

M U N I
F S S

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Psychotherapy
Research

What makes a good therapist



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The psychotherapist

- Traditionally, psychotherapy research has focused more on the study of **psychotherapies**, rather than **psychotherapists**, “as if therapists, when properly trained, [were] more or less interchangeable” (Orlinsky & Ronnestad, 2005, p. 5)
- However, the differences among therapists overshadow the differences among treatments (Luborsky et al., 1986; Wampold, 2001)
- Consequently, researchers are beginning to pay more attention to the person of the therapist (Baldwin & Imel, 2013) and training and supervision (Hill & Knox, 2013)
- Competency movement has been established in psychotherapy and psychology in general (e.g., Kaslow et al., 2004)

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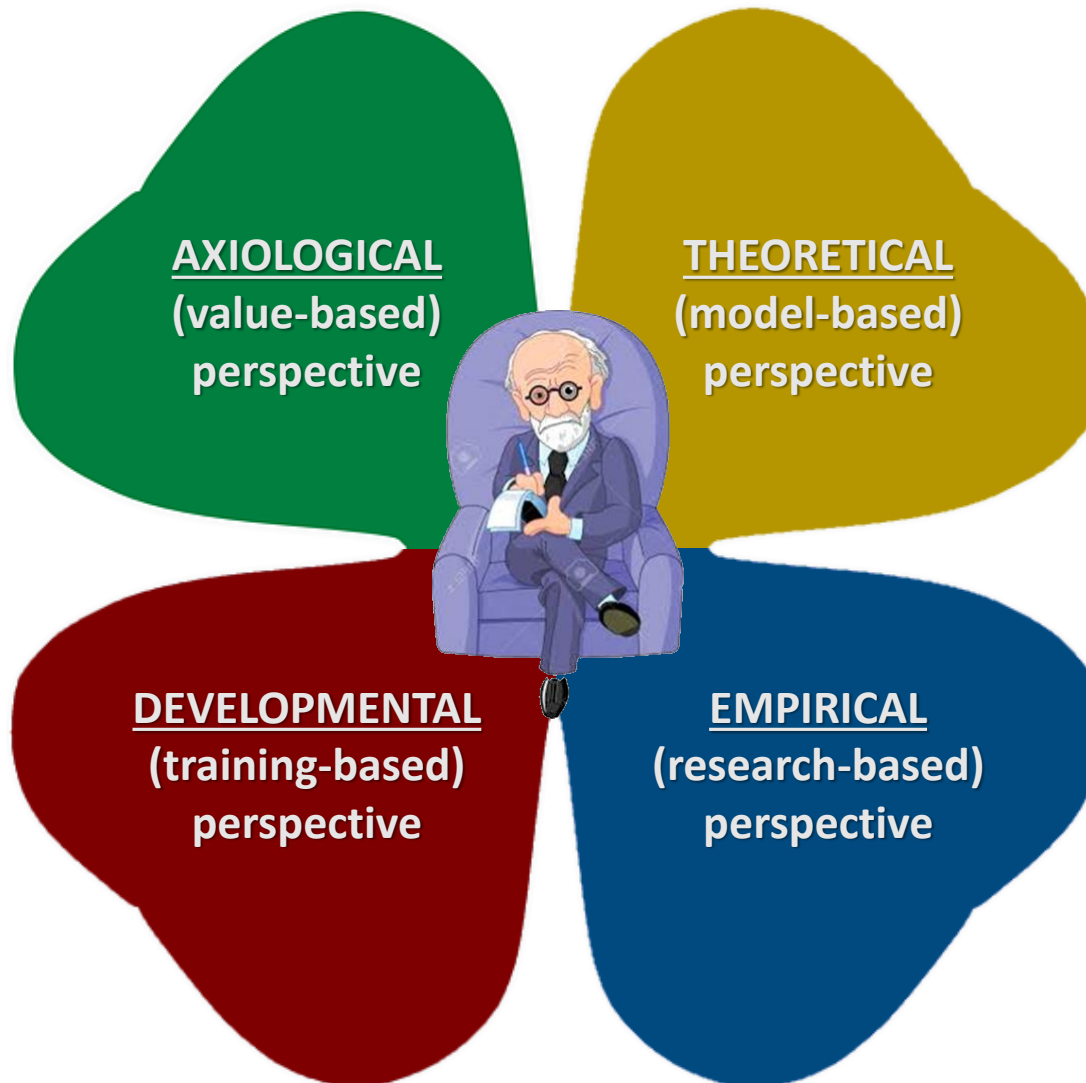
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How can we approach psychotherapist competence?





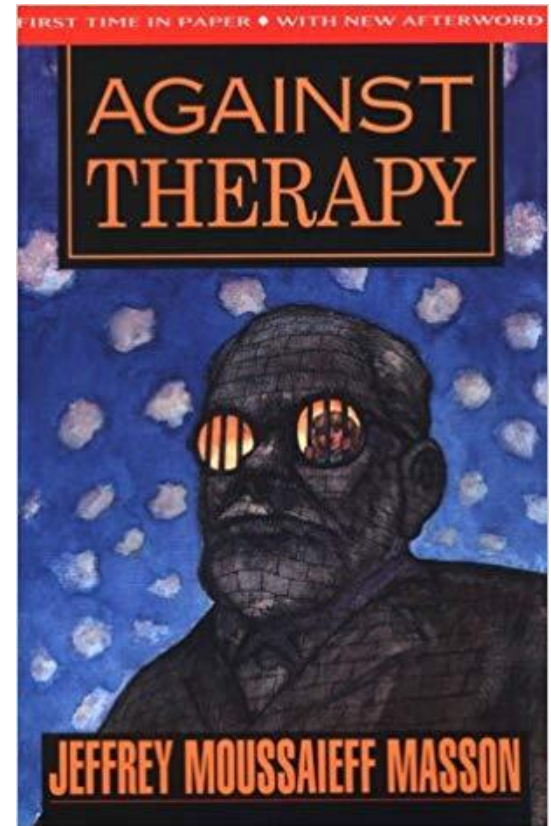
AXIOLOGICAL
perspective

There are principles we (usually) do not question...

Psychotherapists should

- *be responsible for the consequences of their acts*
- *not engage in any practices that are inhumane or that result in illegal or unjustifiable actions*
- *respect the confidentiality of information obtained from clients*
- *refrain from providing misleading or deceptive information*
- *refrain from undertaking any activity that may harm a client*
- ...

Statement of Ethical Principles of the EAP (2002)

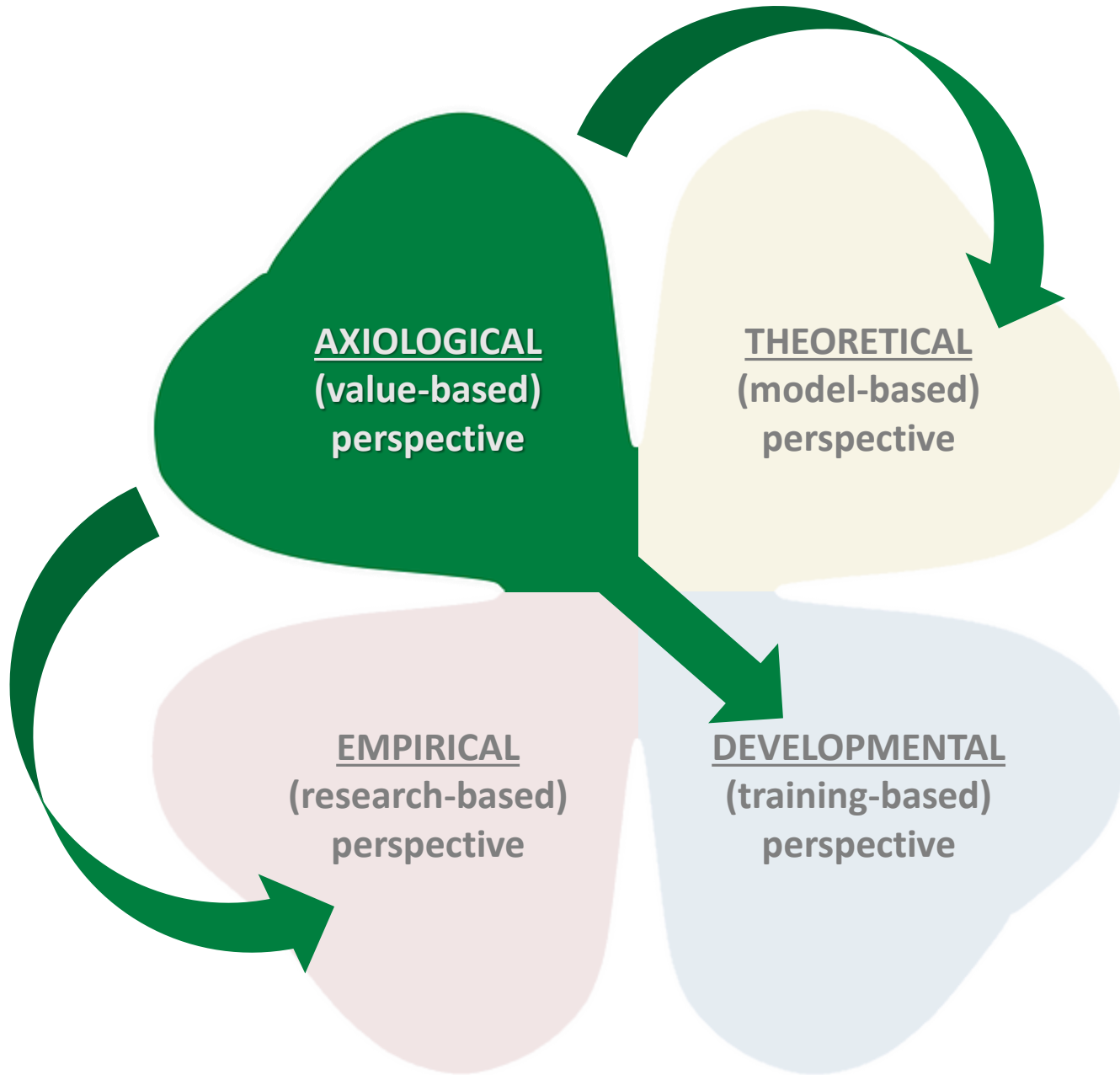


Culture-based assumptions

- Can we use *Ayahuasca* in therapy? (Blainey, 2015; González et al., 2017)
- Can we invoke and tame daemons in therapy? (Benda, 2010; Hájek, 1998)
- Can we use fasting & meditation therapy for the treatment of psychosomatic problems? (Suzuki, 1976, 1979)
- Can we view psychotic states as an expression of spiritual emergency? (Lukoff, 1985)
- ...

Defining “good outcome”

- Symptom reduction (recovery)?
- Ability to make satisfactory relationships?
- Ability to utilize one’s resources/strengths?
- Insight into the origins of one’s difficulties?
- Capability of living one’s life *despite* having a disorder (empowerment)?
- Personal growth (i.e., moving *beyond* the “premorbid” level of functioning, such as in post-traumatic or spiritual growth)?





THEORETICAL
perspective

	SELF-REFLECTION	RELATIONSHIP	ASSESSMENT	INTERVENTION
HUMANISTIC (Farber, 2010)	Self-awareness, use of own subjectivity	Therapists' openness, authenticity, and congruence ; respect for client, emphasis on dialogue	Client as an integrated organism , emphasis on client's experiential world (not history or diagnosis)	Phenomenological self-exploration, presence , needs, repeating patterns, client's experience of the relationship
PSYCHODYNAMIC (Sarnat, 2010)	Ability to contain, observe, elaborate , and utilize one's own emotional, bodily, and fantasy experiences ; accept and process one's needs	Relationship as the agent of change	Whole personality , not just symptoms; conscious and unconscious conflicts, internalized patterns and defenses; use own experience and reactions for diagnosis	Interpretation and engagement in the relationship as inseparable aspects of intervention
CBT (Newman, 2010)	Recognition of scientific basis of CBT and its limits ; evidence-based methods, healthy skepticism	Positive relationship as a condition for change	Scientific attitude : collection of data using reliable and valid methods, formulating and testing hypotheses	Knowledge of many techniques , ability to structure a session and teach skills to a client, directive attitude, balancing manualization and client's individuality
SYSTEMIC (Celano, Smith, & Kaslow, 2010)	Self-experience, exploring therapist's primary family experience	Extended therapeutic relationship (with each family member), the concept of neutrality/balance	Relational case formulation ; awareness of the whole system; ability to adopt perspectives of family members ; primary family patterns, trans-generational transference	Reframing, managing negative interactions, support for cohesion, intimacy, and communication; parental support; support for individual and cultural diversity
INTEGRATIVE (Boswell et al., 2010)	Be aware when particular interventions of type of relationship are ineffective for a client	Breadth and depth of theoretical knowledge, research, and clinical practice; research in client-treatment interaction	Relationship as a factor common across orientations	Multidimensional approach; strengths and limitations of a particular approach; effectively integrate various types of interventions



EMPIRICAL
perspective

Do supershrinks really exist?



Research on therapist effect

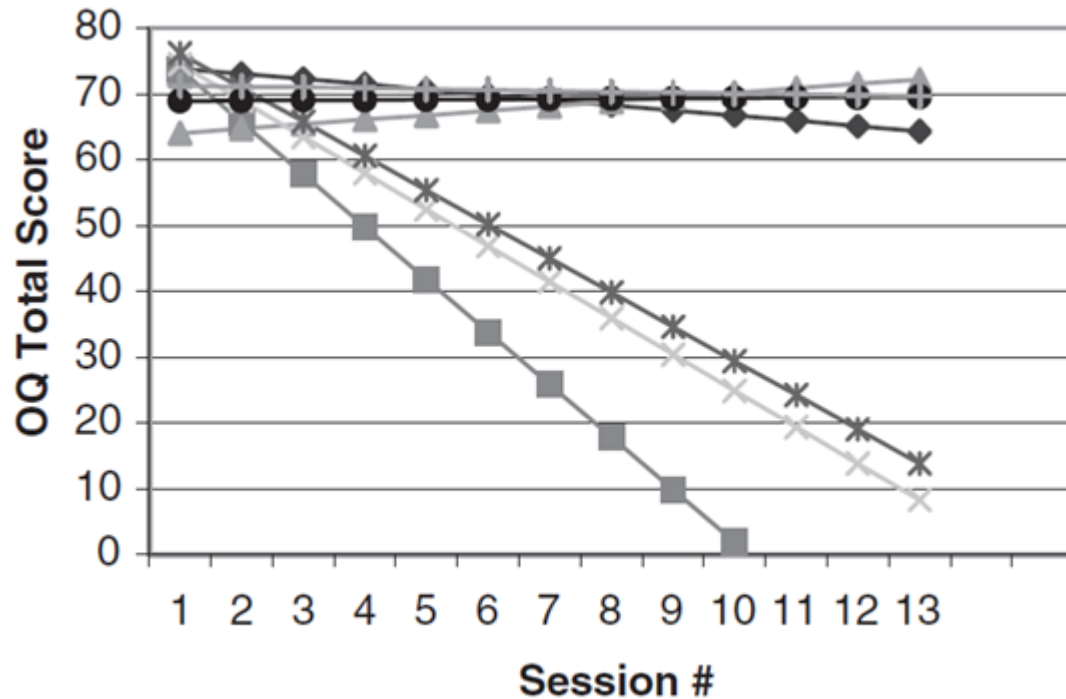
- Data from the *National Institute of Mental Health Treatment of Depression Collaborative Research Program* (NIMH TDCRP) showed that
 - about 8% of the variance in outcomes attributable to therapists
 - 0% attributable to differences between treatments

(Kim, Wampold, & Bolt, 2006)

- Differences between therapists...
 - really exist
 - are reasonably consistent across time
 - are more pronounced in naturalistic settings (**5%** in RCTs vs. **7%** in naturalistic studies)

(Baldwin & Imel, 2013)

Differences among therapists



Three worst therapists
(on average, patients
did not change)



Three best therapists
(on average, patients
improved substantially)

Are “exceptional” therapists exceptional in all areas?

- therapist effectiveness was somewhat domain specific and stable over time (Kraus et al., 2016)

X

- therapists effective (or ineffective) within one outcome domain are also effective within another outcome domain; therapist effectiveness can thus be conceived of as a global construct (Nissen-Lie et al., 2016)
- psychotherapist-related “g-factor” of psychotherapy (Lindgren, Folkesson, & Almqvist, 2010)

How to define

therapeutic expertise?

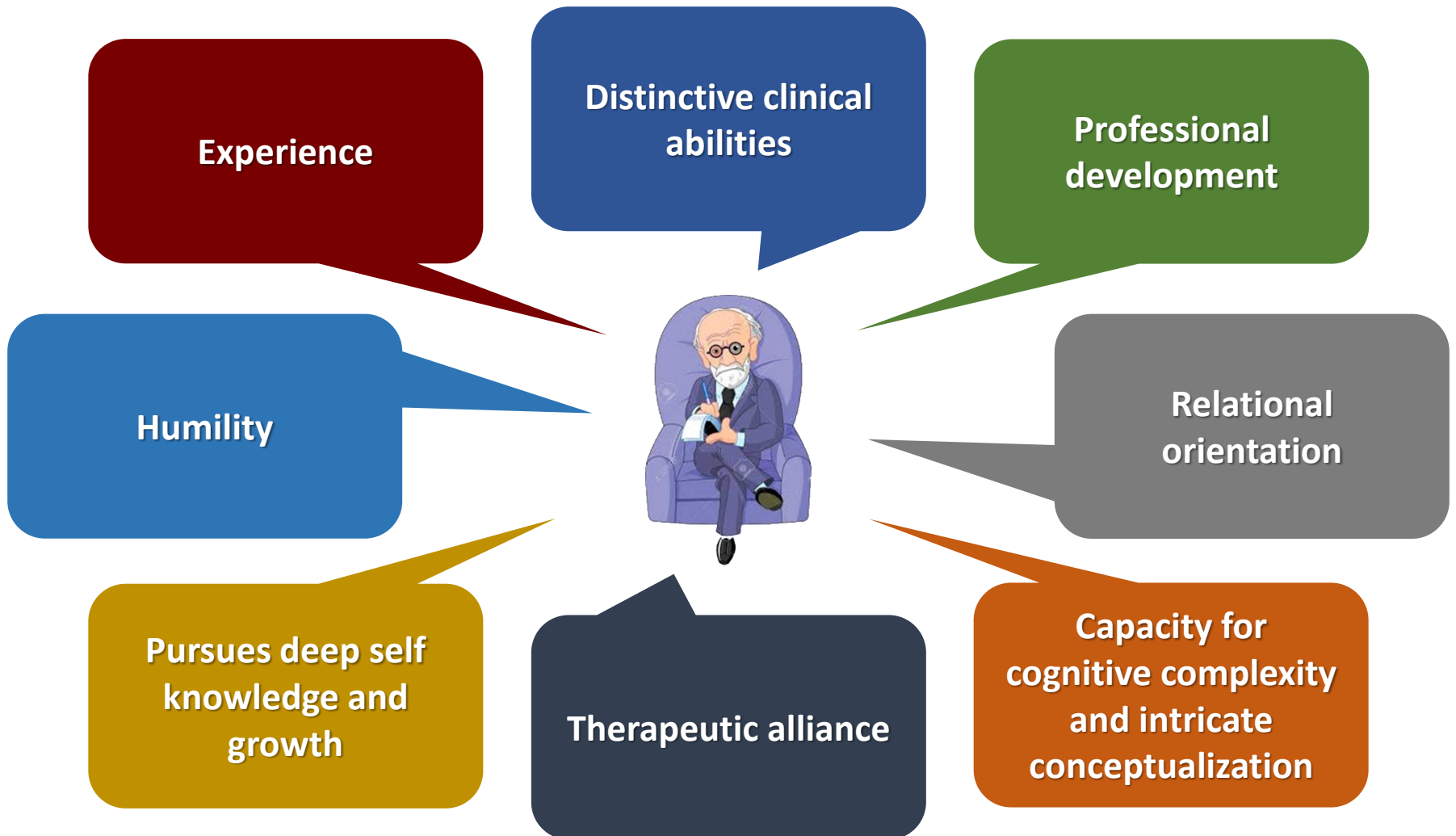
Criteria based on

- **Reputation** (peer-nomination)
- **Performance** (demonstration of skills)
- **Client outcomes** (change measurement)
- Improvement over time

(Tracey et al., 2014)

Reputation:

Studies on master therapists



Paradoxical characteristics

of master therapists

Drive to mastery	AND	Never a sense of having fully arrived
Able to deeply enter another's world	AND	Often prefers solitude
Can create a very safe client environment	AND	Can create a very challenging client environment
Highly skilled at harnessing the power of therapy	AND	Quite humble about self
Integration of the professional/personal self	AND	Clear boundaries between the professional/personal self
Voracious broad learner	AND	Focused, narrow student
Excellent at giving of self	AND	Great at nurturing self
Very open to feedback about self	AND	Not destabilized by feedback about self

Performance:

The role of treatment manuals

What do we know so far?

- Adherence to treatment manuals (protocols) reduces differences among therapists (Crits-Christoph et al., 1991)
- Competence in and adherence to treatment manuals seems to be unrelated to outcome in general (Miller & Binder, 2002; Webb, DeRubeis, & Barber, 2010)
- Strict adherence to protocols might even attenuate therapeutic outcomes (Castonguay et al., 1996; Henry et al., 1993)
- Nevertheless, the debate continues... (e.g., Addis & Cardemil, 2006; Duncan & Miller, 2006)

Client outcomes:

Predictors of the therapist effect

Variables NOT related to outcome

- **Therapists' gender** (Anderson et al., 2009; Okiishi et al., 2003; Xiao et al., 2017)
- **Theoretical orientation** (Anderson et al., 2009; Okiishi et al., 2003; Xiao et al 2017)
- **Primary profession** (Okiishi et al., 2003)
- **Years of training/experience** (Anderson et al 2009; Okiishi et al., 2003; Xiao et al 2017)

Client outcomes:

Predictors of the therapist effect

Positive/inconsistent evidence

- **Severity of patients' difficulties** (Firth et al., 2015; Saxon & Barkham, 2012; problematic: Dinger et al., 2017)
- **Length of treatment** (Goldberg et al., 2016)
- **Caseload** (yes: Firth et al., 2015; no: Anderson et al., 2009)
- **Therapists' age** (yes: Anderson et al., 2009; no: Xiao et al., 2017)

Client outcomes:

Predictors of the therapist effect

Working alliance

- Quality of the therapeutic alliance is more a result of therapist actions or characteristics than that of a client (e.g., Del Re et al., 2012)
- Strong interpersonal skills (Najavits & Weiss, 1994)
- Being flexible, honest, respectful, trustworthy, confident, warm, interested, and open (Ackerman & Hilsenroth, 2003)
- Multicultural competence (Davis et al., 2015)
- Ability to handle interpersonally challenging encounters (Anderson et al., 2009)

Client outcomes:

Predictors of the therapist effect

Working alliance

- Negative personal reactions (e.g., irritation, lack of empathy and respect, frustration) predicted WA negatively
- Professional self-doubt (e.g., lack of confidence, doubts, sense of powerlessness) predicted WA positively
- Warm interpersonal style predicted WA positively
- Using one's own and the patients' emotional reactions in the therapeutic relationship, if not embedded in a warm interpersonal style, predicted WA negatively

(Nissen-Lie et al., 2010)

Client outcomes:

Predictors of the therapist effect

The role of self-doubt

- A combination of self-doubt as a therapist with a high degree of self-affiliation as a person is particularly fruitful
- Exaggerated self-confidence does not create a healthy therapeutic attitude
- *“Love yourself as a person, doubt yourself as a therapist”*

(Nissen-Lie et al., 2014)

From clients' perspective...

- Eri was perceived as “a therapist with charisma, with the ability to make a strong, immediate connection, with a clear and persuasive plan for change based on both medical and psychological principles, and with an expectation of quick change. In line with this, her techniques are designed to empower clients to find their own solutions, and her pragmatic approach does not require lengthy treatment. Thus Eri provides her clients a holistic, top-down view of their psychopathology within the first session, so that they have a working rubric to organize their symptoms and seek to find solutions in a timely period (...) two years and more after therapy, Eri's clients were able to clearly articulate their understanding and use of certain of Eri's therapeutic techniques.”

(Hansen et al., 2015, p. 185)

From clients' perspective...

- Both successful and unsuccessful clients “mentioned Eri's ability to validate, her ability to relate to their pain, her kindness, her personal nature, her acceptance of them as people, and a degree of spirituality. Some of the clients (...) noted that Eri had a particularly effective way to communicate her understanding of pain, which also tended to communicate to patients that facing and learning to handle pain may be an important aspect of therapeutic change. Also, the importance of Eri's spiritual qualities appeared several times in the interview transcripts.”

(Hansen et al., 2015, p. 186)

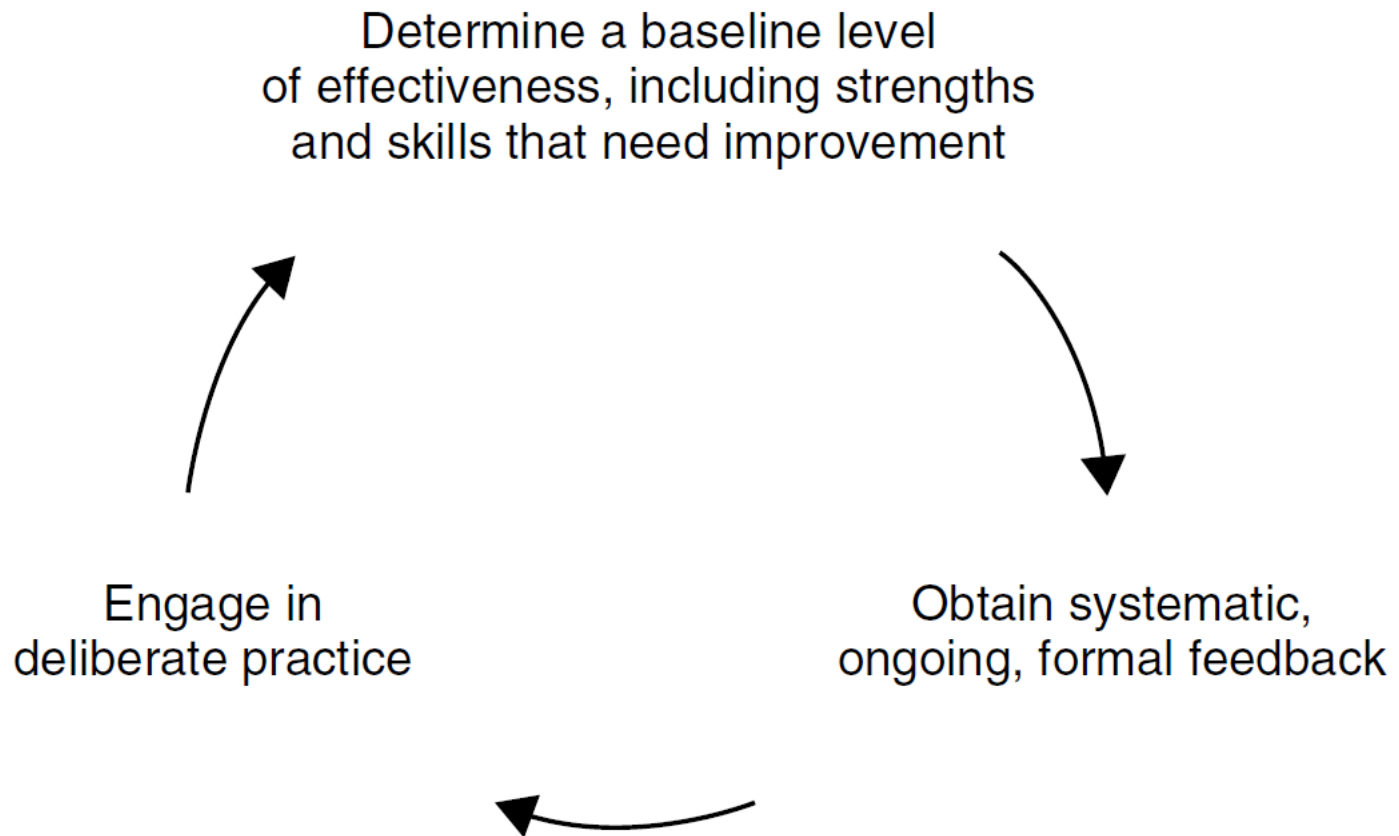
Client outcomes:

The role of feedback

- Therapists tend to overestimate their skills and success rates (Walfish et al., 2012)
- Therapists tend to have difficulty recognizing (Hatfield et al., 2010), as well as predicting (Hannan et al., 2005) client deterioration
- Continuous feedback on outcomes was suggested as a remedy (e.g., Lambert et al., 2003), although existing studies did not show persuasive effects (a series of meta-analyses presented in SPR, Oxford, 2017)
- Yet, therapists do not seem to learn from feedback (Goldberg et al., 2016)
- The effect of feedback probably depends on the accuracy, specificity, and timing but, most of all, on the therapist using it (Miller et al., 2015; Tracey et al., 2014)
- The role of deliberate practice, i.e. an intentional use of feedback information to improve one's practice (Prescott, Maeschalck, & Miller, 2017; Rousmaniere et al., 2017); see also older concept such as reflective practitioner (Schön, 1983) or local clinical scientist (Stricker & Trierweiler, 1995)

Deliberate practice:

The cycle of excellence





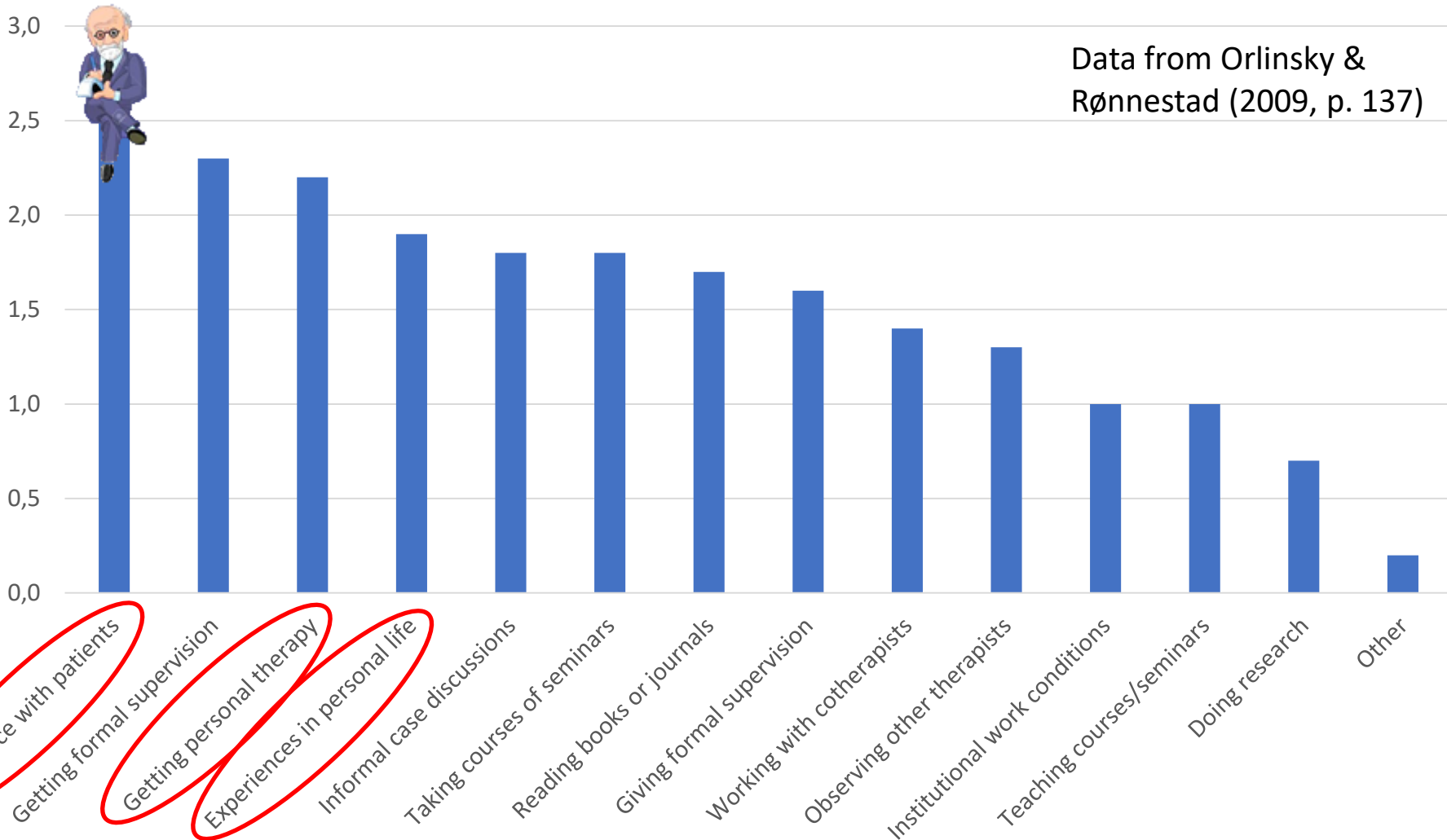
DEVELOPMENTAL
perspective

Do trainings

make good therapists?

- Paraprofessionals perform equal to or better than professionals (Durlak, 1979)
- Critical re-analyses confirmed the initial conclusion (Nietzel & Fisher, 1981; Hattie, Sharpley, & Rogers, 1984; Berman & Norton, 1985) and so did more recent studies (e.g., Montgomery et al., 2010)
- Higher amount of training is marginally related to better outcomes and smaller dropout rates (Stein & Lambert, 1995)
- Experienced therapists achieve better outcomes with more severely impaired clients (e.g., Mason et al., 2016)

Perceived Sources of Influence on Career Development



Therapists are active constructors of their personal approaches

- Therapists do not apply knowledge mechanically. Instead, they have adapted and extended their knowledge based on their own experience (Betan & Binder, 2010)
- “rather than adhering to a pure version of what they have read, [psychotherapists] are privately engaging in theory building” (Stiles, 2007, p. 1)
- Trainees actively construct their personal theories of psychotherapy, constantly defining and redefining theoretical orientations, assimilating new elements into their existing theoretical frameworks, as well as accommodating these frameworks to fit new experience (Fitzpatrick, Kovalak, & Weaver, 2010; Wolff & Auckenthaler, 2014)

Therapists are active constructors of their personal approaches

- Prevalence of integrationism in psychotherapy practitioners **> 95%** (Hollanders & McLeod, 1999; Řiháček & Roubal, 2017)
- A tendency to combine approaches was found in a naturalistic setting (Ablon, Levy, & Katzenstein, 2006), in randomized clinical trials (e.g., Ablon & Jones, 2002), and in expert therapists' demonstration videos (Solomonov et al., 2016)
- A vast majority (79%) of training directors believed that having been trained in one therapeutic model is not sufficient for therapists (Lampropoulos & Dixon, 2007)

Therapists are active constructors of their personal approaches

How do we choose?

- Congruence (*It fits me. It is consistent with my worldview. It feels natural. I can use it.*)
- Perceived efficacy (*It works with my clients. It worked in my personal therapy.*)

(Fitzpatrick, Kovalak, & Weaver, 2010; Maruniaková, Řiháček, & Roubal, 2016; Řiháček, Danelová, & Čermák, 2012; Vasco & Dryden, 1994)

“[E]very therapist integrates modes that originate in other approaches into his or her approach. But he or she does so in an individual, idiosyncratic way – one that fits his or her particular gifts, capacities, and needs” (Carere-Comes, 2001, p. 107)

Therapists are active constructors

of their personal approaches

PERSONAL

Natural capabilities and limits

Personal values and worldview

Personal history and experience

Personal therapy

PROFESSIONAL

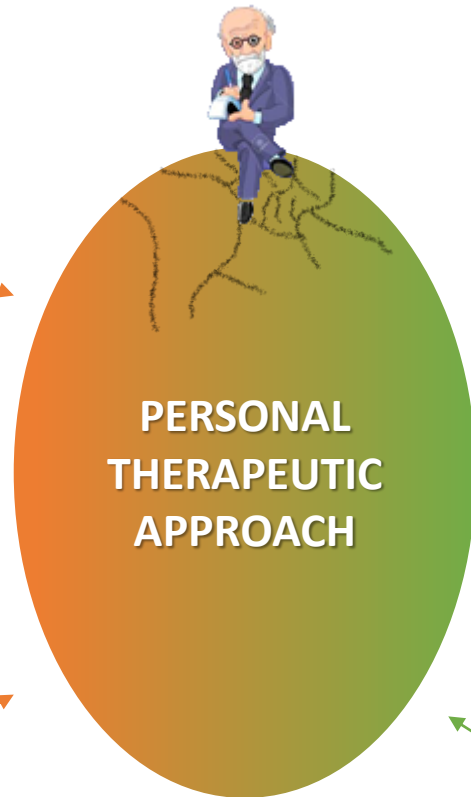
Professional rules and ethics

Therapeutic theories

Techniques and interventions

Own practice

Vicarious experience



Therapists constantly develop throughout their careers



Lay-helper mode

(based on sympathy and purely personal resources)

Adherence to a model

(building attachment to one's home orientation, doing things right)

Transition phase

(encountering limitations, assimilation of other approaches/
becoming atheoretical, focusing on "whatever works")

Integrated personal style

(consolidation, seamless integration of personal and
professional aspects)

So what makes a good therapist?

A brief summary



Stay humble (“doubt yourself as a therapist”)

Search for feedback. And use it

Embrace contradictions and multiplicities of life

Refine your facilitative interpersonal skills

Reflect (critically) on the cultural assumptions and foundations of psychotherapy and mental health

Conclusion

The complementarity of the four perspectives

