New Therapist

Indispensable survival guide for the thinking psychotherapist

September/October 2009

Interpersonal wisdom
The capacities and characteristics of the best talk therapists

In search of effective psychotherapy
Charting the converging roads of the psychotherapy effectiveness programme

The Expert Edition

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Brain scans shed light on borderline personality disorder

Researchers based at Mount Sinai School of Medicine, suggest that individuals with a diagnosis of borderline personality disorder (BPD) are unable to activate neurological networks that help control feelings.

Using functional magnetic resonance imaging (fMRI), researchers viewed how the brains of people with BPD reacted to social and emotional stimuli. They discovered that when people with BPD attempted to control and reduce their reactions to disturbing emotional scenes, the anterior cingulate cortex and intraparetical sulci areas of the brain, that are active in healthy people under the same conditions remained inactive in the BPD patients.

Harold Koenigsberg, professor of psychiatry at Mount Sinai School of Medicine states: "This research shows that BPD patients are not able to use those parts of the brain that healthy people use to help regulate their emotions,"

He adds: "This may explain why their emotional reactions are so extreme. The biological underpinnings of the disordered emotional control systems are central to borderline pathology."

According to the article, which is due to be published in the journal Biological Psychiatry, borderline personality disorder is a common psychiatric condition affecting up to two percent of all adults in the United States, mostly women.

Common characteristics of BPD include being very emotionally reactive, which leads to further symptoms of anxiety, depression and anger, as well as being interpersonally hypersensitive and being impelled to self-destructive and even suicidal behaviour. Patients with BPD may also exhibit other types of impulsive behaviours, including excessive spending, binge eating and risky sex. A diagnosis of BPD often coincides with other psychiatric conditions, particularly bipolar disorder, depression, anxiety disorders, substance abuse and other personality disorders.

The disorder is found in 10-20% of people in psychiatric care and approximately 10% of people with this disorder die of suicide. It has only been recently that researchers have begun to identify the biological factors associated with this condition.

"Studying which areas of the brain function differently in patients with borderline personality disorder can lead to more targeted uses of psychotherapy and medications, and also provide a link to connect the genetic basis of the disorder" says Dr Koenigsberg.

Coming out of captivity: Not all smooth sailing

Parents Terry and Carl Probyn are faced with an immeasurable challenge as they are reunited with their 29-year-old daughter, Jaycee Lee Dugard as she returns home after being kidnapped when she was 11 years old.

Researchers at The Family Institute at Northwestern University say that Dugard may find it tremendously difficult to readjust to her new environment. The article appeared in *Psycport* online in August 2009.

Dugard was kidnapped by a couple 18 years earlier as her stepfather was dropping her off at school. She was held captive in a backyard tent and kept isolated from the outside world.

As Dugard's parents celebrate the home coming of their daughter they also grieve the childhood she lost. They face the crucial challenge of restoring Dugard and her two children, fathered by Phillip Garrido (Dugard's captor), to ordinary family life and reintegrating them into society.

Jeff Sugar, a child psychiatrist at the University of Southern California notes that Dugard may have developed Stockholm syndrome, whereby victims of kidnapping identify and become attached to their captors. He says, "She might be very confused about who and what this person is to her. She may have some attraction to him, even loving feelings for him. Often there's a lot of shame associated with the trauma and feelings of guilt." Dugard's stepfather, Carl Probyn, confirmed that his daughter expressed guilt over bonding with Garrido.

A further challenge is that faced by Dugards' children, who are 11- and 15-years-old and who have formerly had no contact with the outside world and no form of education.

Lois Nightingale, a psychologist in California, holds an optimistic viewpoint on the situation. She says, "Our emotions come from what we say about things. If the family has a family story of: 'We're survivors. We are strong and we had a faith about this and we went through this for a reason,' they will be able to use that to survive. If the media and their friends and teachers see them as victims and keep saying, 'Poor, poor you,' it will be harder for them. The more they can develop a story of power and gratitude, the better the children will do."

Specific brain region determines personal space

Every individual differs in terms of the personal space they need in order to feel at ease. Researchers at the California Institute of Technology have found that the amygdala (known as the seat of emotional processing) is linked to an individual's need for boundaries in terms of their personal space. The research findings appear in the journal *Nature Neuroscienc*e in August 2009.

The findings became evident while studying a woman, known as SM, who has extensive damage to the amygdala on both sides of her brain. The researchers note that SM as a unique clear bilateral lesion in her amygdala with damage on both sides of the brain. This makes it possible to study the role of the amygdala in humans.

Existing research showed evidence of an association between the amygdala and personal space in monkeys. Monkeys with amygdala lesions were found to prefer closer proximity in comparison to healthier monkeys.

The researchers noted that SM had difficulty in recognizing fear and judging trustworthiness in others. Studies performed prior to the current study showed that these responses are both related to the functioning of the amygdala. She was also very outgoing and friendly, potentially violating what others may perceive to be their personal space.

One of the lead authors of the study, Daniel Kennedy says," She is extremely friendly, and she wants to approach people more than normal. It's something that immediately becomes apparent as you interact with her."

The authors of the study devised an experiment using what is known as the stop-start technique, whereby they could compare the social tendencies between SM and other volunteers. In the experiment, the research participants were asked to stand a predetermined distance from the experimenter and then walk toward the experimenter and stop at a point where they felt most comfortable. The distance between the participant and experimenter was then measured using a digital laser.

The average distance between the other volunteers was found to be 0.64 metres. SM's preferred distance was 0.34 metres. Unlike the other participants, SM never showed any signs of discomfort when the experimenter walked toward her. Furthermore, her distance didn't change based on the how well she knew the experimenter.

Kennedy says, "These findings suggest that the amygdala, because it is necessary for the strong feelings of discomfort that help to repel people from one another, plays a central role in this process. They also help to expand our understanding of the role of the amygdala in real-world social interactions."

In a second experiment, led by Ralph Adolphs, the participants were told when the experimenter was either close by or far away. The fMRI (functional magnetic resonance imaging) findings showed increased activity in the amygdala region when participants thought the experimenter was close by. However, no activity was detected when the respondent thought the experimenter was on the other side of the room.

Kennedy says that the study shows that "the amygdala is involved in regulating social distance, independent of the specific sensory cues that are typically present when someone is standing close, like sounds, sights, and smells."

Authors of the study note that interpersonal distance is not something we consciously think about. However, we become intensely aware when our space is being violated.

They note that accepted interpersonal distances can vary dramatically among diverse cultures. The researchers explain that these cultural experiences of responding differently to spatial boundaries may be accounted for by the long-term effect these preferences have on the brain over time.

"Respecting someone's space is a critical aspect of human social interaction, and something we do automatically and effortlessly," Kennedy says.

The researchers hope that their findings might generate some insight into disorders concerning social distance, such as autism.

Kennedy says, "We are really interested in looking at personal space in people with autism, especially given findings of amygdala dysfunction in autism. We know that some people with autism do have problems with personal space and have to be taught what it is and why it's important. It's clear that amygdala dysfunction cannot account for all the social impairments in autism, but likely contributes to some of them and is definitely something that needs to be studied further."

arch

What a women sees in a mans face

Women evaluate facial attractiveness in two different levels, a sexual and a non-sexual one, according to researchers at Penn State University in Pennsylvania. The research findings appear in the *Journal of Experimental Social Psychology* in August 2009.

The study comprised fifty heterosexual female college students, who were asked to rate the attractiveness of a series of photos of male and female faces as candidates for dating and as lab partners. Rating the candidates for dating was designed to invoke a sexually based response, while seeing them as lab partners a non-sexual response. The researchers split the faces of the candidates in half so that the participants would rely more on specific facial features to determine attractiveness.

Authors of the study note that when women evaluate a man's face on a sexual level they focus on specific facial features, such as the symmetry and structure of the jawbone, cheekbone and lips. Lead author of the study Robert Franklin says, “At the most basic sexual level, attractiveness represents a quality that should increase reproductive potential, like fertility or health.”

On the other hand women evaluate the overall impression of facial aesthetics on a non-sexual level. Franklin adds, “On the nonsexual side, attractiveness can be perceived on the whole, where brains judge beauty based on the sum of the parts they see.”

The researchers explain that existing research suggests that women’s biological routes of sexual attraction derive from an instinctive reproductive desire, relying on estrogen and related hormones to regulate them. The overall aesthetic approach is a less reward-based function and is driven more by progesterone.

Franklin says, “We do not know whether attractiveness is a cultural effect or just how our brains process this information. In the future, we plan to study how cultural differences in our participants play a role in how they rate these faces. We also want to see how hormonal changes women experience at different stages in the menstrual cycle affect how they evaluate attractiveness on these two levels.”

Money doesn’t improve life satisfaction

New research which examines the impact of public policy programmes aimed at alleviating poverty and improving the lives of families, seems to indicate that money won’t necessarily make the poor happier and that the poor are not, in fact, significantly less happy that those who don’t live in poverty.

The research, which appears online in Springer’s journal Applied Research in Quality of Life, examined data from a yearly national survey run by the University of Costa Rica between 2004 and 2006. Researcher Mariano Rojas expanded the questionnaire to include subjective items on life satisfaction as well as more specific questions regarding satisfaction with health, job, family relations, friendship and self, as well as the community environment.

The findings indicated that the majority of people rated their lives as satisfactory or more than satisfactory with not all people who were considered "poor" experiencing low levels of life satisfaction and not all people who were not poor reporting being happy with their lives. Rojas observed that only 24% of people classified as "poor" rated their life satisfaction as poor while 18% of people in the "non-poor"category also reported low life satisfaction. Rojas remarks: “This paper has shown that it is possible to jump over the income poverty line with little effect on life satisfaction. Income is not an end but a means to an end."

This research suggests that poverty alone does not account for an individual's overall well-being and that it is possible to come out of poverty and still remain less than satisfied with life. Furthermore, a person whose income is low can be relatively satisfied with his/her life as long as he or she is moderately satisfied in other areas of his/her life such as family, self, health and job.

Based on this research, Rojas argues that social programmes need to recognise that wellbeing depends on satisfaction in a multitude of life domains and not just income. Therefore many qualities and attributes need to be considered when designing these programmes, including leisure, education, the community and consumer skills (learning how to spend wisely).

The reduction of poverty is one of the main priorities in the design of both foreign and local aid programmes due to the assumption that raising people’s income translates into greater wellbeing. ojas challenges this assumption and argues that measures of life satisfaction should also be taken into account when designing and evaluating poverty-abatement programmes. He says: “There is a big risk of neglecting and underestimating the importance of wellbeing-enhancing factors when focusing only on income poverty. It is important to worry about getting people out of income poverty, but it is more beneficial to also worry about the additional skills people need to have a more satisfying life.”

At risk of an affair? Odds higher than you think

Infidelity occurs in 30-45% of marriages, according to Dr. Lynn Margolies a former faculty at Harvard Medical School. The article appears online in *PsychCentral* in August 2009.

Margolies explains that affairs are often motivated by excitement, sex, escape, the need to feel desirable, emotional connection or a vehicle to leave an already flawed marriage.

Even happily married couples are at risk according to Margolies. All one needs is an opportunity, which can lead one into temptation—a dangerous pair for a lonely partner.

Margolies research shows that the typical man who seeks help after having an affair is a conventional one with traditional values and is in love with his wife. Margolies says that affairs come as the biggest surprise to these men, as dutiful, loyal and honest men they deny that they could be vulnerable to falling into temptation.

Margolies holds that the most common driving force behind an affair is fantasy, the idea of a "vacation-like relationship". However, once this dissipates the new relationship is rarely sustainable. Existing researches shows that marriage to an affair partner is a major contributing factor to higher rates of divorce in second marriages.

Recent MRI (Magnetic Resonance Imaging) findings show that during the infatuation state of romance, the brain shows the same changes as it does with the use of cocaine. This rush of feelings can often result in impaired judgement and responsibilities as values and morals take the back seat.

Margolies notes that these intense feelings of being in love are also coupled by a failure to realize the comfort safety and security provided by the current marriage. In a lonely or unhappy marriage, a person may only see in a new relationship what they do not have in their current one.

To manage the intense conflict that arises from acting on feelings that are against a person's values, Margolies notes that individuals tend to compartmentalise and rationalise the situation in a way that allows them to lead a "double life" without registering what they are doing.

Being completely immerged in a fantasy-type situation is what makes affairs so much easier to get into that to escape from, Margolies concludes.

Picking up the pieces

Marriages are often more durable than given credit for, according to Margolies. Many marriages have a good chance of withstanding an affair as the crisis allows for an opportunity to make up for what was wrong before. A crisis can also gaurd the relationships against complacency.

Common dangers to marriages are grudges, unhappiness, neglect and secrecy. According to Margolies, when trust is violated by an affair, it destroys the underlying sense of security and safety in the relationship thereby undermining the stability of the relationship.

Margolies notes that accountability, reparation and restoring trust are critical aspects of rebuilding the foundation of a marriage crippled by an affair.

She elaborates on each point explaining that accountability means acknowledging responsibility for one's own actions and bearing the cost. Responsibility includes refraining from temptation to blame others.

Reparation involves understanding the need for making concrete concessions toward restoring trust and good faith. Reparation may include openness to scrutiny without defensiveness. This isn't the time to assert "right to privacy" issues. Making amends includes honoring specific, reasonable requests that offer objective assurances.

Restoring trust is undeniably difficult once credibility has been damaged. Trust is re-established gradually through unwavering reliability in doing precisely what is promised. Even minor infractions can reopen mistrust and impede healing. She explains that healing involves understanding what unmet needs were filled by the affair, facing unresolved marital issues and fulfilling unmet expectations.

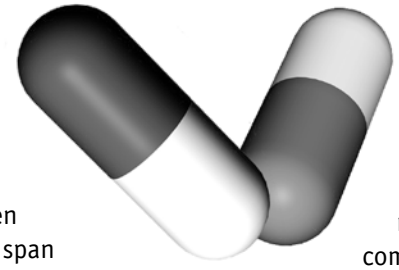
Margolies notes that a common mistake made by couples trying to rebuild their marriage is that of holding grudges and punishing the guilty party for what they did. She explains that this only leads to them feeling defeated an demoralized - a pattern which creates a power imbalance and causes the marriage to once again be at risk.

She concludes, "In a healed relationship, both partners understand their roles in the dynamics which provided the backdrop for the affair, and are committed to preventing recurrence. They no longer feel trapped, or in the marriage by default. Instead, they make a renewed commitment, actively choosing the relationship. Partners in marriages which thrive after an affair hold a gut-level awareness of the reality of losing one another, channeling it into a healthy vigilance and active appreciation of each another."

Anesthetic drug proves effective in rapidly treating depression

Ketamine, a drug that was previously used as an anesthetic, has been found to rapidly reduce suicidality among depressed patients, according to researchers at Mount Sinai School of Medicine in New York, the University of New Jersey and Harvard University in Cambridge. Findings from the study appear in the *Biological Psychiatry* journal in September 2009.

Treatment for depression is known to take a few weeks before the beneficial effects are felt. This puts those with an immediate risk of suicide at risk. The findings showed rapid antidepressant properties in Ketamine. Research participants reported relief within 24 hours of a single infusion. This reduction was maintained when patients received follow up doses over the span of two weeks.



One of the lead authors of the study, Rebecca Price, says, “If these findings hold up in larger samples of high-risk suicidal patients, Intravenous Ketamine could prove an attractive treatment option in situations where waiting for a conventional antidepressant treatment to take effect might endanger the patient's life.”

The study involved a small sample of depressed patients. The researchers admit that further research will be needed in order to replicate the results. However, they maintain that the findings are promising and may result in improved treatment for suicidal patients.

Nicotine aids memory formation

Nicotine in cigarettes "tricks" the brain into forming a memory association between environmental cues and smoking behaviour, according to researchers at Baylor College of Medicine. The findings from the study appear in the journal *Neuron* in September 2009.

The researchers explain that our brains normally make associations between positive aspects of our environment and behaviours that lead to success. In other words, the brain sends reward signals when we act in a ways that contribute to our well-being. However, nicotine seems to command this subconscious learning process in the brain so that we begin to think and behave as though smoking is a positive action. These environmental cues therefore become cues that prompt the urge to smoke.

Typical environmental cues that are associated with an increased urge to smoke may include alcohol, a meal with friends or even the drive home from work.

Co-author of the study, John A Dani says: "We found that nicotine could strengthen neuronal synaptic connections only when the so called reward centers sent a dopamine signal. That was a critical process in creating the memory associations even with bad behavior like smoking."

The study comprised mice, who were allowed to roam through an apparatus with two separate compartments, in one compartment, they received nicotine and in the other, benign saline solution. The researchers recorded how long the mice spent in each compartment and also recorded the brain activity with in the hippocampus, an area in the brain responsible to memory formation.

Nicotine was found to strengthen the neuronal connections in the brains of the mice by up to 200% Dani notes, "This strengthening of connections underlies new memory formation." Consequently the mice learned to spend more time in the compartment where they received nicotine compared to the saline compartment.

The researchers predict that their findings may help to understand the mechanisms responsible for creating memories and could have implication in future research and treatments for memory and signaling disorders like Alzheimer's disease and Parkinson's disease.

Interpersonal Wisdom

The capacities and characteristics of the best talk therapists

The inspiring song by Dar Williams, *What do you hear in these sounds*? is a tribute to her psychotherapist. As I listen to that song I find myself wondering if I could ever earn the honor to have a help-seeker experience our relationship that way. The lyrics go like this:

I don't go to therapy to find out if I'm a freak
I go and I find the one and only answer every week
And it's just me and all the memories to follow
Down any course that fits within a fifty minute hour
And we fathom all the mysteries, explicit and inherent
When I hit a rut, she says to try the other parent
And she's so kind, I think she wants to tell me something,
But she knows that its much better if I get it for myself...
And she says….. What do you hear in these sounds?

I say I hear a doubt, with the voice of true believing

And when I talk about therapy, I know what people think
That it only makes you selfish and in love with your shrink
But oh how I loved everybody else
When I finally got to talk so much about myself....

Bad Press for Psychotherapists

So often psychotherapists[1] are depicted badly in the media, as incompetents, or power hungry narcissists. Just as damaging to our image is the portrayal of psychotherapists as misplaced scientists who get satisfaction from analyzing human beings who may as well be laboratory rats. The "scientist-practitioner" identity in psychology unfortunately sets us up to play out that ill-conceived role and many of us become the part, instead of being the genuine and caring person our clients need us to be. Most people don't want a scientist for a for a talk therapist. This is an occupational hazard that affects many of us and contributes to poor outcomes.

In the land of mechanized western Turbocapitalism, many of us have adopted the mindset that we should settle for mediocrity because that is the price we have paid for an ever-growing economy and the steady expansion of jobs. The rise of the mega-clinic and the proliferation of managed care during the past thirty years has contributed to the standardization of psychotherapy models and practices and in so doing advanced the belief that all talk therapists are the same.

In the industrialized Western world, a talk therapy professional therefore has become a cultural extension that exists to keep the economic system functioning with little regard for his or her unique purpose in the human community. Individual excellence takes a back seat to those cultural extensions, which dominate our lives and makes the deeply interpersonal and universal function of a talk therapist, to heal the soul, seem almost obsolete. A talk therapist has become a mass produced commodity.

Creating our Own Future by Honoring the Past

In the popular culture, heroic patients are often exalted because that makes good media, as it should because so many people are struggling against the cultural tide and reaching out to us for a life raft. Exemplary psychotherapists doing noble things on the other hand, apparently make mediocre copy, even within our own ranks. We are suffering from a professional inferiority complex, which is unfortunate because the current generation of professionals needs some hope in this post-guru stage of our development. We can no longer look to the psychotherapy pioneers for our sense of professional identity and purpose because our masters are sadly moving on. Many of them are gone. They have left us to our own devices, to carry on the excellence they started but to do that in our own way. This article is my effort to honor that cherished legacy those pioneers left behind by identifying the powerful things that many of our colleagues are doing well so that more of us can learn to do what works to make a better world.

Maurizio Andolfi captures the legacy of our pioneers well in this description below from his moving tribute to Carl Whitaker in, *Let it Flow, The Philosophy of Becoming* (1996).

"Whitaker the man and the teacher will continue to flow into the story of our knowledge about human beings. His life, his thought, and his rapport with human suffering will continue to be appreciated by new generations of family therapists. As they grow tired of the endless models, new approaches, and super techniques, in the end, they will yearn to find human beings and their qualities in the real world and not in the microscope. Whitaker's legacy will be revalued even by those who kept their distance during his lifetime, labeling him as "bizarre" and "irrational." Carl was a pioneer in family therapy, a giant, who did not allow himself to be seduced into creating a myth around his personality. He died without any official disciples, but he trained a multitude of therapists around the world, sometimes unbeknownst to them, with the power of integrity and coherence. He taught us more about life than about techniques. He taught us about the search for ourselves and our own spiritual essence, through the experience of suffering and solitude.

Psychotherapy Works but Some Do it Better than Others

The good news is that psychotherapy works. We know this from research on psychotherapy effectiveness summarized by Wampold (2001) that psychotherapy is four times as effective as no treatment and two times as effective as placebo. Fifty percent of clients change after 7-9 sessions and 50% recover after 7-9 sessions. That is a very good track record that parallels or beats other professional services including medicine, which is often deemed to be a more scientifically rigorous discipline than psychotherapy. Our aggregate outcomes are excellent.

So, why do so few people have faith in psychotherapists (Consumer Reports 1995)? One of the reasons may be that we don't even understand our own strengths. We get caught up in the wrong things, the things that sell the books and feed the masters at the top of our food chain, instead of identifying and learning from those around us that are actually getting the best results.

In their landmark article, *Waiting for supershrink[2] : an empirical analysis of therapist effects,* Okiishi, Lambert, Nielsen, and Ogles (2003) conducted a large two-and-one half-year study at a university counseling center and were able to identify what they called, *empirically supported psychotherapists*. The authors found that there was a

[1] In this article I use psychotherapist and talk therapist and psychotherapy and talk therapy interchangeably. I prefer talk therapy and talk therapist because the prefix, "psycho" has attracted a connotation that may be stigmatizing to some help-seekers.

[2] The use of the colloquial term, "Supershrink" throughout the paper reflects the challenge of finding accurate and succinct terminology to describe superlative performance. The label, Supershrink, refers to talk therapists who consistently get the best service outcomes. It is contrasted with "good enough" providers who perform in the median range of all therapists.

significant amount of variation among therapists' clients' rates of improvement and those differences had little to do with the theoretical orientation or the level or type of training the therapist had received. The authors concluded that some psychotherapists were *Supershrinks* and others were ineffective, and surprisingly, the colleagues and supervisors of both groups could not tell them apart.

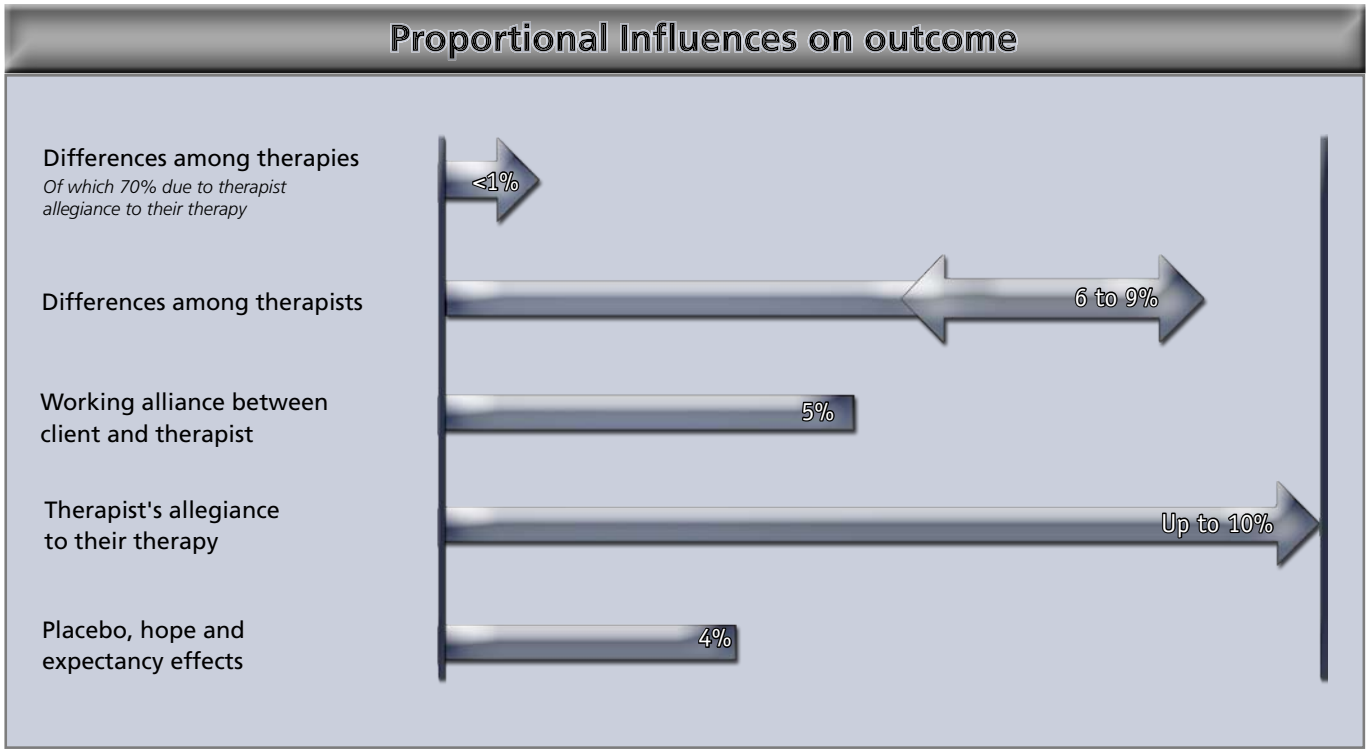
Based on the Okiishi et. al. findings, which opened the door for further investigation (Hubble, Duncan, Miller, 2007) it is fair to conclude that *Supershrinks* may be among us in our private offices, our counseling centers, and our schools. I believe they do their jobs with a little more passion, a little more character, a little more skill, and a little more humanity. They may not have the most letters next to their names or have the biggest offices. They would make us proud if we knew them. They would help us understand what really works in psychotherapy so that we could nurture those capacities in order to change the profession for the better.

Interpersonal Wisdom in Psychotherapy

The purpose of this paper is to identify the everyday excellent therapist capacities, which are a constellation of skills, attitudes, behaviors, beliefs, and some difficult to describe ways of being, that I refer to as *Interpersonal Wisdom*. I selected this term to reflect that psychotherapy is a real and profound relationship between human beings that includes a relational complexity not usually found in other human relationships. Anderson, Ogles, and Weiss (1999) used the term *facilitative interpersonal skills* to describe a similar therapeutic acumen. I prefer *interpersonal wisdom* because it connotes a more encompassing and "something-I-know-not-what" character-based therapeutic capacity rather than an action potential, and it does not imply that anyone can develop it with skills-based training. Interpersonal wisdom is both born and bred. It defies convention and expresses itself in the mysterious space between two imperfect human beings.

New Directions for Therapist Factors

In the marriage and family therapy literature, Blow, Davis, and Sprenkle (2007) have offered a compelling advancement of the narrative that calls attention to therapist factors are far more important than model factors in predicting the success of psychotherapy. The authors cite Wampold (2001), Wampold and Messer (2002), Wampold & Brown (2005), and Beutler (2004) as proponents of the finding that therapist factors as more potent predictors of outcome in therapy than the treatment models employed or any other non-client change factors *(see chart below)*. Wampold maintains



The chart above, which is incorporated from (McFadzean 2006) is a striking illustration of the primacy of therapist factors. So what are these critical therapist factors?

McFadzean highlights the proportional influence of therapist factors relative to other common factors, the largest of which are extratherapeutic (Lambert, 1992) or outside the direct influence of the therapist. McFadzean groups alliance, allegiance, expectancy, model, and difference among therapists together. So, about 70% or so of the outcome variance, he would suggest, might be accounted for by extratherapeutic factors. Those are chance factors, timing, things that occur outside the therapy itself and the difficult-to-define things that impact whether or not someone gets better.

that existing studies conclude that therapist factors are up to nine times as potent as model or technique factors. Blow et. al. believe that being a competent therapist is itself a major common factor and that more attention needs to be paid to therapist variables as contributors to positive psychotherapy outcomes. Their work enlivens the common factors debate and has the potential to transform the way therapists are educated and trained.

Beutler (2004) offers the following ways of classifying therapist capacities, characteristics, and competencies: observable traits, observable states, inferred traits, and inferred states, as indicators of therapist variability. This work is a well-researched and conservative review of specific therapist contributions that I have been similarly calling *interpersonal wisdom*. Like Blow et.al. Beutler believes there are things we can know about therapists that allow us to begin to understand what therapist factors have the best chance of contributing to success in psychotherapy. Understanding these therapist capacities, competencies, and characteristics would allow us to shape the profession in such a way that the most effective therapists could be trained and nurtured in the trans-theoretical, model-independent ways of being that tend to work in psychotherapy and those aspects would be interwoven into all programs and practices regardless of the specific therapeutic model or tradition. While it may be that some of these characteristics are related to personality, biology, and other static variables and therefore cannot be significantly altered within the therapeutic encounter, there are many other capacities and competencies that can be assimilated through education or personal development.

"Interpersonal wisdom contains the recognition that authenticity trumps action. "

Implications for Research

A review of the existing psychotherapy effectiveness research generates some conclusions that I believe can be made about therapeutic excellence with confidence. Each of these competencies or characteristics deserves an entire paper dedicated to a full understanding of its power as a therapist common factor and some of these factors have already received such attention. There may be other capacities that are equally important or promising that I chose not to emphasize here due to space considerations and in order to keep with the specific focus of this article.

"The best therapists are genuine people with strong character who exude something difficult to define that breeds trust and confidence."

The second section lists an idea synthesis based on my interpretation of the psychotherapy effectiveness literature (much of it already reviewed here), and concepts from other change traditions such as existential psychotherapy (Whitaker, 1975), neo-object-relations therapy (Masterson, 1988) (Scharff & Scharff, 1987), self psychology (Kohut, 1971), interpersonal theory (Sullivan, 1953), Bowen theory (Bowen, 1978) and later interpersonal psychotherapy (Weissman et.al. 2000), and client-directed outcomes informed therapy (Duncan et.al., 2004). The list is intended to stimulate the reader's thinking for further study beyond the scope of the established tenets of those traditions. Additionally my hope is to offer a convergence point with others who are trying to foster progressive conversations about ways the profession might alter therapist education, development, and supervision to prioritize crucial therapist common factors.

Empirically-Supported Findings

- Race, gender, age, cultural background, professional identity (counseling vs. psychology vs. social work) and even professional experience (defined as years of practice) are unrelated to counseling outcome (or at least overrated in the therapeutic relationship). Matching of clients and counselors on these dimensions (e.g. client and counselor of same race working together) does not result in increased efficacy (Sexton, 2004).
- Supershrinks have a counter-cultural attitude (Hubble et. al., 2007) Whitaker (1975).
- Supershrinks adjust what they are doing when clients tell them it is not helpful or could be done better. They are expert at soliciting feedback, especially early in the process, which sets them apart from less effective therapists (Duncan, Miller, Scharff, 2004).
- Supershrinks match therapeutic directiveness to level of resistance. More resistance requires less directiveness and vice versa (Norcross & Hill, 2004).
- Supershrinks are expert at repairing inevitable alliance ruptures (Norcross & Hill, 2004).
- Supershrinks assess motivation for change early and are able to skillfully design their approach based on that readiness for change (Prochaska & DiClemente, 1992).
- Supershrinks are highly skilled at eliciting and reinforcing client "change talk" especially at the end of sessions (Amrhein et.al., 2003).
- Supershrinks are perceived by their clients to have congruence between their personalities and their office settings (Levitt, Butler, Hill, 2006).
- Supershrinks employ client-informed and well-managed flexible structure to the therapy that includes relevant and well-managed goal setting (Levitt, Butler, Hill, 2006).
- Supershrinks are realistic optimists that believe people are resilient and can change. They offer their clients hope without losing empathic attunement (Schneider, 2001).

Interpersonal Wisdom in Practice

Being is more important than doing

Interpersonal wisdom contains the recognition that authenticity trumps action. The best therapists are genuine people with strong character who exude something difficult to define that breeds trust and confidence. These talk therapists are not performing as technicians. They are exchanging the fullness of their humanity. This point of view is connected with the humanistic tradition that advances the counter-intuitive notion that people with the highest college degrees or the most degrees have often lost their inherent therapeutic abilities (Small, 1981).

Both of these characteristics, authenticity and strong character, come from the existential/humanistic psychotherapy tradition (Whitaker, 1975) (Rogers, 1951) but they incorporate my own sense that there may be a confident free agency tendency that many excellent talk therapists exude naturally that allows them to be experienced by clients as high character (trustworthy) individuals. This is an intuitive felt sense that many clients and professionals openly express when they are asked about their experiences in psychotherapy but it may not be amenable to objective measurement and thus has not been well researched.

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A curious personality

It would seem that one could not convey the necessary amount of interest and empathy to foster change without being the type of person that enjoys learning about the experiences of others. One can learn this skill set in therapist training but if one is naturally disinclined toward people curiosity one may have difficulty becoming the best.

Flexible maneuvering but solid grounding

Interpersonally wise therapists are comfortable with relational complexity and they know how to continuously maneuver within the evolving therapeutic relationship. But at the same time they are perceived to have high integrity because while they are flexible as to their thinking apparatus and in implementing their approach they are seen as consistent with regard to their own personal narrative, their personal characteristics, and their expressed values.

This is a "both/and" characteristic that is a sign of good emotional intelligence generally, and probably makes for high performing people regardless of their professional field. Levitt et.al. (2006) identified something close to this characteristic in their recent study in their finding about the importance of the personal narrative of the therapist, but few have ventured into the terrain of therapist thinking styles, personal character, and values. Doherty (1995) is a notable exception.

Artful continuous relational assessment

Most psychotherapy traditions offer the false notion that assessment, like joining or rapport building, is something that only occurs at the beginning of the process. My contention is that the best talk therapists are continuously assessing the impact of their relatedness and they are able to do this in the moment using all means necessary and without conveying that they are "analyzing". Their primary focus is the client's perception of the fluctuation of the therapeutic alliance and whether anything has occurred to impact the alliance negatively as this is the major reason for unhelpful experiences in therapy and resulting early termination (Wampold, 2001). Many therapists rely on intuition while others ask their clients for verbal feedback frequently throughout their sessions. Some therapists rely on written alliance rating scales that they administer at the end of every session (Hubble et.al., 2007). The best talk therapists are continuously and meticulously aware of the vicissitudes of client engagement whether they arrive at their assessments intuitively or via the spoken or written word or all three methods.

Interpretations that hit the emotional mark

Interpersonally wise therapists are able to offer accurate intra or extra relational interpretations that hit the mark and make their client(s) feel understood. The

significance of this finding which has a long history within the broad interpersonal psychotherapy tradition (Sullivan, 1953) (Kohut, 1971) (Weissman et.al. 2000) is that interpretations are not primarily a means of offering information to provide a cognitive "aha" moment for clients but as a means of conveying empathy. The cognitive content matters less than the emotional process. When clients feel understood in the encounter they improve regardless of the phenomenological "truth" of the interpretation. This hypothesis suggests that many therapists may overvalue their interpretive abilities. Hitting the interpretive mark is primarily an emotional rather than a cerebral victory.

"There is a universal human desire to be seen and known by a significant person who can tolerate the full experience of our being."

Interpersonally wise therapists apparently take risks earlier in the process and are not people-pleasers, thus often resulting in lower client satisfaction ratings in early treatment.

There does appear to be evidence that high performers receive lower client satisfaction ratings early in treatment (Hubble et.al., 2007). But we don't know why. I propose a hypothesis, which is based on my twenty years of experience doing psychotherapy, observing many others, and following the effectiveness research closely, that Supershrinks courageously tell their truth early and often. They have the audacity to tell the truth and have people stay with them because their clients see them as authentic and therefore credible. They don't try to please their clients with low-risk alliance tricks that appeal to the lowest common denominator. They tell the truth as they see it even if it temporarily disrupts the emerging alliance and it often does. They artfully accomplish this feat in a respectful, well differentiated, and sometimes fairly bold manner.

It is likely that Supershrinks are better at soliciting honest answers from clients but it may also be that Supershrinks are also better at being honest! Most clients respect a professional that they perceive to be straightforward even if they may disagree with what the person is saying to them.

Hubble et.al. (2007) focus on the therapist's ability to set the table for client honesty, and especially honesty about the alliance. My contention is that a more important capacity is therapist truthfulness, which can disrupt early alliance formation but facilitate a stronger relationship over time. This is not unlike what happens in a love relationship wherein sparks can fly early, which often leads to some uneasiness, and then forges the opportunity for reparation, reconciliation, and deepening of the love. There is a universal human desire to be seen and known by a significant person who can tolerate the full experience of our being.

Good timing, especially when relaying sensitive information or when challenging clients.

Clinical supervisors often talk about timing, although it is almost always during retrospective supervision. This is an area that may get better with experience as talk therapists learn from their therapeutic mistakes and develop better anxiety management ability. Poorly timed interventions can lead to disruptions in the alliance or narcissistic injuries. This may be one of the biggest reasons for premature endings in therapy although I could find no literature to support this view. Our focus tends to be on the content rather than the timing of the intervention.

Supervision traditions that routinely employ video recordings, like family therapy, may be the best opportunities to help inexperienced therapists develop a sense of timing in therapy.

When genuineness creates tension an interpersonally wise therapist is able to skillfully repair a therapeutic alliance and generate an even more productive working relationship.

This is a hypothesis based on the existing literature on repairing alliance disruptions (Norcross) (2004) and also an expansion of the work on contained confrontation in psychotherapy (Masterson, 1988). It is well established that an alliance often gets stronger if it survives the disruption (Stiles et.al., 2004). My hypothesis presupposes that some talk therapists have the capacity or the natural tendency to stimulate a therapeutic alliance disruption either accidentally or intentionally, which they have a chance of surviving. I believe we need a better understanding of what happens during this cycle of disruption and repair.

Interpersonally wise therapists create a safe environment for the exploration of emotional issues by being laid back AND direct and by being in charge but not controlling. In so doing they foster the therapeutic containment that is necessary for optimal growth and change.

The importance of therapeutic containment in stressed in the object relations literature (Scharff & Scharff, 1987). But there is little research that indicates which personality types and therapeutic styles are most conductive to fostering containment, just that it needs to be fostered for the therapy to work. My contention is that some therapists have a natural capacity or have become good emotional containers through practice. Some therapists may stimulate a felt interpersonal sense, especially for clients that are highly intuitive. For other excellent therapists it may be an advanced sense of confidence or timing that they have cultivated through practice. The recent work from Gladwell (2008) seems to favor the idea that high performance is enhanced through repetition although we do not yet know if this is true in psychotherapy.

Interpersonally wise therapists believe that positive and negative energy can be transmitted between human beings and they make a choice to transmit the positive. In so doing they help clients discover the positive energy that summons the extratherapeutic factors (Lambert, 1992) in their lives that are largely responsible for bringing about change.

This is one of the capacities that is difficult to measure but may be most important for change. All of us have been with people that make us feel better about humanity. Perhaps it is their sense of humor or their hopeful nature, but something about them helps us to feel better about our own lives. I believe excellent talk therapists possess this quality. Most likely this is a temperamental quality rather than a learned skill but it may also be something that folks in recovery in a broad sense bring to the encounter as they may have already overcome some significant adversity and therefore live their lives with a sense of serenity that most people do not possess.

Interpersonally wise therapists believe power is usually used for good. They own their own strength but do not take themselves too seriously.

Personal power is an attribute that has both built and destroyed civilizations. Without it we are left without the interpersonal energy society needs to nurture its young, teach its children, or carry innovative ideas to their fruition. The misuse of power corrupts, demoralizes, or destroys.

A talk therapist is a positive force for change. That is why people come to us. So, we must use our personal agency to help people discover better lives. Or they should not waste their time with us. At the same time, a high performing talk therapist knows that she is a mere vehicle being used as a carrier of community good will. She is both glorious and miniscule.

Summary

In summary, interpersonally wise therapists are non-conventional, congruent, curious and bold. They are realistic optimists with high character that convey genuine caring for their clients and seem to intuitively understand how to offer the right amount of active listening, direction AND containment simultaneously. They have faith in the universe, which allows for client agency and activation of the extra-therapeutic factors that lead to change. They have high tolerance for relational complexity and excellent anxiety management ability in ambiguous and stressful conditions. They solicit ongoing feedback from clients and alter their approach continuously based on that feedback, but they do not come across as squishy or people pleasing. They are adept at reading people and adjusting their approach based on the full range of interpersonal cues coming from clients. They are expert at repairing therapeutic relationships after inevitable working alliance disruptions. Most importantly, they have the ability to like a lot of different people because they have a deep appreciation for the humanity beneath the presentation.

In addition to the aforementioned core qualities, an interpersonally wise therapist is humble about his/her own place in the universe. The humble healer attitude allows for legitimate faith in one's own capacities and actions as an agent of change through access to the benevolent power that all accomplished healers possess. Much of that power to change is discovered within the help-seeker but it also comes from the positive spirit entrusted in us by the community.

Hope for the Future of Psychotherapy

Implications for Training

One of the conclusions that can be drawn from this grouping of factors is that training programs, therapist coaching, and clinical supervision should address them intentionally and directly. Rather than placing most of the emphasis and spending most of the time and resources on psychiatric classification, theory/model development, and model adherence, training programs should develop training that enhances these critical therapist factors. If that shift were made, as Blow et.al. (2008) also recommend, the psychotherapy profession might change substantially.

"The humble healer attitude allows for legitimate faith in one's own capacities and actions as an agent of change through access to the benevolent power that all accomplished healers possess."

Implications for Public Policy

Public policy should shift from supporting a service delivery system that favors increasing mass access to services by growing mega-industrial organizations over generating better individual client outcomes. Identifying the therapist factors that lead to excellence would be one way to change the services delivery system so that the best healers were identified, nurtured, and rewarded, thus improving retention rates for the best providers. In addition, inculcating those critical therapist factors across the services landscape would also raise the therapeutic excellence throughout the services delivery system, thus improving overall outcomes.

Conclusion

Psychotherapists have the capacity to contribute to a better world one individual, one family, or one organization at a time. Some of our Supershrink colleagues are doing that routinely in the trenches, in private practices, in clinics, in places of worship, in organizations, in residential centers, and in other nontraditional settings. We are only just beginning to appreciate what they do so well and we can learn much more from them.

In this paper, my way of talking about these excellent healing capacities has been through the abstraction I have been calling interpersonal wisdom. Others are using different terms to describe similar capacities. If our profession could get past its obsession with model mongering and the ceaseless commodification of our methods we might begin to do justice to the pioneers that left us their important legacy by encouraging interpersonally wise ways of being in therapy.

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In search of effective psychotherapy

Charting the converging roads of the psychotherapy effectiveness research programme

By Bob Bertolino

Abstract

With the efficacy of psychotherapy established, divergent agendas in research have focused more exclusively on determining what makes psychotherapy effective. Although the research questions and methodologies that guide each of these agendas differ, they most frequently involve the same studies and body of research. Thus, there are significant paths of intersection and convergence amongst the agendas, which reveal common points of change. The purpose of this article is to engage in a preliminary dialogue about these commonalities and their relationship to effective therapy. It is hoped that this initial discussion will spawn further exploration of how varying perspectives in research share core elements which contribute to common principles that are correlated with improved therapeutic outcomes.

The Intersection of Research and Emerging of Principles of Change

Research has legitimized psychotherapy as an efficacious treatment (Asay & Lambert, 1999; Lambert & Ogles, 2004; Lipsey & Wilson, 1993; Smith, Glass, & Miller, 1980). Although less data is available regarding couples and family therapy, the results are consistent with those of individual psychotherapy (Sexton, Alexander, & Mease, 2004; Shadish, Ragsdale, Glaser, & Montgomery, 1995). Gains made by clients who engaged in therapy are statistically significant, clinically meaningful, and surpass those of clients who received placebos or went untreated (Lambert & Ogles, 2004).

With the efficacy of psychotherapy established, divergent agendas in research and practice have focused more exclusively on determining what makes psychotherapy effective. This commitment has contributed to a considerable expansion of knowledge. Accordingly, much has been written about the

individual benefits and shortcomings of research agendas as separate entities. The primary purpose of this article is to explore how these agendas in research converge to reveal common points of intersection and subsequently, principles of change. By exploring these commonalities, a new panorama of possibilities emerges for maximizing the capacities for individual, relational, and systemic change. This article represents a preliminary discussion of these findings.

Ecology and Convergence

In the book, The Medici Effect, author Frans Johnasson (2002) explores how varying, independent perspectives and disciplines intersect, leading to the resolution of problems—many of which are global. Although individual disciplines and theories within those disciplines maintain their integrity and usefulness as stand-alone approaches (i.e., an approach may provide a good fit for a particular person or situation in which there is a specific, well-defined concern), collectively each viewpoint contributes to an expanded perspective with potentially far greater benefits. The idea of merging different realms of thought or disciplines is a common one. The process of incorporating multiple perspectives has proven novel in the arts, sciences, politics, economics, social policy, health, education, and other areas affecting human existence (Bateson, 1972). A growing constellation of professional and popular literature also reflects this movement, creating new and emerging pathways of knowledge.

In psychotherapy, practitioners routinely draw on adjacent disciplines such as anthropology, art, education, spirituality, and sociology. This is further evidenced within the field of itself where there have been numerous in-depth explorations of various theoretical combinations in attempts to address the limitations of single theories. With a few exceptions, these attempts have focused primarily on creating new explanatory theories about personality and psychopathology, with the end point being the development of new integrative models (Norcross & Goldfried, 2005), although not necessarily a unified "metatheory" (Allen, 2007). Parallel to other fields, the investigation of ideas that are complementary and advance psychotherapy and family therapy has created new avenues of practice for clinicians (see Breunlin, Schwartz, & Mac Kune-Karrer, 1992; Mones & Schwartz, 2007; Norcross & Goldfried, 2005; Pinsoff, 1995, 2005; Prochaska & DiClemente, 2005; Sexton, Ridley, & Kleiner, 2004; Stricker & Gold, 1993). This exploration has also demonstrated a degree of responsiveness to a climate in which between one-quarter and one-half of therapists have considered themselves integrative or eclectic, utilizing a mixture of techniques in their practice (Bechtoldt et al., 2001; Jensen, Bergin, & Greaves, 1990; Norcross, Karpiak, & Lister, 2005).

At both macro (i.e., accessing and employing ideas from other disciplines) and micro (i.e., combining specific theories and methods within the discipline itself) levels, psychotherapists have embraced the notion of merging different avenues of thought. Despite this, the field has been slow to apply the idea of convergence to the primary, overarching research agendas that encompass the field itself and from which both individual theories and integrative perspectives have been drawn. Because the major "platforms" in research inform the practice of psychotherapy, a next step is for emphasis to be placed on identifying common principles that are complementary, correlated with successful outcomes, and exist across these agendas (Bertolino, 2010). In the next section each of these overarching research agendas will be discussed in brief.

Primary Agendas in Psychotherapy Research

Various attempts to understand the effects and impact of psychotherapy have been captured through four primary research agendas: empirically supported treatments (ESTs) and evidence-based practices (EBPs), common factors (CF), empirically supported therapy relationships (ESRs), and outcomes management (OM). Each of these agendas represents an effort to further legitimize the field of psychotherapy by recommending directions for practice and standards of care.

Agenda 1: Empirically Supported Treatments (ESTs) and Evidenced-Based Practices (EBPs) (Model-Based Research)

The most visible and debated agenda in psychological research is based on the question first posed by Paul in 1967, "What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances?" (p. 111). This inquiry spawned concentrated movements to identify models that, when practiced competently and consistently, will produce results that are reliably superior to others. With numerous models fitting the criteria for more than one classification, these general movements have included:

- empirically supported treatments (ESTs) [formerly empirically validated treatments (EVTs)] (Chambless, 1996; Chambless & Holon, 1998; Christophersen & Mortweet, 2001; TFPP, 1995),
- evidence-based practices (EBPs) (Drake, Merrens, & Lynde, 2005; Fisher & O'Donohue, 2006; Freeman & Power, 2007; Kazdin & Weisz, 2003; Norcross, Beutler, & Levant, 2005; Weisz, 2004), and
- what works/treatments that work (Carr, 2001; Fonagy, Target, Cottrell, Phillips, & Kurtz, 2002; Goodheart, Kazdin, & Sternberg, 2006; Nathan & Gorman, 2007; Roth & Fonagy, 2004).

Although the criteria for the various movements within the model-based agenda share similarities and differences, commentaries have consistently referred to these movements synonymously, whereas others have aimed at making distinctions, particularly between ESTs and EBPs (Westen, Novotny, & Thompson-Brenner, 2005). For the purposes of this discussion, emphasis will be on the shared theme of identifying treatment methodologies for which there is scientifically collected evidence that treatments work.

Spearheaded primarily by the American Psychological Association's original Task Force on Promotion and Dissemination of Psychological Procedures (TFPP, 1995), which later became the Committee on Science and Practice, this agenda focuses on identifying through stringent, clinically based, empirical studies, specific treatment approaches for specific mental-health disorders. Although primarily emphasizing therapies for adults, work groups were also established to determine psychosocial interventions for children and adolescents diagnosed with depression, anxiety disorders, conduct disorders, attention-deficit/hyperactivity disorder, and autism.

Model-based research is most frequently based on randomized clinical trials (RCTs). This involves pairing treatment modalities with "disorders" or clusters of problems defined by pre-established criteria. Chambless and Hollon (1998), stated, "We do not ask whether a treatment is efficacious: rather, we ask whether it is efficacious for a specific problem" (p. 9). "Problems" are most commonly categorized as some form of mental disorder with the Diagnostic and Statistical Manual for Mental Disorders, Fourth edition (DSM-IV-TR) (American Psychiatric Association, 2000) providing the standard nosology. To be deemed "empirically supported" a model needs to be tested in two separate, independent studies (RCTs) and outperform a no-treatment alternative or placebo condition. This is important research as it establishes a context where models are tested under stringent conditions. It also provides empirical rationale for understanding the available psychotherapeutic options given a particular problem or disorder. It is a reasonable assumption that some approaches provide a better therapeutic fit for some clients, under some circumstances, and therefore would yield meaningful outcomes (Sprenkle & Blow, 2004).

Agenda 2: Common Factors

A second perspective is grounded in meta-analytic studies as opposed to RCTs. Meta-analysis is an efficient and objective process of pooling or clustering various studies that meet predefined inclusion criteria. These studies are then evaluated statistically to identify quantitative relationships between study features and results obtained. Meta-analysis has been used to explore the effects of specific treatment approaches and diagnoses such as depression and anxiety (see Lambert, 2004). It has also been utilized in a broader sense as a means of addressing the general benefits of psychotherapy regardless of the model employed (Lambert, 1992; Smith & Glass, 1977; Smith, Glass, & Miller, 1980; Wampold, 2001).

Arguably, the most compelling finding of meta-analytic studies is the hypothesis that successful therapeutic outcome is more contingent on general effects or "common factors" than methods, models, or what researchers refer to as specific effects or ingredients. General effects refer to the benefits produced by aspects that are nontheory-specific—they are not unique to any one model or approach. Rather, they are common among effective modalities and account for the significant portion of positive change (Hubble, Duncan, & Miller, 1999; Lambert, 1992; Wampold, 2001). Specific effects or ingredients refer to the benefits of specific actions (for example, techniques, methods, models) considered necessary for the success of treatment (Wampold, 2001). It is suggested that these common variables, not differences that account for the majority of the variance in change and positive outcome (Lambert, 1992; Wampold, 2001). Said differently, effective psychotherapeutic models are more similar than different, sharing core principles that are not random nor are they aligned with any one model, field, or research perspective.

Hypothesized as early as the 1930s (Rosenzweig, 1936) and studied in depth in recent years (Frank, 1973; Frank & Frank, 1991), the idea of commonalities among treatment approaches has gained significant momentum (see Duncan, Hubble, & Sparks, 2004; Wampold, 2001). Michael Lambert (1992) suggested four specific factors: extratherapeutic change (client factors), therapeutic relationship, expectancy (placebo effects), and techniques.

Client factors represent resources such as internal strengths and social support systems, as well as faith, family relationships, membership in a community or religious sect, or any factors that clients bring to therapy. Lambert (1992) indicated that these factors account for the most significant portion of improvement that occurs in any form of psychotherapy and up to 40% of the variance in outcome. Relationship factors have been estimated to account for as much as 30% of the variance in treatment outcome. More recently the therapeutic relationship has been expanded to a broader concept known as the therapeutic "alliance," a more encompassing term that emphasizes collaborative partnership

between clients and therapists (Horvath, 2001; Horvath & Bedi, 2002). Expectancy and placebo factors relate to the portion of improvement derived from clients' knowledge of being helped, the installation of hope, pretreatment expectancy, therapist confidence and enthusiasm, and the credibility of methods and techniques from the perspective of clients. Lambert (1992; Asay & Lambert, 1999) initially estimated that expectancy and placebo in therapy contributed approximately 15% of the variance in therapeutic outcome. The fourth factor, model and technique, includes but is not limited to asking particular questions, using specific interventions, assigning tasks, making interpretations, and teaching skills. Most techniques or procedures are designed to get clients to do something different, such as experience emotions, face fears, change patterns of thinking or behavior, and develop new understandings or meanings. Lambert (1992) suggested that model and technique account for the same percentage contribution to outcome variance as placebo factors—about 15%.

Lambert's (1992) initial assignment of percentages to the four common factors was based on an interpretation of, not a statistical analysis of, 40 years of data. However, Wampold's (2001) scientific evaluation and statistical analysis of the data found that Lambert correctly interpreted that the significant portion of variance in psychotherapeutic outcomes are due to general effects. Moreover, Wampold found that ingredients such as model effects accounted for at most 8% of the variance and only 1% of the overall variance could be assigned to specific technique. This leaves approximately 22% in variance. Furthermore, Wampold's (2001) findings suggest that nontheory-based elements, contributing 70–92% (or more) of the variance, are by far the most significant contributors to therapeutic outcome.

Agenda 3: Empirically Supported Therapy Relationships (ESRs)

A third agenda, also created by the APA, is represented through a task force known as the Division of Psychotherapy (Division 29). This task force was formed to identify elements of effective therapy relationships that affect treatment outcomes and determine efficacious methods of customizing therapy to individuals on the basis of their characteristics (Norcross, 2002). This meant including client and therapist factors and variables that influence relationships and affect change (Beutler & Castonguay, 2006). Division 29 made clear delineations between its efforts and those set forth by Division 12 (Norcross, 2002). Beyond a shift from focusing on treatments and technical interventions to researching elements of therapy relationships and client and therapist characteristics, ESR researchers examined different forms of methodological design. These included RCTs, naturalistic, process-outcome, and correlational studies.

The task force set forth a series of conclusions and recommendations for practice, training, research, and policy (Steering Committee, 2001). Central to these recommendations was that practitioners adapt therapy relationships to specific client characteristics and routinely monitor clients' responses to therapy and ongoing treatment. The steering committee also proposed, "Training programs in psychotherapy are encouraged to provide explicit and competency-based training in the effective elements of the therapy relationship" (p. 496). A decade prior to Division 29 and Norcross' pioneering efforts, Lambert and Bergin (1992) stated, "Of all of the common factors investigated in psychotherapy, none has received more attention and conformation than the importance of the therapeutic relationship" (p. 371). Consistent with this point of view is that with some clients, relationship factors will contribute more or less to the variance of change. Further, relationships can be ruptured, damaged, or strengthened through therapeutic processes. It is therefore essential that clinicians are adept at skills that enhance relationships and are responsive to ongoing changes in the therapeutic milieu.

Agenda 4: Outcomes Management

The final research and practice agenda is sometimes referred to as "patient" or "client-based." Operationalized through outcome measurement and management, this movement involves monitoring the responses of those receiving services. It is important to distinguish between outcomes measurement and outcomes management. According to Brown et al. (2001), "Outcomes measurement involves assessing clinical outcome of treatment though the use of standardized measures of clinical severity" (p. 925). This is done by calculating change from at least two different data points, most often one at the beginning of treatment and another at some later time such as the conclusion or in follow-up. Outcomes management is a more comprehensive system of monitoring and tracking data and using that data to improve services. It is focused on improving the effectiveness of therapy (Brown et al., 2001). Outcome is generally measured through alliance and outcome

strategies. Alliance measures track clients' ratings of the therapeutic relationship. Outcome measures track clients' ratings of the impact of services on major dimensions of life functioning. These areas include individual functioning (personal and symptomatic distress), interpersonal (close, intimate) relationships and well-being, and social role functioning (for example, satisfaction with work, school, and relationships outside of family).

Alliance and outcome measures are used on a consistent basis, often in every session or interaction. Information gleaned from ongoing, "built in" feedback mechanisms is incorporated directly into sessions and shapes the approach being utilized. Therefore the approach employed in any given situation and frequently in single interactions is client-driven and largely determined through real-time processes. This makes for "practice-based evidence," which increases the factor of fit between providers and clients and allows for greater malleability in service provision (Duncan, Miller, & Sparks, 2004). Practice based evidence, then, involves the ongoing integration of information gathered through alliance and outcome measures into treatment. Although a relatively new movement, outcome-management methods are being applied in numerous settings and have been shown to enhance treatment outcome (Lambert, 2004; Lambert, Whipple, Smart et al., 2001; Lambert, Whipple, Vermeersch et al., 2002).

General Criticisms and Strengths of the Research Agendas

The four movements in research and practice present both shortcomings and strengths. Whether in support of or criticism of a particular agenda, it is important to understand that these agendas are based primarily on interpretations of the same studies and the same body of research (Beutler & Castonguay, 2006). What follows are general criticisms and strengths associated with the research agendas described.

Criticisms

ESTs/EBPs have faced criticisms regarding problems with RCTs, claims of efficacy versus a placebo condition and lack of differential efficacy in comparative analysis (Elkin, Shea, & Watkins, 1989; Lambert, 2004; Lambert & Bergin, 1994; Shadish et al., 1995; Smith, Glass, & Miller, 1980; Wampold, 2001), efficacy versus effectiveness studies (i.e., laboratory-based experimental trials versus "real life" clinical settings) (Lambert, 2004), and allegiance effects (Lambert & Ogles, 2004; Luborsky et al., 1999; Wampold, 2001). The CF agenda has been challenged as vague, theory-less, difficult to articulate, and for its reliance on meta-analyses. Similarly, ESRs have faced remarks that parallel those associated with the common factors agenda and its emphasis on ambiguous concepts as opposed to specific methods and techniques. Finally, criticisms of OM have focused on the issue of clients' ratings of the alliance and outcome noting that they do not always provide accurate representations of change. The implication is a reliance on client feedback numbers can inadvertently lead to "false positives" or indicators of success.

Strengths

When the various agendas are studied in terms of their strengths, consistent crossroads of intersection emerge, revealing significant common ground and agreement about the underpinnings of successful practice. Figure 1.1 provides a list of these points of convergence. A convergence among research perspectives suggests that in effective therapy there are universal premises that increase the likelihood of positive outcomes, highlighting a collective strength of research agendas.

The concept of convergence and unifying ideas that inform practice is a growing one. Castonguay and Beutler (2006) suggested that a focus on empirically supported "principles of change" (ESPs) that encompass a variety of therapeutic factors is overdue. They state, "We think that psychotherapy research has produced enough knowledge to begin to define the basic principles that govern therapeutic change in a way that is not tied to any specific theory, treatment model, or narrowly defined set of concepts" (p. 5). This position echoed by researchers who have suggested that common principles of practice that underscore effective services be outlined and disseminated (Duncan, Miller, & Sparks, 2004; Rosen & Davison, 2003; Wampold, 2001).

Points of Convergence/Principle of Change

A review of the major agendas in research and practice reveals six points of convergence and principles of change including: client contributions, the therapeutic relationship and alliance, cultural competence, change as a process, expectancy and hope, and method and factor of fit. Each of these will be discussed next.

Client Contributions

Clients are the single most important contributors to outcome (Tallman & Bohart, 1999). Estimates are that client factors provide between one third and one half of the overall variance in outcome, making them the engineers of change (Lambert, 1992; Wampold, 2001). Client factors are comprised of internal strengths and external resources and supports. Internal strengths include optimism, persistence, resilience, protective factors, coping skills, and abilities utilized in vocational, educational, and social settings. Resilience and protective factors refer to those qualities and actions on the part of clients that allow them to meet and survive the difficulties and challenges of life. External resources refer to relationships, networks, and systems that provide support and opportunities. Examples are family, friends, employment, educational, community, and religious supports. External resources also include affiliation or membership in groups or associations that provide connection and stability. Client support systems are central in maintaining long-term change. Evoking and amplifying client strengths and contributions to change does not mean downplaying real-life difficulties, pain, and suffering that people have experienced or are currently going through. Rather, it means acknowledging and attending to the hardships that clients face while simultaneously

focusing on the possibilities for change. In addition to the evocation of client strengths, effective therapy involves the use of psychoeducational activities to facilitate change. This corresponds to assisting clients though educational and experiential activities in learning and developing new understandings and skills.

Points of convergence amongst primary research agendas

- Change is predictable
- Change begins early in the therapeutic process
- The client(s) is the most significant factor in change (i.e., identify and build on internal strengths and social support systems)
- The strength of the therapeutic relationship and alliance from the client's perspective
- Empathy (a person's ability to understand another's perspective or way to experience the world), Positive regard (a person's warmth and acceptance toward the self or another), and Congruence (sometimes referred to as genuineness, is characterized by a person's personal involvement in a relationship and willingness to share this awareness through open and honest communication)
- The client-practitioner match
- Sensitivity and respect for the unique cultural and contextual characteristics of each client
- The creation of a respectful therapeutic climate in which clients are able to explore and express their personal stories or narratives and associated emotions
- Inclusion of clients in processes (i.e., preferences, service planning, safety planning, goal setting, tasks, etc.)
- Selection and matching of methods with clients according to factors such as preferences, level of need, state of readiness, level of distress/impairment, and coping style
- Educational and developmental processes that increase social skills, coping skills, and self-regulation
- Incorporation of client-practitioner "real time" feedback loops (i.e., monitor the strength of the alliance and outcome/the subjective impact of therapy)
- Attention to alliance ruptures
- Attention to practitioner contributions to change (e.g., expectations, preferences, level of personal awareness, patience, etc.)
- Structure/focus in sessions/meetings/interactions
- Exploration of client expectations
- Creation or rehabilitate hope
- A future focus
- Self-disclosure

Figure 1.1

Tapping into client contributions involves respecting their motivations. Therapists who are making the most of client contributions are attending to and matching clients' levels of motivation. This means learning how clients situate themselves in relation to their concerns (for example, involved, not involved, their problems, other people's problems) and what they feel needs to happen for their lives or situations to improve (for example, nothing, new perspectives, new actions, change in interactions). This information assists with matching methods with the client's levels of motivation as a means of increasing the chance of a successful outcome.

The Therapeutic Relationship and Alliance

Numerous studies have indicated that client ratings of the therapeutic relationship are significantly related to therapeutic outcome and possibly the best and most consistent predictors of improvement (Bachelor & Horvath, 1999; Orlinsky, Grawe, & Parks, 1994; Orlinsky, Rønnestad, & Willutzki, 2004). Those who are engaged and connected with their therapists are likely to benefit most from therapy. Client ratings of therapists as empathic, trustworthy, and nonjudgmental are better predictors of positive outcome than therapist ratings, diagnosis, approach, or any other variable (Horvath & Symonds, 1991; Lambert & Bergin, 1994). Said differently, it is not whether therapists believe they are connecting with clients, but whether clients experience connection with their therapists. Connection, most frequently monitored through client self-report measures and feedback processes, is consistently linked with high ratings of empathy, genuineness, and positive regard on the part of therapists. Therapists convey these core relational dynamics through listening and attending, acknowledging, and validating what clients experience. This includes feelings, sense of self, bodily sensations, and sensory experience. Therapists also pay close attention to the ways that clients use language and talk about their lives, situations, and concerns. Client satisfaction ratings are related to similarity in the client-therapist linguistic style. Therapists strengthen relationships by accommodating and matching clients' use of language, and nonverbal communication (Bedi, 2006).

The therapeutic alliance is a broader term highlighting the collaborative partnership between clients and therapists. In addition to the strength of the client-therapist bond, the degree to which clients collaborate with regard to processes (e.g., how to meet, when to meet), directions of therapy, establishment of goals, and methods to achieve those goals is paramount (Bordin, 1979). Orlinsky, Grawe, and Parks (1994) noted that the quality of the client's participation in therapy is a crucial determinant of outcome. Negative outcome is often traced to clients being excluded from therapeutic processes. Effective therapists monitor their relationships with clients and remain responsive to changes throughout the course of therapy.

Cultural Competence

A core premise underlying research and practice agendas is culture. Identifying a gap in current practices, Wampold (2001) stated, "Because specific ingredients of most treatments . . .

are designed and implemented without consideration of race, ethnicity, or culture, these treatments are recommended for a disorder, problem, or complaint blind to the client's cultural values" (p. 221–222). Without these influences, clients, their lives, situations, and problems cannot be adequately understood.

Culture refers to a system of shared beliefs, values, customs, behaviors, and artifacts among various groups within a community, institution, organization, or nation. It reflects gender, race, ethnicity, nationality, religion/spirituality, sexual orientation, socioeconomic status, and physical abilities. From generation to generation, members of society use their cultural references to cope with their world and with one another. Context is associated with and inclusive of culture as well as other variables that influence thinking and behavior. These include but are not limited to family history, social relationships, development (in other words, physical, cognitive, emotional), genetics and biology, politics, and economics. Context also includes time and space (in other words, when, where, duration, intensity) and conditions and settings (i.e., cultural, philosophical, physical, psychological, and social dimensions). Context has two primary connotations. First, it refers to the healing environment and relationship and the meanings attributed to it by participants (Frank & Frank, 1991). Next, context refers to individual differences and variables that may influence problems, possibilities, and solutions including but not limited to culture, family history and background, social relationships, genetics and biology, religion/spirituality, gender, sexual orientation, nutrition, and economics (Bertolino & O'Hanlon, 2002).

"Client ideas are often embedded in their language and can be cultivated through careful listening. More powerful than therapist explanations are clients' perceptions and attributions regarding the influences of context on their problems."

Contextual aspects do not cause problems or solutions, they influence and shape them. Given that any one problem can have multiple influences, what is most important are the meanings clients attribute to aspects of context. It is not that clients always enter therapy with clear-cut theories of causation, yet they do often have ideas about the nature of or influences on their concerns (Bertolino, 2003; Brickman et al., 1982; Wile, 1977). Client ideas are often embedded in their language and can be cultivated through careful listening. More powerful than therapist explanations are clients' perceptions and attributions regarding the influences of context on their problems.

Practitioners who have diverse backgrounds can draw on such experiences and knowledge to match clients' ideas about problems, possibilities, and potential solutions. Therapists engage in conversations with clients where a multitude of possibilities can be generated and explored. They encourage dialogues that open up space for new perspectives to emerge. Thus, knowledge of different perspectives is beneficial as it allows therapists to view situations from varying perspectives without having to align with any one viewpoint. It also brings with it a wider repertoire of methods, which may be helpful in therapy.

Change as a Process

Each of the major agendas emphasize different ways of facilitating change. Change is constant; people, situations, and problems are not static. Clients' problems will fluctuate in frequency, intensity, and duration. Recognizing this variability, therapists learn about times when problems are more or less dominating or absent altogether and about the influence that clients have over problems and factors that increase this influence. Explorations of differences and influences assist with understanding how change occurs in clients' lives and how they are able to mobilize their resources in problematic situations. Because the significant portion of change occurs in situations outside of therapy sessions therapists take care to notice moments of change regardless of where or when they happen and incorporating those changes into therapy.

Change is also predictable. Miller et al. (1997) found that "all large-scale meta-analytic studies of client change indicate that the most frequent improvement occurs early in treatment" (p. 194). Most major positive impact in therapy happens during the first six to eight sessions (Fennell & Teasdale, 1987; Howard, Kopta, Krause, & Orlinsky, 1986; Howard, Lueger, Maling, & Martinovich, 1993; Ilardi & Craighead, 1994; Smith, Glass, & Miller, 1980). Further, studies have demonstrated that 60–65% of clients experience significant symptomatic relief within seven sessions (Brown, Dreis, & Nace, 1999; Howard, Kopte, Krause, & Orlinsky, 1986; Howard, Moras, Brill, Martinovich, & Lutz, 1996; Lambert, Okiishi, Finch, & Johnson, 1998; Smith, Glass, & Miller, 1980; Steenbarger, 1992; Talmon, 1990; Talmon, Hoyt, & Rosenbaum, 1990).

Consistent with the concept of change occurring early on in services, regardless of the model employed, the average length of time that clients attend therapy is 6 to 10 sessions (Garfield, 1989; Koss & Butcher, 1986). Although clients end therapy for a variety of reasons (with many getting the results they expected in a single session), these findings indicate that not only does the majority of change happen early on, but clients expect at least some degree of change to happen early on and more often than not, before 10 sessions. These findings underscore the importance of therapists maintaining an eye on being as effective as possible by learning from clients what minimally needs to happen in each interaction or session to bring about meaningful and noticeable improvement.

Clients can benefit from therapy that extends beyond eight sessions. However, as treatment progresses, there is a reliable course of diminishing returns with more and more effort required to obtain just noticeable differences in client improvement (Howard et al., 1986). Even though the amount of change decreases over time, as long as progress is being made then therapy can remain beneficial. Further, if clients are "early responders" and experience meaningful change in the first handful of sessions, the probability of positive outcome significantly increases (Lambert, 2002). In contrast, when clients show little or no improvement or experience a worsening of symptoms early on in treatment then they are at significant risk for negative outcome (Lebow, 1997). It

is not the number of sessions that is most important, but collaborating with clients to determine when needs, goals, and outcomes have been achieved. Therapists consider that clients will vary in their use of therapeutic services, with some moving in and out very quickly. Others will attend therapy over extended periods of time or in "rounds" (i.e., intermittently, a few sessions at a time). Given this, flexibility in terms of allowing for entry, termination, and reentry on the part of clients, is needed.

Expectancy and Hope

These factors refer to the portion of improvement derived from clients' knowledge of being treated, the installation of hope, and the credibility the client places on the rationale and techniques used (Duncan, Miller, & Sparks, 2004). Researchers estimate this combination of elements contributes a minimum of 15% to the variance in outcome (Asay & Lambert, 1999; Lambert, 1992). Despite the wide variance, the influence of these aspects is clear. Effective therapists not only maintain an awareness of expectancy and hope, they focus on ways of increasing these factors in all aspects of services.

Clients' and therapists' expectations about therapy are crucial, involving both parties believing in the procedures and restorative power of therapy. Clients' expectations that therapy can help serves as a placebo, and can counteract demoralization, activate hope, and advance improvement (Frank & Frank, 1991; Miller, Duncan, & Hubble, 1997). In most cases it will not be the technique or method that leads to a specific change, but the client's belief in the technique or method and the therapist (that they are in "good hands") that accounts for a significant portion of difference. What also seems to be important is whether: 1) the processes and practices used by therapists contribute to the expectancy for change and increase hope; 2) clients and practitioners believe in the treatments and the rationales behind them; and 3) the fit between methods and clients' perspectives, including their ideas about problems and possibilities for solution.

Expectancy and hope offer a remedy to impossibility. When things are going poorly, most people, at some level, would like their lives to improve, at least minimally. This is not about looking at the world through rose-colored glasses; it is recognizing that if people have choices, most will prefer things to be better. An underlying philosophy of pessimism or negativity (when it is not with the intent of matching and joining with clients) can dampen hope and represent the difference between clients having a positive experience and continuing services.

"Clients' and therapists' expectations about therapy are crucial, involving both parties believing in the procedures and restorative power of therapy."

Method and Factor of Fit

All therapeutic approaches help clients with making changes in one or more areas in their lives. Methods used to facilitate change can be general, as with using listening and attending skills, or open and closed questions. Or, they can be specific such as assigning tasks, making interpretations, and teaching skills. Most procedures are designed to have clients experience emotion, change sensory sensations (i.e., visual, auditory, kinesthetic), change thinking, develop new understandings or meanings, or change patterns of behavior. It has been suggested that this is a primary aim of effective therapies—to create shifts in systems that are the result of new perspectives, thereby leading to second-order change (Fraser & Solovey, 2007).

Empirical findings have indicated that methods, models, and techniques account for no more than 8% of the variance in outcome (Wampold, 2001). Although nontheory-specific effects account for the majority of the variance in outcome, this does not imply that methods are irrelevant. Instead, it highlights the issue of how methods are selected and used. Methods are more likely to be effective when they evolve from collaborative conversations with clients, match their orientations (in other words, ideas about problems and possibilities for solution), and activate and enhance the contribution of general effects (in other words, the factors described in the first five principles). When clients experience therapists as working with them in ways that are consistent with their views of concerns, problems, and the resolution of those concerns and problems, then there is an increased "factor of fit."

Factor of fit can be increased by determining the validity of methods by checking with clients. Most clients will not know whether a specific technique is being used, however, how they respond to therapists' use of questions, for example, can make a difference. Further, as discussed, clients' beliefs about particular focuses (for example, emphasizing thoughts, behaviors, interactions) in therapy weigh in heavily on the fit of the approach. A lack of fit (for example, the therapist is focusing on cognitions and insight, whereas the client sees the problem as relational) can have detrimental effects by negatively affecting the therapeutic relationship, dampening hope, and curbing expectancy for positive change (Bertolino, 2003). Therapists draw on their knowledge of theories to match clients' ideas about problems, possibilities, and potential solutions. This allows therapists to view situations from varying perspectives without having to align with any one model or viewpoint.

Methods are rituals, practices that therapists use as part of personal therapeutic traditions. The selection of methods must be based on client interactions and sound rationale. They should also be practiced respectfully, be culturally sensitive, and allow space for clients to give feedback. By monitoring the factor of fit, clients continue to be in charge of change processes and increase their chances of reaching their goals and achieving positive outcomes. In the best sense, methods mobilize and activate clients' resources.

Discussion

The research agendas and principles of change described above reflect a shift toward broadening the platforms and parameters of research and how recommendations for practice are determined. This perspective has been espoused by the

American Psychological Association, which in 2005 established a task force in evidence-based practice in psychology (EBPP) (APA Presidential Task Force on Evidence-Based Practice, 2006). Reflecting a more encompassing perspective, the task force redefined EBPP as: "The integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273). Wampold, Goodheart, and Levant (2007) further commented on this progression, stating that EBPP "is a general framework that subsumes various forms of evidence drawn from various data sources for particular purposes" (p. 617). This more recent definition of EBPP represents the broadest characterization to date of what constitutes "evidence-based practice," closely resembling the definition of EBP adopted by the Institute of Medicine, which states: "Evidence-based practice is the integration of best research evidence with clinical expertise and patient values" (Sackett, et al., 2000). It also acknowledges previous factors, including client characteristics and variables that have been noticeably absent in past definitions, while underscoring the importance of convergence amongst adjoining disciplines.

Although criticisms remain (Stuart & Lilienfeld, 2007), there are indications that gaps between research and practice agendas are closing. For example, whereas RCTs were at one time considered the standard in psychological research, there is growing support for other forms of research which reflect a multiplicity of viewpoints and methodologies. A further indication of this is a movement toward the recognition of outcomes management as an EBP. These examples represent the emergence of a more comprehensive meta-view of therapy and on helping relationships in general.

The various independent research agendas have contributed to a wealth of knowledge about the ingredients that underscore effective psychotherapy. This knowledge informs the six core principles outlined in this paper. These principles represent points of convergence amongst the agendas and yet are not independent ingredients to be viewed in isolation of one another. By conceptualizing each principle as a distinct, independent entity, the relative effectiveness of their interrelatedness would be minimized. In contrast, when used in concert these principles create a foundation for enhancing therapeutic outcomes. There are no definitive answers nor are there "one-size-fits-all" approaches. However, through the study of the various research and practice agendas, therapists can enhance their effectiveness by incorporating principles that underscore therapy in general.

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Title: Our desire of unrest: Thinking about therapy
Author: Michael Jacobs
Publisher: Karnac Books
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Reviewed by: T.B Broll

This book is a collection of unpublished articles and lectures that the author has written over the span of his career. His readers are given the opportunity to glean what they can from his own process of exploration during his journey as a psychotherapist. The title of the book, *Our Desire of Unrest*, encapsulates the spirit of this collection of challenging enquiries. We are urged to cultivate a creative uneasiness in the course of our work as therapists—to always be curious, exploratory and never sure. Although eschewing the dogma of psychoanalysis, the author places explicit value on the field of psychoanalysis as a metaphorical language for understanding the unconscious and the complexity of the therapist/client relationship. His facility and expertise in the area of psychoanalytic thinking are clearly demonstrated in texts he has written on Freud and Winnicott, some of which have undergone numerous translations. However, in the interests of therapeutic flexibility he refers to himself as 'psychodynamic' rather than psychoanalytic.

Our Desire for Unrest is a potpourri of psychotherapeutic debates and issues in amongst which we find treatises on the therapist's use of self, the value of diagnostic labelling and naming, expectations for therapeutic change, supervision, revenge, fame, fate and the maturing therapist. The author takes a largely humanist position in these discussions valuing the therapeutic importance of human authenticity over devotion to technique. In a similar sentiment to Self Psychologists he promotes the human face of psychoanalysis, reminding us of the immense value of the work of analysts such as Harold Searles. In his own desire for unrest, he has valued the creative promise of the unknown and the potential of doubt and curiosity. In this vein, he articulates the difference between diagnostic labels and the process of naming. Since psychotherapy is more of an art than a science the use of flexible metaphor in the process of naming can bring healing order to the psyche.

The section on the relationship between revenge and caring is particularly compelling. Here the author takes us through the creative potential of jealousy, envy and revenge. A consideration of the therapist's need for revenge on the client for injuries sustained to omnipotent fantasies of reparation provides much potential for unrest in the reader. A need for revenge in an individual can also enhance the motivation to care and produce constructive as well as destructive results. This chapter contains a wealth of useful material.

In a later chapter on supervision, the author reminds us as well that the supervisory process is a unique and complex setting that is not simply a parallel process to the supervisee's therapy with their client. Supervision has its own mysterious dynamics that deserve continual exploration. He refers to Harold Searles whose challenging work pre-empted many of the contemporary debates in psychoanalysis, especially in the complexity of the shared fantasy between patient

oks

and client and supervisor and supervisee. Jacobs writes, "The relationship is not that of master and apprentice. Supervision works because the emotional atmosphere between supervisor and therapist is less intense than that in the therapist-client relationship." (p.95) Being mindful of this phenomenon brings the appropriate humility to both parties in the supervisory process.

What characterises the mature professional, the author muses in his final chapter, is that there is enough confidence and experience to challenge the boundaries of training. He gives examples of some of our most famous professionals, such as Freud and Winnicott, who have trusted their humanness at crucial moments in psychotherapy. He concludes that the therapeutic task is not about change, but rather about the therapeutic relationship. It is this crucible that offers the optimism for change.

"This collection of works by a now mature and experienced therapist, is primarily a call to other psychologists to embrace a professional life of curiosity, questioning and searching."

This collection of works by a now mature and experienced therapist, is primarily a call to other psychologists to embrace a professional life of curiosity, questioning and searching. I think it is the spirit of this call that is the strength of this book rather than offering anything new to the reader. The author would like the reader to cultivate a 'desire for unrest'. When something captures your imagination, travel with it—research it, write about it, lecture on it. In a way, he is sharing with us the most important learnings of his professional life: be circumspect about dogma, trust the human element of the healing process, embrace not knowing, chaos and the creativity of the search.

Since this is a collection of works from the past two decades, many of the issues have by now been well trodden. In this sense the book is not essential reading or a must have for the library shelf but rather an important reminder of the place of humility and doubt when faced with the complexities of the human psyche. There are perhaps too many long direct quotes from other authors which detracts from the flow of the authors voice. However, this is a worthwhile read and the use of theological and literary references gives depth and resonance to the read.

About the author

Michael Jacobs, now in retirement, has spent most of the last three decades of his professional life at the coalface of psychotherapy. His most widely read publications Psychodynamic Counselling in Action (2004, 3rd Edition) and The Presenting Past (2006, 3rd Edition) stand as seminal texts in the area of psychotherapeutic training. Although he resides and has worked mainly in the United Kingdom, his work has had impact beyond these borders. A large part of his professional life has been spent as director of the Counselling and Psychotherapy programme located at the University of Leicester. South African readers would be interested to know that he co-authored a book in 2003 entitled Conscious and Unconscious with David Edwards of Rhodes University, an important South African centre for training in Counselling and Clinical Psychology.

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