DEVELOPING and SUSTAINING SUCCESSFUL GROUP LEADERSHIP PRACTICES

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Learning Objectives

1. Illustrate the evidence based factors that contribute to enhanced group psychotherapist effectiveness and ethical practice
2. Identify approaches that maximize therapeutic opportunities within the patient-therapist relationship and in the here and now of the interpersonal group therapy setting
3. Articulate the principles of therapeutic metacommunication and processing within the therapeutic relationship
4. Explore therapist use of self and judicious therapist transparency

NO FINANCIAL DISCLOSURES OR CONFLICTS

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Achieving and Sustaining Group Therapist Effectiveness

1. The therapeutic relationship matters more than the group model
2. Aim to use yourself as a group therapist as fully as possible
3. Think in terms of a co-creation and two person psychology
4. Emphasize adaptation first; pathology second
5. Filter everything through the lens of therapeutic alliance: the convergence of patient and therapist on goals, tasks and bond
6. Cohesion is the group equivalent of the therapeutic alliance
7. Utilize the here and now of the group as a social microcosm
8. Be attentive to the expression of patient pathogenic beliefs and the maladaptive transaction cycle in the group interactions
9. Disconfirm pathogenic beliefs and reinforce growth thru insight and experience
10. Recognize when and what hooks you interpersonally
11. Welcome and utilize countertransference as data
12. Metacommunicate to unhook
13. Process, process, process
14. Group therapy will be part of the solution or part of the problem for your patient

Achieving and Sustaining Psychotherapist Effectiveness

Consistent meta-analytic and review evidence that the psychotherapies have been undersold in light of robust effectiveness on symptoms and global functioning, and the capacity to impact the brain thru the mind (*APA 2012; Weissman, 2013; Kivlighan et al 2015*) and highly sought after by pts. *(McHugh, 2013)*

- Rigorous meta-analysis and comparison studies show: There is no single gold standard psychotherapy *(Driesen, et al, 2013; Leichsenring & Steinert, 2017; Steinert et al 2017)*
- We can recommend group therapy as effective (*Lorentzen et al, 2013; Grenon et al 2017*) and equivalent to 1:1 with moderate ES 0.5-0.6 (*Burlingame et al, 2016)*
- Although there is fundamental equivalence of therapies & models there is no such equivalence with regard to therapists *(Norcross & Wampold,2011; Baldwin and Imel,2013; Wampold and Imel, 2015; Stiles and Horvath, 2017)*
- Ethical demand to remedy the quality gap*:* despite more access to treatment, prevalence of mental illness is rising *(Jorm et al, 2017)*
- Beyond patient characteristics, the therapist and the relationship most impacts outcome across all treatments including pharmacotherapy *(Greenberg 2016)*
- Therapist effects account for 8% of clinical outcomes – medium effect size *(Wampold and Imel, 2015)*

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Achieving and Sustaining Group Therapist Effectiveness

- Aim to be an evidence based practitioner- blend the art and science of our work
- Do not rely on experience alone *(Tracy et al, 2014*) but target specific feedback and training – be deliberate in enhancing your effectiveness *(Chow et al, 2015*)
- Viz., reviewing challenging cases, attending training workshops, reflecting on past sessions, and reflecting on what to do in future sessions.
- Feedback on our work is essential: observation or patient tracking data
- Theory teaches us where to head: Technique teaches us what to do when we arrive there
- Recognize and utilize evidence supported therapist interventions
- Train neophytes to competence and model relationship skills in all we do
- Embed in ethical practice – fiduciary nature of our work; risk of negative outcomes/deterioration/steward precious treatment resources/ongoing training to maximize therapeutic effectiveness

The Effective Psychotherapist

Study of therapist variance in naturalistic settings of 71 therapists of varying models treating >6000 clients in a college counseling center using OQ45 (*Okiishi et al 2006)*

- No effect of gender, age, experience, or model
- Hard to distinguish 2nd and 3rd quartile Tx re effectiveness
- Top 10% vs. bottom 10% revealed:
- 44% recovery rate & 5 % deterioration rate vs.
- 28% recovery rate & 11% deterioration rate
- Range of deterioration rates 1%-19%, randomly distributed patients

The Effective Psychotherapist

Studying therapist variance in naturalistic settings 696 therapists of varying models of 16 session therapy treating 6960 patients utilizing the TOP (Treatment Outcome Package) *(Kraus et al,2011)* TOP is a 58 item, 12 domain therapist rated scale

- Effective therapists had average +ve ES of 1.00-1.52
- Ineffective therapists had average –ve ES of 0.91-1.49
- Overall 55% of patients improved significantly, while 16% deteriorated
- In a subsequent study of 59 therapists and 3500 patients – therapists demonstrated consistency with effectiveness but all therapists struggled with some patients – no one is good with all problems and all patients; particular challenges with substance abuse *(Kraus et al 2016)*

The Effective Psychotherapist

Studying therapist variance in a PRN - 85 therapists of varying models treated 10,000 patients with mood and anxiety disorders *(Saxon et al, 2016)*

- If patients completed treatment 72% improved; 7 % deteriorated; but overall 34% dropped out.
- Comparing top vs. bottom quintile showed:
- 12% vs. 49% drop out rate
- 4.7% vs. 15% deterioration rate
- Distinguished by Tx empathy; capacity to build and sustain alliance; judicious use of interventions and management of countertransference.
- Therapist flexibility; fit /adapt to patient's needs and patient's response to Rx. (*Nissen-Lie et al 2016)*

The Effective Group Psychotherapist

- Strong empirical support for role of - Based upon robust meta-analyses thru APA Task Force:

1. **Group Cohesion and Therapeutic Alliance**
2. **Empathy** >kindness: re tailored & depth understanding: Neurobiological base

- Includes **receptive and expressive** capacities **– KEY THERAPIST SKILLS**
- Adapt to and privilege the patient's position and Rx experience (*Norcross & Wampold, 2011; Wampold, 2015)* and attachment style *(Mallinckrodt and Jeong, 2015)*
- Keys: Emotional bond; healing context; an adaptive, accessible culturally resonant explanation; enhance self efficacy *(Laska et al 2014)*

3. **Client-centered Tracking**

- Encouraging evidence to support value of goal consensus and collaboration, positive regard and managing countertransference (*Norcross & Wampold, 2011)*
- **Tri-modal approach to Evidence Based Practice**:

  i) ESTs, ii) Practice guidelines *(Bernard et al, 2008- AGPA),* **iii) Practice based evidence – PBE** *(Leszcz & Kobos, 2008; Burlingame et al 2013)*

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Cohesion: Core Mechanism of Action

- Facilitates other group therapeutic factors
- A ubiquitous mechanism that operates across all therapeutic orientations
- May explain more patient improvement than specific mechanisms of action, models or protocols
- Task and bond elements as well as group and individual member dimensions re relatedness: m-m;m-g;m-l
- Encompasses relationship structure and relationship quality
- 30 item Group Q: +ve bond; +ve work; -ve rel'n (*Krogel et al 2013*)
- Synthesizes cohesion, alliance, empathy and group climate (*Burlingame et al 2017)*
- Positive and significant linear rel'n of cohesion with outcome (*Burlingame et al 2011*) Correlation at 0.25: small-moderate but significant & important
- Moderators younger age;>12 sessions; size (5-9); IP focus; Tx actions
- Linked to higher self-disclosure, feedback and may buffer members when conflict appears in work phase of group (*Bernard et 2008*)

Evidence-based Principles Related to Cohesion

(*Bernard et al 2008; Burlingame et al 2013*)

1.Use of Group Structure

- ***Principle One.*** Conduct pre-group preparation that formulates a plan, sets treatment expectations, defines group rules, and instructs members in appropriate roles and skills needed for effective group participation and group cohesion. Establishes also patient's informed consent and limits of confidentiality.
- ***Principle Two*****.** The group leader should establish clarity regarding group processes in early sessions since higher levels of early structure are predictive of higher levels of disclosure and cohesion later in the group.
- ***Principle Three*****.** Composition requires clinical judgment to balance *intrapersonal (individual member)* and *intra-group (amongst group members)* considerations.

Evidence-based Principles Related to Cohesion

2.Verbal Interaction

- ***Principle Four*.** The leader models real-time observations, guiding effective interpersonal feedback; maintaining a moderate level of control and affiliation may positively impact cohesion.
- ***Principle Five.*** The timing and delivery of feedback are pivotal considerations for leaders as they facilitate the relationship-building process. These important considerations include the developmental stage of the group (for example challenging feedback is better received after the group has developed cohesiveness) and the differential readiness of individual members to receive feedback (members feel a sense of acceptance).

Evidence-based Principles Related to Cohesion

3.Establishing and Maintaining an Emotional Climate

- ***Principle Six.*** The group leader's presence not only affects the relationship with individual members but all group members as they vicariously experience the leader's manner of relating. Thus, the leader's management of his or her own emotional presence in the service of others is critically important: a leader who handles interpersonal conflict effectively can provide a powerful positive model for the group-as-a-whole.
- ***Principle Seven.*** A primary focus of the group leader should be on facilitating group members' emotional expression, the responsiveness of others to that expression/disclosure, and the shared meaning derived from such expression.

Presence

"An appropriate communicated understanding of the patient's primary concerns as they are rooted in his antecedent life story" *(Viederman, 1999)*

- Presence alone can be schema disconfirming
- Healing context: our words are most powerful when they are expressed in an emotional, fully attuned, context that leads to a new experience for the patient *(Wampold, 2015)*
- Related to mentalization: experience of being held in mind *(Fonagy et al 2017)*
- Provision of an adaptive, relational experience that disconfirms the patient's negative expectations and pathogenic beliefs
- Neophyte therapists' pre-training level of interpersonal skills – clear communication, warmth, empathy, managing conflict and criticism predicted better clinical outcomes across manualized treatments
- Adherence to model did not predict better outcomes*(Schottke et al, 2016)*
- Early responders retain gains and respond prior to specific techniques applied *(Lambert 2007)*

Evolution Of Psychotherapy

- When the therapist's attempt to understand is an insufficient response, the therapist may need to be willing to be shaped by the required interaction to create with the patient, the developmentally necessary, new and contrasting relational experiences *(Mitchell, 1993)*

- Will the psychotherapy be experienced as a new relationship, emphasizing facilitation and growth or as a recreation of prior relationships, inadvertently generating impasse or failure?

- Treatment will disconfirm or reconfirm prior pathogenic beliefs about the self in relation to the world

- Empathic attunement includes awareness of physiological state of our patients re arousal, distress and dysregulation

Evolution Of Psychotherapy

- Synthesis of repetitive occurrences of intersubjective conjunctions and intersubjective disjunctions
- Persistently reflective therapist posture required
- Promote patient experiential processing – reflect on self; engage in the immediate, and construct meaning *(Pascual-Leone and Yeryomenke, 2016)*
- How we work with the therapy relationship is the essence of our effectiveness (or not) *(Hill and Knox, 2009):* immediacy; use of Tx self; countertransference and metacommunication
- Non-blaming and co-construction approach to the relationship
- Anticipate “tear and repair”
- Mindful of subtle or overt expressions of power, hostility or rejection

Therapeutic Focus – Transference Related Measures

Major focus of contemporary study, reflecting:

- Greater precision in formulation contributes to improved outcome by increasing the congruence of interventions and empathy *(Hoglend 2014)*
- Dynamic and cognitive psychology interface re concepts of schemas, as sites of conflict and germinators of symptoms
- Strong correlation of transference work (pt-Tx relationship/here and now and link to ext relationships and patterns) and outcome – esp. for patients with difficult interpersonal relationships/character path (*Hoglend et al 2008)*
- Skilled clinicians often fail to agree on transference pattern, without a guiding structure
- Bias of reader/observer shapes interpretation of the patient's narrative
- Demonstrated reliability and validity with high inter-rater reliability

The Plan Formulation Model

(Weiss, 1993; Leszcz and Malat, 2012; Leszcz 2015)

- The Plan is the manner in which the individual will work in psychotherapy to seek safety to disconfirm PBs, overcome obstructions and achieve goals.
- Control (safety) –Mastery (overcome fear) Theory (*Rappaport 2002*)
- Our patients seek growth: Respect adaptive efforts *(Stone, 1996)*
- Misconstrual-misconstruction sequence enacted (*Strupp and Binder, 1984)*
- Cyclical psychodynamics *(Wachtel, 2011; 2017)*

Plan-congruent interventions, regardless of transference focus:

↑self-awareness

↑ access to affect and self-reference and genetic anamnesis

Pathogenic belief disconfirmation:

↑ access to genetic material, previously covert

↑ Progressive emboldenment on the patient's part

Plan Formulation Model

(Weiss, 1993; Leszcz and Malat, 2012;Leszcz 2015)

I. GOALS

- Developmental tasks, relatedness, self, growth

II. OBSTRUCTIONS

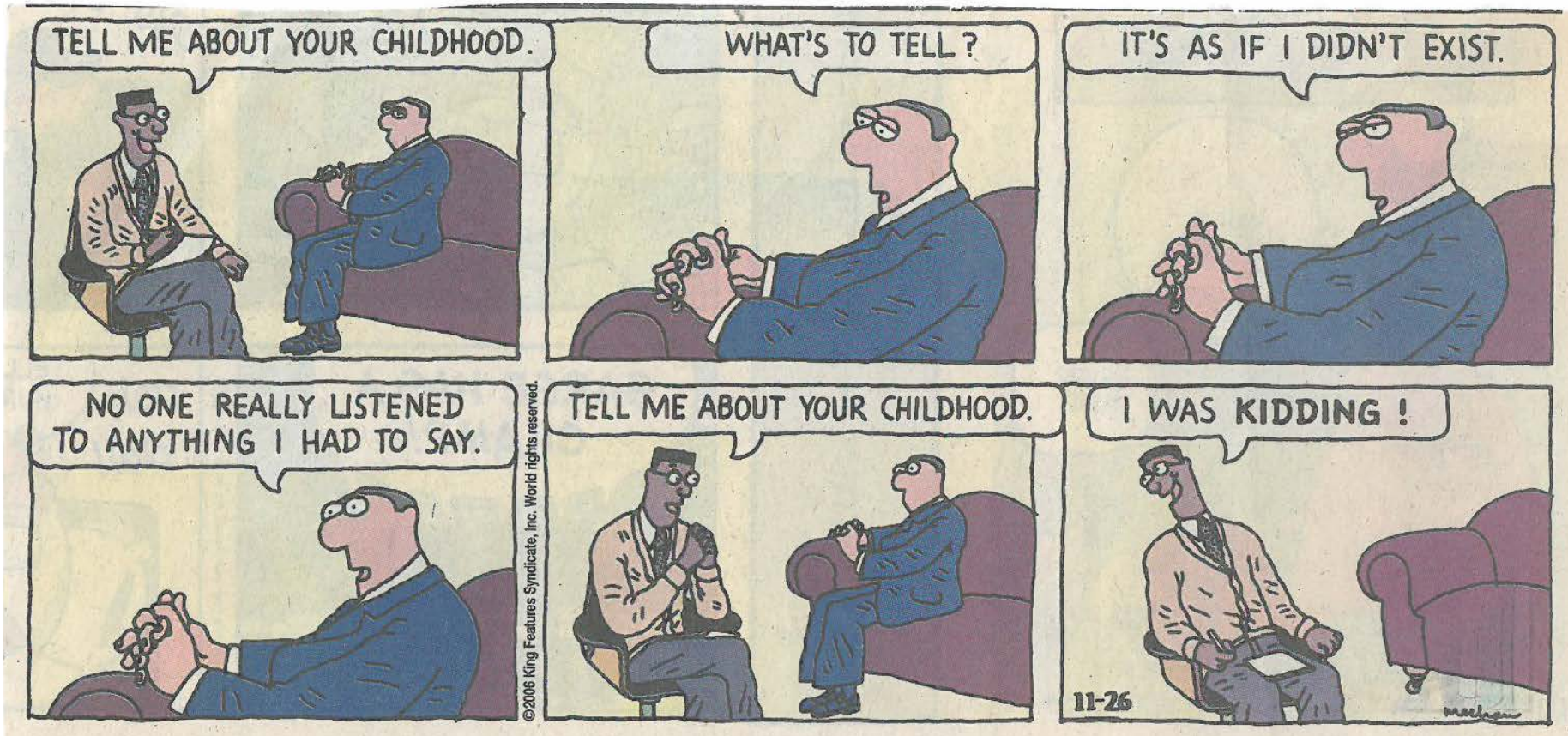
- Pathogenic beliefs, emerging from early life
- 6 core PBs – Self-doubt; Doubt of others; Anger/Assertiveness; Fear of Closeness; Guilt re success; Guilt and responsibility for others *(Sammet et al 2007)*
- Shaped by danger/costs of goal attainment to self or others

III. TESTS

- Transference tests articulated in interpersonal & relational terms
- Displacement of past onto present or,
- Inversion of passive into active
- Seeking PB disconfirmation and relational/therapeutic safety
- Driven by hopefulness, yet dreading reconfirmation
- Both insight and relational experience matter in altering a MTC

IV. INSIGHT

- Patient's accumulating awareness that challenges obstructions
- What would group say?



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Treatment Constructs for the Group Therapist

(Yalom and Leszcz, 2005; Leszcz and Malat, 2012; Leszcz, 2014)

- The focus of clinical study is the here-and-now interpersonal interaction and the patient's phenomenology **The Here-And-Now**
- Interpersonal recapitulation driven by cognitive-interpersonal schema and pathogenic beliefs- patient's **PLAN** **The Group as Social Microcosm**
- Group provides multiple interactional opportunities and peer transferences
- Hooking-unhooking phenomenon - recruitment of predictable interpersonal responses
- Impact message - pulls for a restricted interpersonal response
- Interpersonal markers of the patient
- Transference/countertransference illumination through the therapist's function as participant-observer

The Group Working in the Here and Now

1. Social Microcosm

- In-vivo
- Being, not just describing or reporting
- Limits of dyadic treatment
- Face validity of the experience-near exploration

The Group Working in the Here and Now

2. The Here and Now

- Alive to the moment and immediacy: intimate engagement - likely to be resisted
- The then and there → "What does this have to do with why I'm coming here?“
- Affective stimulation and cognitive integration, in balance
- Stimulate emotional experience and then foster self-reflection
  - Content and process
  - Track analogues to experience of outside relationships
  - Track phenomenological experience of here-and-now relatedness

The Here and Now

- Horizontal vs. vertical disclosure
- Centripetal focus: each person integrally involved at each moment; not a turn-taking model
- Plunge the group into exploration of each member's here- and-now emotional life
- It will feel unnatural and prone to regressive avoidance

The Here and Now

- Think here-and-now – 4 vectors
- Maintenance (bridging) vs. mutative interventions (feedback)
- Levels of inference, choice point analysis
- Dynamic insight is depth indeed and essential to interpersonal change
- Linear causality which emphasizes the past is delimiting and may invite stagnation and blaming, diminishing personal responsibility
- Collaborative exploration of circular causality
- Once illuminated – opportunities for repair ensue

Treatment Constructs for the Group Therapist

(Yalom and Leszcz, 2005; Leszcz and Malat, 2012; Leszcz 2014)

- Repeat or repair: confirm or disconfirm
- Insight and experience linked **Corrective Emotional Experience**
- Experience near → "hot" processing or,

  Experience far → "cold" processing
- Collaborative feedback and exploration to deepen awareness of schema: explore the phenomenology of the contemporary interaction
- Role of metacommunication - communication about communication
- Understanding of schema is always evolving - dynamic
- Broaden the interpersonal behavior repertoire **Interpersonal Learning and create an adaptive spiral**
- Cohesion and therapeutic alliance are prerequisites

The Corrective Emotional Experience

- The group is an unnatural place for natural relationships, not a natural place for unnatural relationships
- Genuine and authentic
- Illumination **and** disconfirmation - both by understanding and experience
- Endorsing new behaviors and risks
- Empathic resonance: affect attunement
- Activation of attachment thru the exploration of past, current, member-member and member to therapist relatedness *(Fonagy and Bateman, 2006)*

The Corrective Emotional Experience

- **Mentalization** – the capacity to think about the state of mind (feeling and intentionality) of others requires the experience of being held in mind developmentally or psychotherapeutically. Therapy counters the inhibition of mentalization resulting from neglect/abuse/ deprivation; derailment due to affective overload and the avoidance of thinking about the abuser's state of mind *(Fonagy and Bateman, 2006; Fonagy et al 2017)*

- Promotes restoration of epistemic trust *(Fonagy et al 2017)*

- Both an implicit and explicit process at different times and linked to empathy *(Choi-Kain &Gunderson, 2008)*

- The group provides an opportunity for the co-construction of restored emotional regulatory capacity *(Flores and Porges, 2017)*

The Corrective Emotional Experience

- Risk of role lock
- Therapist as advocate, even for the antagonist
- Hooking-unhooking: buy time to reflect: don't bite at the bait
- No behavior or interaction is meaningless - assume it is either schema confirming or disconfirming
- The cognitive-interpersonal schema develops honestly through life experience - it served an adaptive purpose once; acknowledge its adaptive origins *(Stone, 1996)*

Interpersonal Feedback

(Morran et al 1998; Yalom and Leszcz, 2005; Leszcz, 2014)

- Collaboration on treatment goals and tasks
- Sender takes a self-disclosure risk
- Explore sender's and receiver's experience of feedback
- Support and reinforce risk taking
- Nonjudgmental nor inflammatory – well paced; positive precedes negative
- Focus on observable behavior in H & N
- Mutative impact on contemporary relationships, rather than highly inferential genetic reconstructions
- Invitation for desired behavior as opposed only to rebuke – link to goals of therapy
- Encourages the receiver's responsibility for change without coercion – alert to group pressure/destructive potentials
- Genetic material follows rather than precedes

The Impact Message

(Kiesler, 1996)

- Identifying and metabolizing the patient's interpersonal impact message as we get hooked and then unhooked – viz. recognize the transference test
- Alert to what we as therapists bring to the mix, regarding our cognitive-interpersonal schema

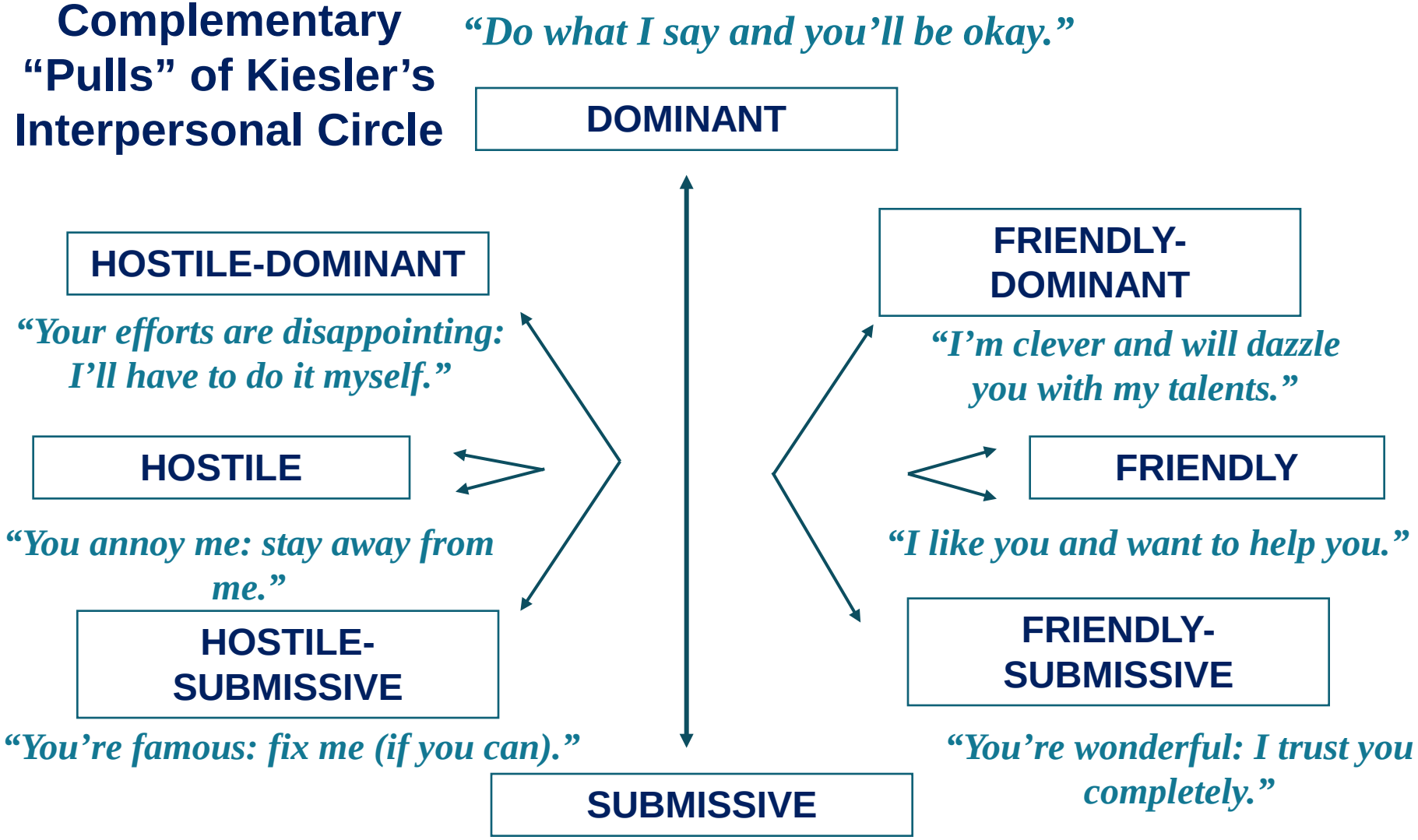
Consider:

- Your experience with the patient

Identify:

- **Direct feelings** - when I am with this person he (she) makes me feel _____
- **Action tendencies** - when I am with this person he (she) makes me feel that I want to _____
- **Perceived evoking messages** - when I am with this person he (she) wants me to feel and behave by relating in this way _____
- **Fantasies** - sometimes when I am with this person it seems to me as though (image or metaphor) _____

Octant Complementary "Pulls" of Kiesler's Interpersonal Circle



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The Maladaptive Transaction Cycle

- Circular causality: interpersonal recapitulations - the attempted solution becomes the problem *(Kiesler, 1996)*
- The Maladaptive Transaction Cycle - the unbroken causal loop and personal authorship
- Potential for self-fulfilling or self-defeating sequence; rupture and repair sequence

The Maladaptive Transaction Cycle

- The heart of treatment is the therapeutic relationship – effective therapists work in the immediate and here and now to address the necessary problems that emerge in the therapy relationship *(Hill and Knox, 2009)*
- It is the **processing** of the relationship that is therapeutic
- Authentic and genuine processing and repair associated with improved outcomes and fewer dropouts (*Muran et al 2005)*
- Acknowledge; explore; shared attribution; validation; negotiation; revisit patient experience> rigidity (*Bennett et al 2006)*
- Hazards of therapist blame, anger, dismissiveness, power, justifying, or insincerity *(Harmon et al 2007; Norcross & Wampold, 2011)*

Countertransference

- Defined in a variety of ways "Joint creation" : A 2-person field *(Gabbard, 1993; Leszcz, 1994; Kiesler, 2001)*
- Unconscious and sometimes overt attitude and feeling the therapist carries toward the patient that may interfere with optimum understanding and responsiveness to the patient
- Valuable source of clinical data – objective and predictable as source of data (*Betan et al , 2005; Colli et al, 2014*) > Tx error
- Omnipresent in interprofessional health care/nursing *(Scheick, 2010)* but most highlighted in MH
- CT enactments are a common cause of alliance ruptures *(Fatter and Hayes, 2013*)
- Intersubjectivity underscores mutual impact - the therapist impacts on the patient and the nature of the transference
- Psychotherapy is a fiduciary relationship: Dual relationships prohibited.
- Boundary crossings vs. boundary violations require standard of objective scrutiny in addition to self-scrutiny *(Gutheil & Gabbard, 1993, 1998)*

Countertransference

- Subjective countertransference (therapist-based):
  - What the therapist habitually brings into the treatment reflecting the therapist's early or concurrent experiences within significant relationships that may get reactivated in the present; unresolved issues
- Objective countertransference (patient-based):
  - What the specific patient/treatment generates within the therapist, via projection or projective identification and/or what the patient habitually generates in terms of others' responses
- A third source: a unique creation within the specific therapist/patient dyad - totalistic
- Effects capacity for responsiveness and containment or amplification – more challenging patients generate more challenging countertransference *(Satir et al 2009)*
- Our theories may be a source of countertransference that limits responsiveness *(Purcele, 2004)*

Countertransference

- Requires spirit of inquiry on part of the therapist without blame: distinguish fantasy from action
- The therapist's subjective experiences inform about the therapist and/or the patient
- Requires therapist to be close enough to get hooked, with subsequent task of getting unhooked
- Unlock fixed complementarity/impasse and interrupt negative recapitulation
- **Metacommunication**: skill in use of language
- Meta-analysis *(Hayes et al, 2011)* Unaddressed countertransference clearly correlates with negative outcomes but when worked thru, significantly correlates with positive outcomes.
- BUT – positive CT may diminish therapeutic action *(Markin et al, 2013)*

Management of Countertransference

(Gelso and Hayes, 2007;2011; Fatter and Hayes, 2013)

- Self-awareness and self-insight
- Self-integration: self vs. other differentiation
- Anxiety modulation
- Conceptualization skills re the patient's concerns
- Empathy – receptive capacities
- Empathy – expressive capacities
- Two key domains – i)understanding self and client & ii) self-integration and regulation (Perez-Rojas et al 2017)
- Reflection and space for thinking *(Mollon, 1989)*
- Non-reactivity – role of experienced meditation/reduced reactivity

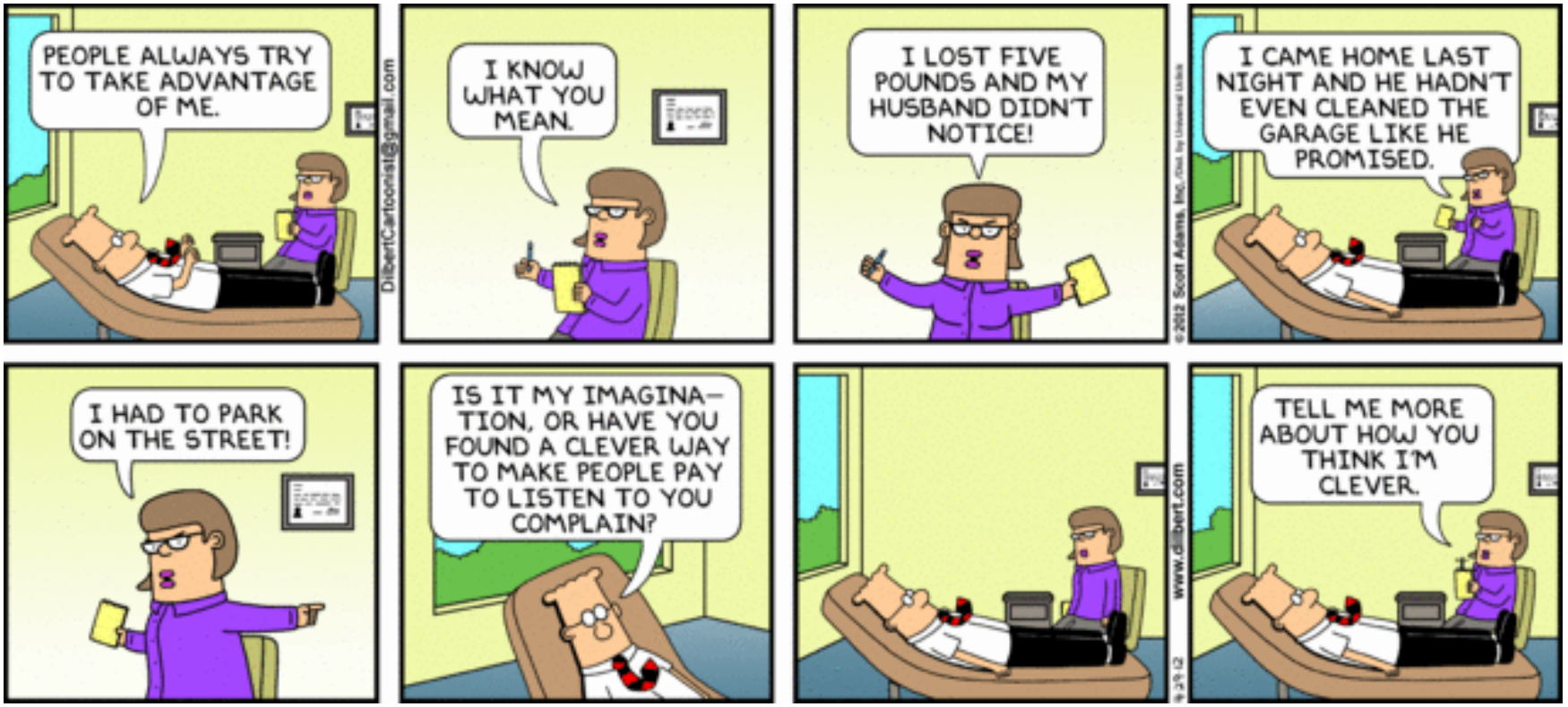
Therapeutic Metacommunication and Feedback

- What is therapeutic metacommunication?
- “Any instance in which the therapist provides to the client verbal feedback that targets the central, recurrent and thematic relationship issues occurring between them in the therapy sessions” *(Kiesler ,1996, p.29)*
- It is predicated upon being first hooked and then getting unhooked and processing the interaction and relationship.
- Use language that is accessible>power driven jargon
- Verbal, paraverbal and nonverbal elements are all relevant re empathic attunement

Propositions for Metacommunication

(Kiesler, 1996; Yalom & Leszcz, 2005; Leszcz, 2015)

- Communication about communication – Processing
- Essential therapist skill – align intent and impact and maximize patient utility
- Process of unhooking begins with identification of the impact message
- Collaboratively explore the presence of the identified pattern to refine or corroborate – remember the alliance
- Use metaphors, if it is helpful to reduce intensity
- Reduce incubation period prior to feedback
- Seek every opportunity to bring focus back to the process of interaction in the here and now
- Provide feedback in challenging but supportive fashion, from position of lower affective intensity, rather than greater intensity
- Manifest positive regard, blending tact with authenticity
- Language is our surgical skill



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Therapist Transparency & Self- Disclosure

(Yalom & Leszcz, 2005; Leszcz, 2009, Wachtel, 2011)

- Well processed and metabolized
- Distinguish what is induced by the patient from the therapist's contribution - e.g. subjective and objective countertransferences
- Determine the purpose of your disclosure – ethical imperative
- Transparency is a tool, not an end in itself; cost and benefits
- Comprehensive exposition of reactions to the here-and-now, ahistorical >>> than personal, historical elaboration
- Find palatable ways to say unpalatable things

Therapist Transparency & Disclosure

(Yalom & Leszcz, 2005; Leszcz, 2009, Wachtel, 2011; Leszcz et al 2015)

- Risk of damage to the treatment with unchecked therapist hostility
- Essential modeling and norm setting
- Too extreme a position regarding transparency, in either direction constricts efficacy
- Timely, thoughtful therapist self-disclosure correlates with improved outcomes and maintenance of constructive relationship

Therapist Transparency & Disclosure

(Yalom & Leszcz, 2005; Leszcz, 2009, Wachtel , 2011)

- Protect the frame of treatment
- Alert to timing and stage of treatment
- Mirroring of growth and communicative matching
- Disciplined personal therapist involvement *(McCullough, 2006)*
- Psychotherapists invariably become more self-disclosing as they gain experience reluctant to encourage junior colleagues to do so for fear of boundary tensions *(Leszcz, 2009)*
- Don't assume your impact – check it out – viz. differential impact of crying by therapist (*Tritt et al, 2015)*

Recognizing Negative Effects

(Lambert, 2012;Chapman et al, 2012;Boswell, 2015; Burlingame et al, 2017)

Therapists underestimate deterioration effects even when asked to search from– 40 Txs detected 3/42 failures *(Hannan et al 2005)*

- Supervision/ consultation enhances Tx reflective capacity *(Kraus et al , 2011)*
- 90% of therapists rate themselves in the top quarter and believe that 85% of their patients improve vs. the 50% who actually do
- Patient-centred tracking offsets therapist positive bias and overestimation of effectiveness; promotes earlier detection which in turn significantly reduces negative outcomes and tenure (*Lambert, 2012; Schuman et al, 2015)*
- Although tracking may add little to treatments that are going well, tracking adds enormously to the 20-30% of unrecognized treatments that are not going well, improving outcomes from 22% to 56% and reducing deterioration rates from 20% to 5%.
- Inexpensive and effective but requires self scrutiny; regular checking and incorporating feedback into therapy
- Patients can be easily engaged using analogy of vital signs and easy to access e-platforms

The Exemplar Psychotherapist

(Van Wagoner et al., 1991; Eels, 1999; Wampold, 2006)

Key capacity is to utilize objective and subjective countertransference well – know oneself as a Tx: negative impact of therapist's anxious attachment; harsh introjects; superego driven

- Characteristics:
  - self-aware
  - able to contain anxiety
  - good conceptual ability and skillfulness
  - empathic capacity
  - general well-being and integration
  - genuine interest, caring and commitment
  - achieves a strong therapist/patient bond
  - emotional healer
  - recognizes limits and fit
  - reflective > reactive

The Exemplar Psychotherapist

(Wampold et al 2017)

Four key characteristics define effective therapists:

1. Ability to form a therapeutic alliance across a range of patients
2. Facilitative interpersonal skills – verbal fluency, warmth emotional expressiveness
3. Professional humility and self doubt that transduces into reflective practice
4. Deliberate practice and investing time learning and refining one's craft