

The Person of the Therapist: One Therapist's Journey to Relationship

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At bottom every man (sic) knows well enough that he is a unique being, only once on this earth; and by no extraordinary chance will such a marvelously picturesque piece of diversity in unity as he is, ever be put together a second time.

—Friedrich Nietzsche

There seems to be a prevailing view that to be an accomplished psychotherapist one must be well versed in evidence-based treatments (EBTs) or in those models that have been shown in randomized clinical trials (RCTs) to be efficacious for different “disorders.” The idea here is to make psychological interventions dummy-proof, where the people—the client and the therapist—are basically irrelevant (Duncan & Reese, 2012). Just plug in the diagnosis, do the prescribed treatment, and, voilà, cure or symptom amelioration occurs! This medical view of therapy is perhaps the most empirically vacuous aspect of EBTs because the treatment itself accounts for so little of outcome variance, while the client and the therapist—and their relationship—account for so much more. The fact of the matter is that psychotherapy is decidedly a relational, not a medical, endeavor (Duncan, 2010), one that is wholly dependent on the participants and the quality of their interpersonal connection.

A long time ago in a galaxy far way, I was in my initial clinical placement in graduate school at the local state hospital. This practicum was largely, if not totally, intended to be an assessment experience. Tina, my first client ever, was like a lot of the clients—young, poor, disenfranchised, heavily medicated, and on the merry-go-round of hospitalizations—and at the ripe old age of 22, she was called a “chronic schizophrenic.”

I gathered up my WAIS (Wechsler Adult Intelligence Scale), the first of the battery of tests I was attempting to gain competence with, and was on my merry but nervous way to the assessment office, a stark, run-down room in a long past its prime, barrack-style building that reeked of cleaning fluids overused to cover up some other worse smell, the institutional stench. But on the way, I couldn't help but notice all the looks I was getting—a smirk

from an orderly, a wink from a nurse, and funny-looking smiles from nearly everyone else. My curiosity piqued, I was just about to ask what was going on when the chief psychologist put his hand on my shoulder and said, “Barry, you might want to leave the door open.” And I did.

I greeted Tina, an extremely pale young woman with short brown, cropped hair, who might have looked a bit like Mia Farrow in the Rosemary’s Baby era had Tina lived in friendlier circumstances, and introduced myself in my most professional voice. And before I could sit down and open up my test kit, Tina started to take off her clothes, mumbling something indiscernible. I just stared in disbelief, in total shock really. Tina was undaunted by my dismay and quickly was down to her bra and underwear when I finally broke my silence, hearing laughter in the distance, and said, “Tina, what are you doing?” Tina responded not with words but with actions, removing her bra like it had suddenly become very uncomfortable. So there we were, a graduate student, speechless, in his first professional encounter, and a client sitting nearly naked, mumbling now quite loudly but still nothing I could understand, and contemplating whether to stand up to take her underwear off or simply continue her mission while sitting.

Finally, in desperation, I pleaded, “Tina, would you please do me a big favor? I mean I would really appreciate it.” She looked at me for the first time and said, “What?” I replied, “I would really be grateful if you could put your clothes back on and help me get through this assessment. I’ve done them before, but never with a client, and I am kinda freaked out about it.” Tina whispered “Sure,” put her clothes back on, and completed the testing.

I was so appreciative of Tina’s help that I told her she really pulled me through my first real assessment. She smiled proudly, and ultimately smiled at me every time she saw me

from then on. I wound up getting to know Tina pretty well and often reminded her how she had helped me. The more I got to know Tina and realized that her actions, stemming from horrific abuse, were attempts to take control of situations in which she felt powerless, the angrier I became about her being used as a rite of passage for the psychology trainees—a practice that I stopped.

I’ll never forget the lessons that Tina taught me in the very beginning of my psychotherapy journey: Authenticity matters, and when in doubt or in need of help, ask the client because you are in this thing together. Thanks, Tina, for charting my course toward relationship.

This chapter addresses the person of the therapist and what qualities of therapists make a difference in outcomes—after the client, the therapist is the most potent aspect of change in therapy, and in most respects *is* the therapy. With that empirically based assertion as a backdrop, the factors that account for change are presented, and through stories of clients, I describe my journey to a relational perspective of psychotherapy.

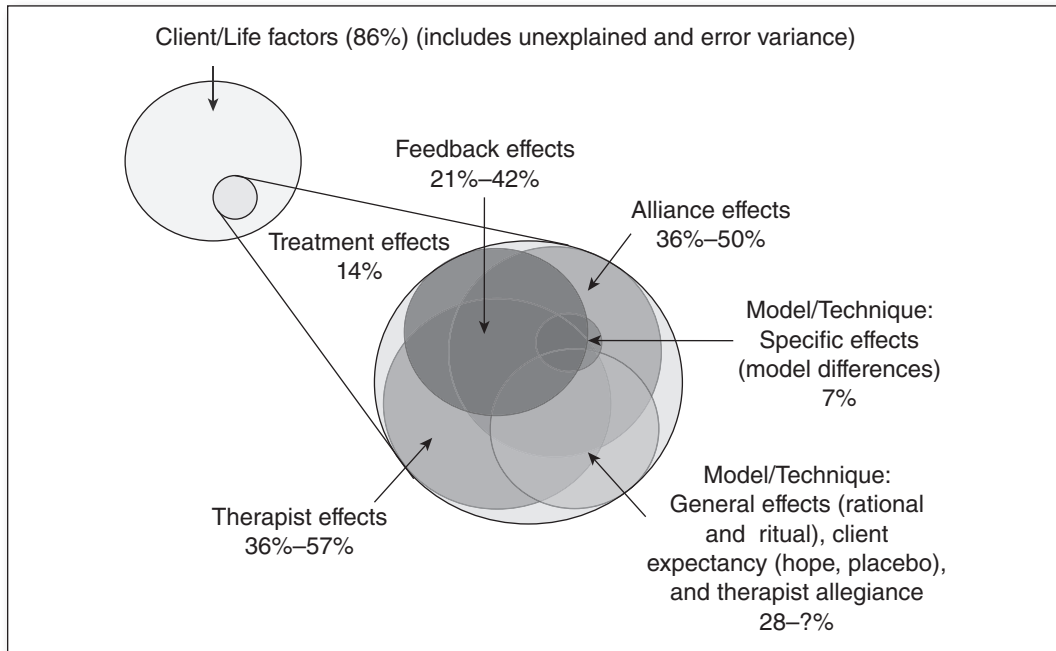
THE COMMON FACTORS

It is easier to discover a deficiency in individuals, in states, and in Providence, than to see their real import and value.

—Hegel

To understand the common factors, it is first necessary to separate the variance due to psychotherapy from that attributed to client/life factors, those variables incidental to the treatment model, idiosyncratic to the specific client, and part of the client’s life circumstances that aid in recovery despite participation in therapy (Asay & Lambert, 1999)—everything about the client that has nothing to do with us (see Figure 29.1).

Figure 29.1 The Common Factors



NOTE: There is some controversy surrounding how potent this effect is, hence the question mark.

Calculated from the oft-reported .80 effect size of therapy, the proportion of outcome attributable to treatment (14%) is depicted by the small circle nested within the larger circle at the lower right side of the left circle. The variance accounted for by client factors (86%), including unexplained and error variance, is represented by the large circle on the left. Even a casual inspection reveals the disproportionate influence of what the client brings to therapy. More conservative estimates put the client's contribution at 40% (Lambert, 2013). As examples, persistence, faith, a supportive grandmother, depression, membership in a religious community, divorce, a new job, a chance encounter with a stranger, and a crisis successfully managed all may be included. Although hard to research because of their idiosyncratic nature, these elements are the most powerful of the

common factors—the client is the engine of change (Bohart & Tallman, 2010).

If we do not recruit these unique client contributions to outcome, we are inclined to fail. When I was an intern, I worked in an outpatient unit that provided “stress management” services but mainly was devoted to clients with the moniker “severely mentally ill.” By that time, I had experience in two community mental health centers and the aforementioned stint in the state hospital. The hospital experience lingered, leaving me with a bad taste in my mouth. Now, in my internship position, my charge was to help people stay out of the hospital, and I took that charge quite seriously.

One of my first clients was Peter. Peter was not very well liked because he sometimes said ominous things to other clients in the waiting room or often spoke in a boisterous way about how the florescent lights

controlled his thinking through a hole in his head. As a new intern, I was put under considerable pressure to address Peter's less than endearing behaviors, particularly because he sometimes offended the stress management clients, who were seen as coveted treasures. Actually, Peter was a terrific guy with a very dry sense of humor, but a man of little hope who lived in dread of returning to the state hospital. His behaviors were mostly distraction efforts from the tormenting voices that told him that people were trying to kill him.

Peter's unfortunate routine was that he was terrorized by these voices until he started taking action that would ultimately wind him up in the state hospital. He might empty his refrigerator for fear that someone had poisoned his food, creating a stench that would soon bring in the landlord and ultimately the authorities. Or, occasionally, he would start threatening or menacing others, those he believed were trying to kill him. Once hospitalized, his medications were changed, usually increased in dose, and he essentially slept out the crisis. These cycles occurred about every 4 to 6 months and had done so for the past 8 years. Peter's "treatment" brought with it tardive dyskinesia and about 100 pounds of extra weight.

I felt profoundly sad for this young man, who was about the same age as me. I also felt completely helpless. I knew he was ramping up for another admission—he had already emptied his refrigerator and left the contents on the kitchen floor.

Only because I had no clue what to do, I asked Peter what he thought it would take to get a little relief from his situation—just a glimpse of a break from the torment of the voices and the revolving-door hospitalizations. After a long pause, Peter said that it would help if he could start riding his bike again, and he told me about what his life was like before the bottom fell out. Peter had been a competitive cyclist in college. I heard the story of a young man away from

home for the first time, overwhelmed by life, training day and night to keep his spot on the racing team, topped off by his falling in love for the first time. When the relationship ended, it was too much for Peter, and he was hospitalized, and then hospitalized again, and again, and so on until there was no more money or insurance—then the state hospitalizations ensued.

Enjoying a level of conversation not achieved before, I asked Peter what it would take to get him going again on his bike. He said that his bike had a broken wheel, and he needed me to accompany him to the bike shop. Peter was afraid to go out in public alone for fear of threatening someone and ending up in the hospital. I immediately consulted with my supervisor, who gave me an enthusiastic green light. The next day, I went with Peter to the bike shop, where I bought a bike as well. Peter and I started having our sessions biking together. Peter still struggled with the voices at times, but he stayed out of the hospital, and they never kept him from biking. He eventually joined a bike club and moved into an unsupervised living arrangement.

You can read a lot of books about "schizophrenia" and its treatment, but you'll never find one that recommends biking as a cure. And you can read a lot of books about treatments in general, and you'll never read a better idea about a client dilemma than will emerge from a unique client in relationship with you—a person who cares and wants to be helpful.

Figure 29.1 also illustrates the second step in understanding the common factors. The second, larger circle in the center depicts the overlapping elements that form the 14% of variance attributable to therapy. Visually, the relationship among the common factors is more accurately represented with a Venn diagram, using overlapping circles and shading to demonstrate mutual and interdependent actions.

Therapist Effects

Therapist effects represent the amount of variance attributable not to the model wielded but rather to *who* the therapist is—it's no surprise that the participants in the therapeutic endeavor account for the lion's share of how change occurs. Depending on whether therapist variability is investigated in efficacy or effectiveness studies, a recent meta-analysis suggested that 5% to 7% of the overall variance is accounted for by therapist effects (Baldwin & Imel, 2013).¹ This is a conservative finding compared with earlier estimates that suggested that 8% to 9% of the variance is accounted for by therapist factors (Wampold, 2005), including a recent investigation by my colleagues and I (Owen, Duncan, Reese, Anker, & Sparks, in press), which found that 8% of the variability was accounted for by therapists. Therefore, in Figure 29.1, a 5% to 8% range is depicted, or 36% to 57% of the variance attributed to treatment. The amount of variance, therefore, accounted for by therapist factors is about five to eight times more than that of model differences.

Although we know that some therapists are better than others, there is not a lot of research about what specifically distinguishes the best from the rest. Demographics (gender, ethnicity, discipline, and experience) don't seem to matter much (Beutler et al., 2004), and although a variety of therapist interpersonal variables seem intuitively important, there is not much empirical support for any particular quality or attribute (Baldwin & Imel, 2013). So what does matter? There's a preliminary possibility and one absolute certainty.

A possibility is experience, but not the generic kind that we were often told would make us better. A criticism often leveled at research investigating therapist experience is that it is not operationally defined and that a more sophisticated look may yield

more positive findings (Beutler et al., 2004). For example, Kraus, Castonguay, Boswell, Nordberg, and Hayes (2011) found that therapist competencies can be domain specific, as some therapists were better at treating certain "conditions." Specificity in the definition of experience may be important. My colleagues and I put this to the test in our examination of therapist effects in the study mentioned above (Owen et al., in press). This analysis revealed that, similar to other studies, demographics were not significant but specific experience in couple therapy explained 25% of the variance accounted for by therapists. So experienced therapists can take some solace that getting older does have its advantages—as long as it is specific to the task at hand.

And the absolute certainty—the client's view of the alliance is not only a robust predictor of therapy outcomes but also perhaps the best avenue to understand therapist differences. Marcus, Kashy, and Baldwin (2009) noted,

High levels of consensus in client ratings of their therapist indicate that clients of the same therapist tend to agree about the traits or characteristics of their therapist, suggesting that there is something about the therapist's manner or behavior that evokes similar response from all of his or her clients. (p. 538)

Baldwin, Wampold, and Imel (2007) found only modest therapist variability (2%) compared with other studies, but they reported that therapist average alliance quality accounted for 97% of that variability. Owen et al. (in press) found that therapist average alliance quality accounted for 50% of the variability in outcomes attributed to therapists. In general, research strongly suggests that clients seen by therapists with higher average alliance ratings have better outcomes (Crits-Christoph et al., 2009; Zuroff, Kelly, Leybman, Blatt, & Wampold,

2010). These results suggest that enhancing alliance abilities may provide a clear pathway to better results (see Duncan, 2010). So the answer to the oft-heard question about why some therapists are better than others is that tried and true but taken-for-granted old friend, the therapeutic alliance.

The Alliance

Bordin (1979) defined the alliance with three interacting elements: (1) a relational bond, (2) agreement on the goals of therapy, and (3) agreement on the tasks of therapy. Historically, the amount of variance attributed to the alliance has ranged from 5% to 7% of the overall variance or 36% to 50% of the variance accounted for by treatment (e.g., Horvath & Bedi, 2002). More recently, Horvath, Del Re, Flückiger, and Symonds (2011) examined 201 studies and found the correlation between the alliance and outcome to be $r = .28$, accounting for a slightly higher 7.5% of the variance. Putting this into perspective, the amount of change attributable to the alliance is about five to seven times that of a specific model or technique.

Based on studies showing that early change accounted for most of the variance attributed to the alliance, some have suggested that the relationship of the alliance to outcome could be a consequence of how much clients are benefiting from therapy (e.g., Barber, 2009). However, several recent studies have confirmed that there appears to be little evidence that controlling for prior change substantially reduces or eliminates the alliance–outcome correlation (Crits-Christoph, Connolly Gibbons, & Mukherjee, 2013; Horvath et al., 2011). Similarly, my colleagues and I (Anker, Owen, Duncan, & Sparks, 2010) found that the alliance at the third session significantly predicted outcome over and above early reliable change. The fact that the alliance is

predictive beyond early benefit suggests a more causal relationship.

Based on the profound work of Carl Rogers (1957), the concepts of empathy, positive regard, and genuineness still represent the best way to understand and facilitate the relational bond. Rogers (1980) defined empathy as the “therapist’s sensitive ability and willingness to understand the client’s thoughts, feelings and struggles from the client’s point of view” (p. 85). It is important to remember that perceived empathy is quite idiosyncratic; some experience empathy as an affective connection, some as a cognitive understanding, and others as a more nurturing experience (Bachelor, 1988). So there is no single, invariably facilitative empathic response, but finding how clients experience empathy is well worth the effort. A recent meta-analysis of 57 studies looking at empathy and outcome (Elliott, Bohart, Watson, & Greenberg, 2011) found a significant relationship, an r of .31. Similarly, another idea championed by Rogers, unconditional positive regard, characterized as warm acceptance of the client’s experience without conditions, a prizing, an affirmation, and a deep nonpossessive caring or love (Rogers, 1957), continues to demonstrate the centrality of the relationship to outcome. A recent meta-analysis of 18 studies examining positive regard and outcome found a significant relationship, an r of .27 (Farber & Doolin, 2011). And finally, there’s congruence/genuineness, “that the therapist is mindfully genuine in the therapy relationship, underscoring present personal awareness, as well as genuineness or authenticity” (Kolden, Klein, Wang, & Austin, 2011, p. 65). Kolden et al. (2011) meta-analyzed 16 studies and found a significant relationship between congruence/genuineness and outcome, an r of .24. Lambert (2013) rightly notes that these relationship variable correlations are much higher than those of specific treatments and outcome. A gas furnace

explosion when Maria was 6 years old had killed both her father and sister. Her mother had collapsed emotionally after the accident and spent most of her days in bed. Maria had essentially grown up without a parent and, partly as a result, had been repeatedly sexually abused by an uncle. By the time I saw her, Maria was 35 and had been in therapy and taking antidepressants for most of her life. She held a responsible but unsatisfying job in a biotechnology company. Maria had tried to kill herself five times, leading to five psychiatric stays. She called her latest therapist eight or nine times a day, leaving agonized messages with the answering service, demanding to be called back. Perhaps because of her borderline diagnosis, Maria's demands were rarely, if ever, met by her therapist, which provoked Maria into escalating levels of distress and self-harming. She was headed toward another suicide attempt when her resentful and burned-out therapist referred her, with a sense of relief, to me and an investigation I was involved in called the "impossible"-case project (Duncan, Hubble, & Miller, 1997).

After consultation with my colleagues, I decided to encourage Maria's calls and nurture rather than limit our relationship. I worked hard to court Maria's favor during our first three sessions, and it wasn't easy. She sat in my office tight-lipped, twisting a handkerchief in her hands. She told me from the first that she wanted her phone calls returned, because she only called when she was in really bad shape. I returned her calls when I had spare time during the workday and again in the evenings after my last client, talking each time for about 15 minutes. Perhaps because I reliably called her back, she rarely called more than once or twice a day. In our sessions, she seemed to get softer.

Then, after our sixth session, I went on a backpacking trip with my son Jesse, entrusting my colleagues to cover for me.

After setting up camp the first night, I felt inexplicably worried about Maria. This was before cell phones. So I hiked 4 miles back to my truck in the darkness and drove to a pay phone in a nearby town to see how she was getting along. She was okay.

That call proved to be a turning point. Afterward, Maria became proactive in therapy and outside it. She started going to church, got involved in a singles group, and signed up for additional technical training that would allow her to change jobs. Her thoughts of suicide stopped, and she discontinued taking antidepressants. In sessions, at her direction, we talked less about how lousy she felt and more about how she could change her life. Over the next 6 months, she left her unrewarding job, where everyone knew her as a psychiatric casualty, and joined a medical missionary project in Asia. Six months later, she wrote to let me know that things were going pretty well for her in northern Thailand:

I picture myself in your office, just telling you stuff and you listening. Every time I called you, you called me back. It didn't always help, but you were there. And I realized that is just what a little girl would want from her daddy, what I had been missing all my life and wanting so badly.

Finally, when I was 35 years old, someone gave it to me. I sure am glad I got to know what it feels like to have someone care about me in that way. It was a beautiful gift you gave me. You also made me realize how much God loves me. When you called me that weekend you went backpacking, I thought to myself, "If a human can do that for me, then I believe what the Bible says about us all the time." So thanks for loving me—because that's what you did.

Maria taught me to honor the client's view of the alliance—she knew that she needed a certain sort of contact to heal, and I gave it to her. That was not all I did, but it was

the affectionate container for our conversations, which included discussions of what she wanted to change and how she could make it happen. Maria also taught me the power found in simple acts of human caring, in empathy and positive regard. Of course, I had no idea of the connection of my actions to her desire for a loving father; it never occurred to me, perhaps because we were close in age. Within the limits of what I can ethically and personally manage, I have learned to provide as much human caring and nonpossessive love as possible.

The more cognitive aspects of the alliance are the agreements with the client about the goals and tasks of therapy. When we ask clients what they want to be different, we give credibility to their beliefs and values regarding the problem and its solution. Collaborative goal formation begins the process of change, wherever the client may ultimately travel. Tasks include specific techniques or points of view, topics of conversation, interview procedures, the frequency of meetings, and all the nuts and bolts aspects of doing the work, including scheduling, cancellation, payment, and between-session contacts. These are all aspects of the task dimension and can count for or against us in the alliance. In our follow-up study of the Norway Feedback Project, we found that the highest category of complaints was the everyday aspects of providing service (Anker, Sparks, Duncan, Owen, & Stapnes, 2011).

Asking for help to set the tasks of therapy further demonstrates respect for client capabilities, and sets the stage for further efforts to enlist participation. This is probably our biggest alliance blind spot. In an important way, the alliance depends on the delivery of some particular treatment or technique—a framework for understanding and solving the problem (Hatcher & Barends, 2006). There can be no alliance without a treatment, and on the other hand, technique is

only as effective as its delivery system—the client–therapist relationship. So you can't have a good alliance without some agreement about how therapy is going to address the issues at hand. Tryon and Winograd (2011) conducted two meta-analyses related to the agreement on tasks—goal consensus (which included agreement on tasks) and collaboration—and their relationship to outcome. Looking at 15 studies, they found a goal consensus–outcome d of .34, indicating that better outcomes can be expected when client and therapist agree on goals and the processes to achieve them. Based on 19 studies, the collaboration–outcome meta-analysis found a d of .33, suggesting that outcome is likely enhanced when client and therapist are in a cooperative relationship. *So your client's perception of any of the big three relational variables as well as agreement about goals and the methods to attain them are individually more powerful than any technique you can ever wield..*

Perhaps the most important part of this collaboration is whether the favored explanation and ritual of the therapist fits client preferences. Swift, Callahan, and Vollmer (2011) conducted a meta-analysis of 35 studies of client preference, breaking client preferences into three areas: role, therapist, and treatment preferences. They found that clients who received their preferred conditions were less likely to drop out and that the overall effect size for client preference was $d = .31$. So it makes sense to ensure that whatever explanation and ritual is chosen is a framework that both the therapist and the client can get behind.

Your alliance skills are truly at play here: your interpersonal ability to explore the client's ideas, discuss options, collaboratively form a plan, and negotiate any changes when benefit to the client is not forthcoming. Traditionally, the search has been for interventions that promote change by validating

the therapist's favored theory. Serving the alliance requires taking a different angle: the search for ideas that promote change by validating the client's view of what is helpful—the *client's theory of change* (Duncan & Moynihan, 1994). The application of any agreed-on explanation or technique represents the alliance in action. Perhaps some idiosyncratic blend of client ideas, yours, and theoretical/technical ones might ultimately be just the ticket. The litmus test of any chosen rationale or ritual is whether or not it engages the client in purposeful work and makes a difference.

THE ALLIANCE: ONE LAST WORD

We all have clients who rapidly respond to us, to whom we connect quickly. But what about the folks who are mandated by the courts or protective services or who just plain don't want to be there (like almost all kids)? What about people who have never been in a good relationship or have been abused or traumatized? What about folks that life just never seems to give a break or those who have lost hope? Well, the therapist's job, our job, is exactly the same regardless. If we want anything good to happen, it all rests on a strong alliance—we have to engage the client in purposeful work. The research about what differentiates one therapist from another as well as my personal experience suggest that the ability to form alliances with people who are not easy to form alliances with—to engage people who don't want to be engaged—separates the best from the rest. For example, Anderson, Ogles, Patterson, Lambert, and Vermeersch (2009) found a significant relationship between how therapists responded to challenging clients on a performance test of interpersonal skills and their outcomes in actual practice.

It's hard work. We often think that "therapeutic work" only applies to clients; it actually applies to us too. We have to earn this thing called the alliance. We have to put ourselves out there with each and every person, each and every interaction, and each and every session. It is a daunting task to be sure, but one whose importance and difficulty are perpetually minimized. It gets so little press compared with models and techniques and is often relegated to statements like "First gain rapport and then . . ." or "Form a relationship and then . . ."—as if it is something we effortlessly do before the *real* intervention starts. The alliance is not the anesthesia to surgery. We don't offer Rogerian reflections to lull clients into complacency so we can stick the real intervention to them! Intervention is not therapy.

When Lisbeth was introduced to me in the waiting room, she told me to go f . . . k myself. I was doing a consult because this 16-year-old was refusing to go to school and had assaulted five foster parents. Lisbeth was one angry adolescent, and my initial thought was "Wouldn't it be sweet if she told me what she was angry about," because I knew there had to be a good reason. In the opening moments, I asked Lisbeth what she thought would be most useful for us to talk about and she said, "What I think of you is that you are a condescending bastard with no understanding of your clients whatsoever!" Whew, she knew how to hit where it hurt! But slowly, and surely, I listened, and I didn't react to her as others had likely responded. I maintained my conviction that if I understood her story, everything—especially her anger—would make complete sense. For example, she told me how she refused medication in one of her many hospitalizations and had threatened to break the kneecaps of the psychiatrist who attempted to force her to take meds. This likely stimulated replies about the inappropriateness of her violent

tendencies, ad nauseam. I simply said that she didn't want to kill the psychiatrist, after all, but only wanted to permanently impair her, a significant difference. And I got a slight smile, and a bit more conversation.

Lisbeth told me that she had been removed from her home at age 13 because of multiple sexual abuses by her mother's boy-friends, and since then, she had been in five foster care homes; the fifth foster care parent was Sophie, who sat before me now. She also told me that the previous 18 months of therapy had not addressed her goal of telling her mother off, once and for all. In fact, no attempt was made to allow any approximation of this to happen.

After a while of allowing her story to wash over me, I ventured a comment that Lisbeth was like a salty old sailor, she cursed like a sailor and had a storied life—she was crusty at the ripe old age of 16. She smiled in a way that acknowledged that I both understood and appreciated her. Lisbeth rewarded me with an explanation of her anger. She told me how she was relieved to be removed from her home and that her first foster care parent expressed her intention to adopt both Lisbeth and her 5-year-old sister. But instead, her sister was adopted, and Lisbeth was dumped. That's when the assaults started and the complete dismissal of school. So the first adult that she trusted, after having none in her life worthy of her trust, betrayed her totally and completely.

There is no more righteous anger than this kid felt. I said that, and we connected. And Lisbeth, via work with others who finally addressed her goal for therapy, completed her GED (General Educational Development) online and settled in with her foster parents. The relationship is not always easy, and it demands a lot from us, but it is almost always not only worth the effort but also why we became therapists—at least, why I became a therapist.

MODEL/TECHNIQUE: GENERAL EFFECTS (EXPLANATION AND RITUAL), CLIENT EXPECTANCY (HOPE, PLACEBO), AND THERAPIST ALLEGIANCE

Ensuring that any selected treatment resonates with both the client (expectancy) and the therapist (allegiance) also complements the so-called placebo factors, or the general effects of delivering any model or technique. Model/technique factors are the beliefs and procedures unique to any given treatment. But these specific effects, the impact of the differences among treatments, are very small—only about 1% of the overall variance or 7% of that attributable to treatment. But the *general effects* of providing a treatment are far more potent. When a placebo or technically “inert” condition is offered in a manner that fosters positive expectations for improvement, it reliably produces effects almost as large as a bona fide treatment (Baskin, Tierney, Minami, & Wampold, 2003). (There is some controversy surrounding how potent this effect is, hence the question mark in Figure 29.1.) Models achieve their effects in large part, if not completely, *through* the activation of placebo, hope, and expectancy, combined with the therapist's belief in (allegiance to) the treatment administered. As long as a treatment makes sense to, is accepted by, and fosters the active engagement of the client, the particular approach used is unimportant. Placebo factors are also fueled by a therapist belief that change occurs naturally and almost universally—the human organism, shaped by millennia of evolution and survival, tends to heal and to find a way, even out of the heart of darkness (Sparks & Duncan, 2010).

Feedback Effects

Common-factors research provides general guidance for enhancing those elements

shown to be most influential to positive outcomes. The specifics, however, can only be derived from the client's response to what we deliver—the client's feedback regarding progress in therapy and the quality of the alliance. Although it sounds like hyperbole, identifying clients who are not benefiting is the single most important thing a therapist can do to improve outcomes. Combining Lambert's Outcome Questionnaire System (Lambert & Shimokawa, 2011) and our Partners for Change Outcome Management System (PCOMS) (e.g., Anker, Duncan, & Sparks, 2009; Reese, Norsworthy, & Rowlands, 2009), nine RCTs now support this assertion. A recent meta-analysis of PCOMS studies (Lambert & Shimokawa, 2011) found that those in the feedback group had 3.5 higher odds of experiencing reliable change and less than half the odds of experiencing deterioration. In addition, collecting outcome and alliance feedback from clients allows the systematic tracking of therapist development, so that neither client benefit nor therapist growth over time is left to wishful thinking. Visit <https://heartandsoulofchange.com/> for more information (The measures are free for individual use and are available in 23 languages.). PCOMS is listed by the Substance Abuse and Mental Health Administration as an evidence-based practice. It is different from what is usually considered evidence based because feedback is atheoretical and therefore additive to any therapeutic orientation and applies to clients of all diagnostic categories (Duncan, 2012).

An inspection of Figure 29.1 shows that feedback overlaps and affects all the factors—it is the tie that binds them together—allowing the other common factors to be delivered one client at a time. Soliciting systematic feedback is a living, ongoing process that engages clients in the collaborative monitoring of outcome, heightens hope for

improvement, fits client preferences, maximizes therapist–client alliance potential and client participation, and is itself a core feature of therapeutic change. Feedback embodies the lessons I learned from Tina, providing for a transparent interpersonal process that solicits the client's help in ensuring a positive outcome.

MY JOURNEY TO RELATIONSHIP: CLOSING THOUGHTS

Listening creates a holy silence. When you listen generously to people, they can hear the truth in themselves, often for the first time. And when you listen deeply, you can know yourself in everyone.

Rachel Remen, Kitchen Table Wisdom

I was recently asked (Kottler & Carlson, 2014) what it is that I do, and who I am, that most made my work effective (assuming that it is). What I do that is most important in contributing to my effectiveness is that I routinely measure outcome and the alliance (via PCOMS). This allows me to deal directly and transparently with clients, involving them in all decisions that affect their care and keeping their perspectives the centerpiece of everything I do. In addition, it serves as an early-warning device that identifies clients who are not benefiting, so that the client and I can chart a different course, which in turn encourages me to step outside my therapeutic business-as-usual, do things I've never done before, and therefore continue to grow as a therapist. This also allows me to focus every session with every client on the alliance, so that I tailor what I do to the client's expectations. Finally, tracking outcome and the alliance also enables proactive efforts to improve, without guesswork or waiting for the platitudes about experience to manifest. It enables our clients—especially

those who aren't responding well to our therapeutic business-as-usual—to teach us how to work better.

That's what I do. But what I bring to the therapeutic endeavor is that I am a true believer. I believe in the client, I believe in the power of relationship and psychotherapy as a vehicle for change, and I believe in myself, my ability to be present, fully immersed in the client and dedicated to making a difference. The odds for change when you combine a resourceful client, a strong alliance, and an authentic therapist who brings himself or herself to the show are worth betting on, certainly a cause for hope, and responsible for my unswerving faith in psychotherapy as a healing endeavor.

I believe in psychotherapy, not in spite of its inherent uncertainty but because of it. Although we long for the structured, scripted, predictable, manualized, surefire way to conduct a session, uncertainty is endemic to the work as it is to life, and therefore is important to embrace. Uncertainty is the place of unlimited possibilities for change. It is this indeterminacy that gives therapy its texture and infuses it with the excitement of discovery. This allows for the “heretofore unsaid,” the “aha moments,” and all the spontaneous ideas, connections, conclusions, plans, insights, resolves, and new identities that emerge when you put two people together in a room and call it psychotherapy. Tolerance for uncertainty creates the space for new directions and insights to occur to both the client *and* you.

Seven-year-old Rosa had gone to live with foster parents—her aunt and uncle, Margarita and Enrique—because the parental rights of her birth parents had been terminated. Her father and mother were addicts with long criminal records; the father was in jail, and the mother was still using. Rosa clearly had been born with two strikes against her: (1) parents missing in action and (2) her development impaired by drugs.

Although much psychopathological gobbledegook accompanied her, it was safe to say that Rosa was a “difficult” child—prone to tantrums, which included kicking, biting, and throwing anything she could find. I began the session by asking Rosa if she was going to help me today, and she immediately yelled, “No!”—leaning back, with her arms folded across her chest. As I turned to speak with Enrique and Margarita, Rosa began having a tantrum in earnest—screaming at the top of her lungs and flailing around, kicking me in the process.

With Rosa's tantrum escalating, Margarita dropped a bombshell. In a disarmingly quiet voice, she announced that she didn't think she could continue foster-parenting Rosa. The tension in the room immediately escalated; the only sound was Rosa's yelling, which had become more or less rote at that point. I felt as if I'd been kicked in the gut. I'd expected to be helping the foster parents contain and nurture a tough child. Now it felt like I was participating in a tragedy in the making. Here was a couple trying their best to do the right thing by taking in a troubled kid with nowhere else to go, but they seemed ready to give up. The situation was obviously wrenching for Margarita and Enrique, but it was potentially catastrophic for Rosa. In this rural setting, they were her last hope, not only of living with family but of living nearby at all, since the closest foster care placement was at least 100 miles away. I contemplated Rosa's life unfolding in foster care with strangers, who'd encounter the same difficulties and likely come to the same impasse—resulting in a nightmare of ongoing home placements.

What's the correct diagnosis for Margarita? Is there an EBT for feeling overwhelmed, hopeless, and not knowing whether you can go on parenting a tough kid?

Margarita continued explaining why she couldn't go on, speaking softly while tears rolled down her cheeks. Not only did she feel she couldn't handle Rosa, she also

worried about the child's attachment to her. As Margarita expressed her doubts in a near whisper, Enrique's eyes began to tear up, and a feeling of despair permeated the room. At that moment, I felt helpless to prevent a terrible ending to an already bad story and didn't have a clue about what to do. Meanwhile, Margarita began gently caressing Rosa's head and speaking softly to her—the Spanish equivalent of “There, there, little one”—until the little girl started to calm down. With her tantrum at an end, Rosa turned to face Margarita, and then she reached up and wiped the tears from her aunt's face. “Don't cry, Auntie,” she said warmly, “don't cry.”

Witnessing these actions was yet another reminder to me of how new possibilities can emerge at any moment in a seemingly hopeless session and the uncertainty of what will happen next. “It's tough to parent a child who's been through as much as Rosa has,” I said. “I respect your need to really think through the long-term consequences here. But I'm also impressed with how gently you handled Rosa when she was so upset and with how you, Rosa, comforted your Auntie when you saw her crying. Clearly there's something special about the connection between you two.”

Margarita replied that Rosa definitely had a “sweet side.” When she saw that she'd upset either Margarita or Enrique, she quickly became soft, responsive, and tender. I began to talk with Margarita and Enrique about what seemed to work with Rosa and what didn't. While Rosa snuggled up to Margarita, we talked about how to bring out Rosa's sweet side more often. As ideas emerged, I was in awe, as I often am, of the fortitude clients show when facing formidable challenges. Here was a couple in their late 40s, who'd already raised their own two children, considering taking on the responsibility of raising another one who had such a difficult history.

By now, the tension and despair present a few moments before had evaporated. The decision to discontinue foster parenting,

born of hopelessness, had lost its stranglehold, though nothing had been said explicitly about that. Now all smiles and bubbly, Rosa was bouncing up and down in her chair. Somewhat out of the blue, Margarita announced that she was going to stick with Rosa. “Great,” I said quietly. Then, as the full meaning of what she'd said washed over me, I repeated it a bit louder, and then a third time with enthusiasm—“Great!” I asked Margarita if anything in particular had helped her come to this decision. She answered that, although she'd always known it, she'd realized in our session even more than before that there was a wonderful, loving child inside Rosa and that she, Margarita, just had to be patient and take things one day at a time. The session had helped her really see the attachment that was already there. I felt the joy of that moment then, and I still do. Follow-up revealed that this family stayed together. Margarita never again lost her resolve to stick with Rosa. In addition, many of Rosa's more troubling behaviors fell away, perhaps as a result of having stability in her life for the first time.

In my view, the session included that intimate space in which we connect with people and their pain in a way that somehow opens the path from what is to what can be. My heartfelt appreciation of both the despair of the circumstance and their sincere desire to help this child, combined with the fortuitous “attachment” experience, generated new resolve for Margarita and Enrique. This session taught me, once again, that anything is possible—that even the bleakest sessions can have a positive outcome if you stay with the process. Just when things seemed the most hopeless, when both the family and I were surely down for the count and needed only to accept the inevitable, something meaningful and positive emerged that changed everything—including me. This is the power of relationship and why my psychotherapy journey continues on course.

NOTE

1. The percentages are best viewed as a defensible way to understand outcome variance but not as representing any ultimate truths. They are meta-analytic estimates of what each of the factors contributes to change. Because of the overlap among the common factors, the percentages for the separate factors will not add to 100%.

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