reflection relevant to practitioners when interpreting psychotherapy research
While assessing a patient for the most effective treatment, the psychotherapist encounters clinical challenges and, as a result, seeks out evidence regarding intervention effectiveness.
STEP 1 – Defining the clinical question
Clarify the clinical problem: which of the following predominates, or in what proportions do all aspects matter in the difficulties you are encountering? • insufficient adaptation of strategies/techniques and their sequencing to the patient's problem; • patient-side factors (e.g. type of diagnosis, persistent symptoms, comorbidities, ambivalence toward the therapeutic goal, varying levels of mentalisation, preferences); • relational factors (e.g. alliance rupture, negative transference, dropout risk, therapist–patient mismatch); • therapist competencies (e.g. flexibility, reflectivity, responsiveness); • unacknowledged sociocultural context in which the patient functions on a daily basis. → **Look for research that addresses the identified clinical problem.**
STEP 2 – Analysing the theoretical assumptions of the study on psychotherapy effectiveness
What ontological and epistemological assumptions underlie the study and the interpretation of its findings? • positivist (empirical realism) → research uncovers the reality of mental health and the laws governing it on the basis of objective measurement of outcomes; • constructionist → research uncovers a world of sociolinguistic constructs of mental health; on the basis of narrative analysis, the therapist constructs and/or recognises individual and socially negotiated meanings of health. **Are these assumptions consistent with your therapeutic approach and the patient's context?** – Yes → you may proceed to the next step. – No → divergence between the ontological and epistemological assumptions of the study and those of your approach prevents you from making use of the findings.
STEP 3 – Identifying the type of study
What type of study is being analysed? • RCT/meta-analysis → high degree of control; potential limitations in external validity; • naturalistic study (effectiveness) → greater correspondence with practice; less control of variables; • qualitative study/case study → rich contextual detail; limited generalisability. Does the study sample correspond to the characteristics of your patient? Can you reasonably expect a comparable level of effectiveness? What important factors/variables were not accounted for in the study and require further literature searching or reflection on treatment outcomes?
STEP 4 – Definition and indicators of change
• Was change described solely in terms of statistical significance (e.g. reduction in symptom severity on a questionnaire), or was clinical significance also taken into account, such as improvement in daily functioning or reduction in experienced distress? • Did the study incorporate multiple perspectives on change – those of the patient, the therapist, and other objective indicators of functioning (e.g. number of hospitalisations)? • What instruments were used for measurement – only self-report questionnaires, or also more complex methods (e.g. clinical interview, diary method)? • To what extent are these change indicators meaningful for this patient? Do they relate to areas that matter to them and represent a genuine, personally experienced therapeutic goal?
STEP 5 – Evaluating the validity and limitations of the study
• External validity – are the study conditions, participant characteristics, and mode of therapy delivery comparable to your patient's situation? If the differences are substantial (e.g. age, comorbidities, cultural context), the interpretation of findings requires greater caution. • Moderators and mediators – were moderators and mediators of change taken into account? Which ones may have been overlooked, yet are relevant to this patient? • Does the study address the relationship between specific therapeutic factors associated with a particular psychotherapy modality and common factors, such as the therapeutic relationship and alliance, which are shaped by characteristics of both patient and therapist? • Limitations – what weaknesses does the study have according to the authors themselves in the "Limitations" section? To which aspects of reality can the conclusions be applied, and what falls outside the study's scope?
STEP 6 – Triangulation of sources of information
• Triangulation across findings from different studies. Do you have access to different types of research on this topic? – No → seek out additional sources or data. Do not rely on a single study. In your area of interest, examine several different types of studies using different methodologies. Are the findings consistent, or divergent/inconclusive? How can any discrepancies be explained (e.g. population, methodology, cultural context)? • Triangulation in terms of integrating research findings with clinical judgement and data relating to the specific patient.
STEP 7 – Preliminary therapeutic decision
• Data integration: combine the information obtained from research with your own clinical judgement and patient-specific data before arriving at a therapeutic decision and selecting an intervention. • Will you follow an established protocol suited to the patient's situation (whether concerning an intervention matched to the problem within a given paradigm, or concerning common factors, such as difficulties with the therapeutic alliance)? – Yes → apply it with flexibility (flexibility within fidelity). Rely on an understanding of the mechanisms of change rather than on the automatic implementation of techniques. – No → adapt your strategies by integrating research evidence, clinical judgement, supervision, and the patient's unique characteristics and preferences.
STEP 8 – Monitoring and modification: analysing the course of the change process in the context of expected patient responses
Monitor progress and adjust interventions according to the patient's responses across the sequence of interventions. Consider how the patient's responses can be understood in the context of the interventions introduced. • What are the patient's responses to sequences of interventions and strategies characteristic of the specific therapy modality? • Do desirable and disruptive events occur in the course of therapy, and if so, which ones, how frequently, and what meaning do you ascribe to them? • Which interventions or therapeutic strategies at a given stage of therapy raise doubts, or prompt you to consider modification or to question that course of action in light of its disruptive effect on the patient? Include interventions that address common factors. Respond to ruptures in the therapeutic alliance and to shifting therapeutic goals. **If the patient does not respond to interventions in the expected way, systematically return to STEP 1 (i.e. formulating the clinical question within the EBP framework).**

Tab. 1. Key areas of reflection relevant to practitioners when interpreting psychotherapy research – a summary

STEP 9 – Tolerating uncertainty
• Ultimately, the determination of whether research findings are applicable to a given psychotherapeutic process takes place in the therapist's or expert's mind, through the integration of multiple sources of information and experience, rather than in the text of the article presenting those findings. • If the data are ambiguous or insufficient, do not abandon reflection prematurely. Cultivate the capacity to maintain a reflective stance in the face of uncertainty and the absence of clear-cut guidance. • Monitor which questions remain in the domain of uncertainty – that is, which require ongoing attentiveness, reflection, self-analysis, and critical scrutiny of their occurrence and the change processes they generate. • Accept that complete certainty in psychotherapy is not attainable and that clinical decisions are always made under conditions of uncertainty.
END POINT
A clinical decision based on evidence; tailored to the individual patient and their context; supported by a readiness to tolerate uncertainty, to make and correct mistakes, and to continuously monitor outcomes and adjust the intervention accordingly.
Note: The term "step" may suggest an algorithmic mode of proceeding. However, the aim of the authors of this article is to illustrate successive phases and domains of clinical judgement. The individual stages do not form a simple, linear sequence. Depending on the needs, it is possible to return to them, combine them, and treat them as elements of a dynamic decision-making process.

Tab. 1. Key areas of reflection relevant to practitioners when interpreting psychotherapy research – a summary (cont.)

RECOMMENDATIONS FOR INTEGRATING SCIENTIFIC RESEARCH WITH PSYCHOTHERAPEUTIC PRACTICE

The advancement of psychotherapy requires the establishment of systemic conditions that support a genuine connection between science and practice. Consequently, we present the following recommendations intended to better integrate scientific knowledge with clinical practice. These are addressed to policy-makers, legislators, leaders within the therapeutic community, training programme authors, and supervisors. Drawing on the premises and needs outlined in this article, we recommend:

1. **Including psychotherapy research in training programmes**
   Training curricula for psychotherapists should systematically incorporate a module dedicated to the fundamentals of psychotherapy research methodology, the interpretation of findings, and their practical application. This training should draw on both knowledge of specific therapeutic factors and literature addressing transtheoretical, universal mechanisms of change, and should evolve in step with advances in this field.
2. **Strengthening awareness of the EBP status of individual methods**
   Specialists must be reliably informed about the EBP standing of particular therapeutic approaches, with due attention to the complexity, limitations, and nuances associated with the relevant research. This should encompass both empirical evidence and knowledge of its clinical utility.
3. **Increasing public and patient access to knowledge about EBP**
   Accessible educational materials should be developed for patients and those seeking psychological support, explaining in clear terms what evidence-based psychotherapy is, what its principles are, and what factors influence therapeutic effectiveness.
4. **Funding initiatives that bridge research and practice**
   We recommend supporting and funding initiatives that facilitate knowledge exchange between researchers and practitioners – including conferences, seminars, and collaborative projects – as well as creating opportunities for practising therapists to participate in and contribute to research.
5. **Designing clinically useful research**
   There is a need for systematic support of research that moves beyond the question of "does it work?" and focuses instead on "for whom?", "why?", and "under what conditions?" psychotherapy produces results. Of particular importance is research exploring mechanisms of change, diverse recovery trajectories, and instances of non-improvement, deterioration, or premature termination of therapy.
6. **Engaging interdisciplinary teams in the educational process**
   It is worthwhile to involve individuals who combine theoretical and research expertise with clinical experience in psychotherapist training programmes. It is essential that such individuals are capable not only of conducting research, but also of discussing its findings in a manner that is clear and useful to practitioners.
7. **Developing reflective thinking and tolerance of uncertainty**
   A key priority is the cultivation of reflective competencies in therapists and their supervisors. These include an awareness of how the methods they use work and of their limitations, and a readiness to make therapeutic decisions under conditions of uncertainty, when clear guidance or obvious answers are lacking.

Conflict of interest

The authors do not declare any financial or personal links with other persons or organisations that might adversely affect the content of the publication or claim any right to the publication.

Author contribution

Original concept of study; collection, recording and/or compilation of data; collection, recording and/or compilation of data; writing of manuscript; critical review of manuscript; final approval of manuscript. MOJ, LC, DG.

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