

**THE THERAPEUTIC RELATIONSHIP AS A COMMON FACTOR: IMPLICATIONS
FOR TRAUMA THERAPY**

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Here is the challenge. I recently retired from my University to assume the position as Research Director of the Melissa Institute for Violence Prevention (see www.melissainstitute.org). In this capacity, I am invited to consult and train clinicians on ways to work with clients who have experienced traumatic events and victimizing experiences. The clients usually have received a diagnosis of PTSD and an array of comorbid disorders such as substance abuse and depressive disorders. For instance, I have been training clinicians who are working with returning service members, torture victims, Native populations who have been sexually abused, as well as clinicians who work in Residential Treatment Centers. If you were in my shoes, what advice would you offer these clinicians? What specific interventions would you recommend?

Consider the treatment options that can most succinctly be summarized in a list of Acronyms. In fact, I have come to the conclusion that you cannot formulate a treatment for patients with PTSD and related disorders unless you have an Acronym. In fact, I think that therapists must come up with the Acronym first, and then develop the therapy. You can choose from the following list:ⁱ

DTE, VRE, CPT, EMDR, SIT, AMT, MBSR, MAGT, ACT, CR, TF-CBT, IBT, CP, CMT, IPT, IRT, and others.

In addition, you can select from an additional array of treatment approaches that have been developed to address the presence of comorbid disorders like **SS, TARGET, and STAIR-MPE**.ⁱⁱ This list of treatment options could be extended if we consider specific interventions that address patient dominant emotional concerns like complicated grief, guilt, shame, anger, moral injuries and spiritually-based interventions.

Remember, as a consultant I am getting paid to help psychotherapists choose the “best” most effective interventions. The catch-words are “evidence-based” and “evidence-informed” interventions.

Now, here is the rub. In my desire to be an “honest broker” and not a specific advocate of any one Acronym therapy, I find myself on the “horns of dilemma”. On the one hand there is the report of the Institute of Medicine (2008) of the efficacy of exposure-based therapies with patients who suffer from PTSD, and the Veteran’s Administration endorsing and training their clinical personnel on Direct Therapy Exposure and Cognitive Processing Therapy.

On the other side of the debate, there are a number of meta-analytic reviews that question the relative differential efficacy of so-called “evidence-based therapies” versus bona fide comparison groups that are “intended to succeed.” Reviews by Benish et al. (2008), Imel et al. (2008), Keijsers et al. (2000), Norcross (2002), and Wampold et al (1997, 2010) have seriously challenged the proposition that any one Acronym form of treatment is the “winner of the race” and should be embraced and advocated by me in my consultative capacity. Moreover, Webb et al. (2010) have reported that the therapist’s adherence to evidence-based treatment manuals is not related to treatment outcome. In fact, “loose compliance” that is tailored to the patient’s individual needs may be the best treatment approach.

Such meta-analytic reviews have not gone without their critics, as highlighted by Ehlers et al. (2010). But, keep in mind that the clinicians that I am called upon to train, still want to know specifically what to do with their challenging patients.

For the moment, let us assume that each of the Acronym therapeutic approaches, do indeed, lead to favorable outcomes with patients diagnosed with PTSD and comorbid disorders. What are the common mechanisms that contribute to such patient improvements?

Another way to frame this question is to share an example of my supervisory role of clinical graduate students at the University of Waterloo in Ontario Canada. In our clinic, we had several interview rooms side-by-side, each with one way viewing mirrors. I would sit on a high-backed chair which had wheels and I could roll up and down the viewing corridor watching several students at one time. Okay, so imagine in each clinical interview room you could watch Edna Foa conducting Direct Therapy Exposure, Barbara Rothbaum using amplified Virtual Reality Exposure, Pat Resick conducting Cognitive Processing Therapy, Francine Shapiro conducting EMDR, Marsha Linehan teaching skills in Dialectical Behavior Therapy, and so forth. What makes these psychotherapists effective? What do “expert” therapists do, and not do, that leads to positive treatment outcomes?

In answering this question keep in mind that there is little or no evidence of the “specificity” of treatment effects. Interventions that are designed to alter specific behavioural skill areas do not usually evidence changes in that domain. Moreover, when dismantling treatment studies are conducted, with the key treatment ingredients omitted or altered, favorable treatment results are still evident (see Rosen & Frueh, 2010).

Hopefully, you are beginning to appreciate the source of my challenge. What would you do? My solution has been to identify and enumerate the “Core Tasks” of what underline treatment improvement. My list is gleaned from both the research literature and my 40 years of clinical work.

Core Tasks of Psychotherapy

What are the core tasks that characterize the performance of psychotherapists who achieve positive treatment outcomes? This question has been addressed from Carl Rogers (1957) initial examination of the necessary and sufficient prerequisite conditions of psychotherapy to Jerome Frank’s (Frank & Frank, 1991) analysis of common persuasive features of behavior change to a search for the “heart and soul” of change by Miller, Duncan and Wampold (2010).

In each instance, a set of common psychotherapeutic tasks have emerged. These tasks are dependent upon the quality and nature of the therapeutic alliance as being central to patient behavioural change. As highlighted by Ackerman and Hilsenroth (2003), Martin et al. (2000), Messer and Wampold (2002), Norcross (2002), Safran and Muran (2002), and Wampold (2001), the quality and nature of the therapeutic alliance accounts for a significant larger proportion of treatment outcome variance than do therapist effects and the specific treatment interventions, or the specific form of Acronym therapy that is being implemented. Approximately one third of treatment outcome is accounted for by the therapeutic alliance, significantly more than does the specific type of therapy (Duncan et al. 2009). The therapeutic alliance relationship is the “cornerstone” of effective therapy (Norcross, 2009). As Irvin Yalom (2002, p. 34), stated, “the paramount task of psychotherapy is to build a relationship together that will become the agent of change.” Walsh, (2011 p. 585) observed that “Ideally, therapeutic relationships then serve as bridges that enable patients to enhance life relationships with family, friends and community.”

The correlation between the quality of the therapeutic alliance and treatment outcome is approximately .26, which corresponds to a moderate effect size. The pattern of patient participation and the degree of patient therapeutic engagement in the first three therapy sessions

is predictive of treatment outcome. Patients with weaker therapeutic alliance are more likely to drop out of psychotherapy (Sharf et al., 2010).

The relationship between the quality and nature of the therapeutic alliance and the treatment outcomes is further strengthened when psychotherapists assess and employ ongoing real-time patient feedback. Lambert and his colleagues (Lambert, 2010; Lambert et al. 2005; Shimokawa, Lambert & Smart, 2010) and Miller et al. (2007) have demonstrated that measuring, monitoring and alerting psychotherapists to potential patient treatment failure on a session-by-session basis by soliciting patient feedback of treatment response maximizes treatment outcomes. Such feedback permits the psychotherapist to individually alter and tailor the intervention to the patient's needs, and thereby strengthens the therapeutic alliance.

The role of the therapeutic alliance in impacting treatment outcome has now been demonstrated with diverse clinical populations. For example, a meta-analysis of 24 studies of couple and family therapy using a variety of self-report alliance measures (Working Alliance Inventory, Couple Therapy Scale and Family Therapy Alliance Scale) found that the interplay of each family member's alliance with the therapist was related to treatment retention and outcomes. Patients who reported feeling "safe" within therapy with the avoidance of excessive cross-blaming, hostility and sarcasm in sessions reported stronger therapeutic alliances and better treatment outcomes. In so far as a shared sense of purpose and the establishment of overarching familial systemic goals were achieved, rather than individual goals, therapeutic alliance development and treatment outcome were enhanced. (Escudero et al. 2011; Friedlander et al. 2011). McLeod (2011) conducted a similar meta-analysis of the relationship of therapeutic alliance and treatment outcome in youth psychotherapy, and reported similar relationships.

A different research approach to studying the role of therapeutic alliance in influencing treatment outcome has been to ask patients what they have found helpful and unhelpful on the part of their therapists. Hamilton and Coates (1993) interviewed abused women who offered the following observations of their psychotherapists.

Helpful psychotherapists

"Listened respectfully and took me seriously."

"Believed my story."

"Helped me see if I was still in danger and explored with me how I could deal with this situation."

"Helped me see my strengths."

"Helped me understand the impact of traumatic events on myself and on others."

"Helped me plan for change."

In contrast, unhelpful psychotherapists

"Did not listen and did not have an accepting attitude."

"Questioned and doubted my story."

"Dismissed or minimized the seriousness of my situation."

"Gave advice that I did not wish to receive."

"Blamed or criticized me."

A similar profile of patient reactions was reported by Elliot (2008).

Whether one considers the findings of meta-analytic studies or the results of interview studies with patients, the degree to which the patient feels respected, heard, accepted, empathetically understood, validated and hopeful enhances the likelihood of positive treatment outcomes. The felt sense of collaboration between the therapist and patient, including an emotional bond and negotiation of therapy tasks and goals has consistently predicted favorable treatment outcomes (Horvath et al. 2011).

The therapeutic alliance has come to be defined as the extent to which the patient and the psychotherapist jointly agree on the goals of treatment and the means or tasks by which to achieve these goals (“pathways thinking”), and the quality of the affective bond that develops between them (Bordin, 1979; Horvath & Bell, 2002; Norcross, 2002). McFarlane (1994) observes that trust is an essential feature of the therapeutic alliance with traumatized patients. The patient must feel secure and confident that the therapist is genuine, empathetic and warm, and moreover, that the therapist can cope with bearing witness to the patient’s reported trauma and understand its significance. These various authors are highlighting that the therapeutic alliance is the primary “vehicle”, “prerequisite”, “process”, “glue”, that permits patients to develop the courage to avoid avoidance, reexpose themselves to traumatic events, reminders, cues, and reengage life.

Additional Core Tasks of Psychotherapy

If we now revisit the various trauma psychotherapists (Foa, Rothbaum, Shapiro, Linehan and the other Acronym Therapists), what do they have in common? Clearly, one thing is their ability to establish, maintain, monitor the therapist alliance and address any potential “ruptures” accordingly. But they do much more. They each:

1. Assess for the patient’s safety (conduct risk assessment) and ensure that basic patient needs are being met.
2. Educate the patient about the nature and impact of trauma, PTSD and accompanying adjustment difficulties and discuss the nature of treatment. Address issues of confidentiality billing, logistics, and the like. But always conveying a “caring” attitude.
3. Conduct assessments of the patient’s presenting problems, as well as their strengths. What have the patient’s done to “survive” and “cope?” They tap the “rest of the patient’s story.”
4. Solicit the patient’s implicit theory about his/her presenting problems and his/her implicit theory of change. The therapist provides a cogent rationale for the treatment approach and assesses the patient’s understanding. Makes the therapy process visible and transparent for the patient.
5. Alter treatment in a patient-sensitive fashion, being responsive to cultural, developmental and gender differences.
6. Nurture “hope” by engaging in collaborative goal-setting, highlighting evidence of patient, family, cultural and community resilience.
7. Teach intra and interpersonal coping skills and build into such training efforts the ingredients needed to increase the likelihood of generalization and maintenance of treatment effects. The effective therapist does not merely “train and hope” for

- generalization, but explicitly builds in such features as relapse prevention, attribution re-training, aftercare, putting patients in a consultative mode (or in the “driver’s seat”), so they become their own therapist.
8. Provide interventions that result in symptom relief and address the impact of comorbid disorders.
 9. Encourage, challenge, cajole patients who have been avoidant to reexperience, reexpose themselves to trauma reminders, cues, situations and memories. Enlist the support of significant others in these reexposure activities.
 10. Teach patients a variety of direct-action problem-solving and emotionally-palliative coping skills (for example, mindfulness activities), to the point of mastery, addressing issues of treatment nonadherence throughout.
 11. Help patients reduce the likelihood of revictimization.
 12. Finally, engage patients in developing “healing stories.”

In short, whatever the proposed Acronym-based intervention (direct exposure, cognitive reprocessing, self-regulatory emotional controls, and the like), it is critical to remember that such specific interventions are embedded in a contextualized process. How much of the patient change that is achieved in trauma therapy should be attributed to each of these component steps and how much to “manualized” treatment procedures.

Table 1 is the Psychotherapist Checklist I use in my consulting role. This Checklist highlights how to make the so-called “non-specifics” of psychotherapy specific, trainable and measurable. It enumerates ways to enhance therapeutic alliance and treatment outcomes. The importance of these psychotherapeutic skills are highlighted by a better appreciation of the goals of trauma therapy from a Constructive Narrative Perspective.

Constructive Narrative Perspective of the Impact of a Therapeutic Alliance

Most individuals (70%-80%) who have experienced traumatic and victimizing experiences evidence resilience and in some instances, post-traumatic growth (Bonanno, 2004; Meichenbaum 2006, 2007, 2009, 2011, 2012). The 20%-30% of the traumatized population who evidence adjustment difficulties and who are candidates for some form of trauma therapy evidence a cognitive emotional, behavioural and spiritual style that contributes to persistent PTSD. Patients who receive the diagnosis of PTSD are likely to engage in:

1. Self-focused, mental defeating ruminative style of thinking;
2. Avoidant thinking processes of deliberate suppressing thoughts, using distracting behaviors that inadvertently reinforce avoidant behaviors and PTSD symptoms;
3. Overgeneralized memories and a recall style that intensifies hopelessness and impairs problem-solving;
4. Contra-factual thinking, repeatedly asking “Why” and “Only if” questions for which there are no readily acceptable answers;
5. Engage in “thinking traps” that reinforce hypervigilance, safety and emotionally distancing behaviors and that contribute to the avoidance of self-disclosing and help seeking;
6. Negative spiritual coping responses (Having a “spiritual struggle”, anger responses, moral injuries, complicated grief, guilt, shame and the like).

The trauma patients tell others and themselves “stories” that lead them to become stuck. One central goal of trauma therapy, no matter what form it may take is to help patients develop and live a “healing story.” There is a need for patients to integrate the trauma events into a coherent autobiographical account, so the traumatic events are landmarks, but not the defining elements of their accounts. Trauma patients need to develop “redemptive” stories that bolster hope, strengthen self-confidence and indicate that their efforts will bear fruit. Changes in story-telling provide access to new solutions. The patient’s ability to generate a coherent narrative helps to reduce distress and hypervigilance, increases a sense of control, reduces feelings of chaos and unpredictability, and helps the patient develop meaning. Narrative coherence conveys a sense of personal self-efficacy and helps the patient makes sense of what happened and points a direction to the future. Trauma is only one part of an individual’s life, rather than the determinant aspect. Effective trauma therapy helps the patient learn to let the “past be the past”. Patients can learn to disentangle themselves from the influences and lingering impact of traumatic events. In trauma therapy, patients engage in a narrative healing process.

Trauma therapists, no matter which form of Acronym therapy they employ, are in the business of helping traumatized patients become “story-tellers” who can evidence resilience, moving from the 20%-30% group to the 70-80% resilient group. The therapeutic alliance is the framework whereby trauma patients can share their trauma accounts, as well as what they did to survive and cope in the past; bolster their courage to confront, rather than avoid trauma-related situations and remembrances; develop and strengthen coping strategies that foster hope; undertake meaning-making missions and reengage life. Move from being a “victim”, to a “survivor”, to a “thrifer.”

In my consultative capacity, I train trauma therapists to become “exquisitive” listeners and help them become collaborators in their patient’s journey to develop “healing stories.” As Stephen Joseph, (2012 p. 43) has observed: “Human beings are story-tellers. We are immersed in stories.” The role of the trauma therapist is to help traumatized patient’s move along this journey of collecting data (results of personal experiments) that will “unfreeze” their beliefs about themselves, others, the world and the future. The therapeutic alliance is the ground in which such growth develops and blossoms (Meichenbaum, 1996, 2007). Its importance to the change process needs to be highlighted, repeatedly.

CHECKLIST OF THERAPY BEHAVIORS DESIGNED TO FACILITATE THE THERAPEUTIC ALLIANCE

1. Convey respect, warmth, compassion, support, empathy, a caring attitude and interest in helping. Be non-judgmental. Listen actively and attentively, and let your patient know you are listening so he or she feels understood.
2. Convey a relaxed confidence that help can be provided and a sense of realistic optimism, but not false hope. Communicate a positive expectancy of the possibility of change. Use phrases like, “As yet”; “So far” and “RE” verbs such as RE-frame, RE-author, RE-engage). Emphasize that your patient can be helped, but it will require effort on both of your parts.
3. Validate and normalize the patient’s feelings. (“Given what you have been through, I would be deeply concerned, if at times you were not feeling overwhelmed and depressed”).
4. Use guided discovery and Socratic Questioning. Use “How” and “What” questions. Stimulate the patient’s curiosity, so he/she can become his/her own “therapist”, “emotional detective”.
5. Enter the narrative text of the patient, using his/her metaphors. Assess the “rest of the patient’s story” and collaboratively discover what the patient did and was able to achieve in spite of traumatic/victimizing experiences.
6. Explore the patient’s lay explanations of his or her problems and his or her expectations concerning treatment. Collaboratively establish “SMART” therapy goals (Specific/Measurable. Achievable, Realistic, and Time-limited). Use motivational Interviewing Procedures.
7. Model a style of thinking. Ask the patient, “Do you ever find yourself in your day to day experiences, asking yourself the same kind of questions that we ask each other here in therapy?”
8. Encourage the patient to self-monitor (collect data) so that he/she can better appreciate the interconnectedness between feelings, thoughts, behaviors and resultant consequences, and perhaps, inadvertently, unwittingly, and unknowingly behave in ways that may maintain and exacerbate presenting problems (e.g., avoidance behaviors reinforce PTSD symptoms).
9. Conduct a pros and cons analysis and help the patient to break the behavioral “vicious cycle.”
10. Address any Therapy Interfering Behaviors and potential barriers. Solicit patient commitment statements. Play “devil’s advocate.”

11. Provide intermediate summaries and a summary at the end of each session. Over the course of treatment have the patient generate this treatment summary. Highlight how the present session follows from previous sessions and is related to achieving treatment goals. Be specific. Have the patient generate the reasons why he/she should undertake behavioral changes.
12. Help patients generate alternative “healing” narratives that empower them to examine their dominant “trauma” story and develop and live personal accounts that contribute to post-traumatic growth.
13. Solicit feedback from the patient each session on how therapy is progressing and ways to improve treatment. Convey that you, the therapist, is always trying to improve and tailor treatment to the needs and strengths of each specific patient. Monitor the relationship for any alliance strains. Accept part of the responsibility for any difficulties in the relationship.

SUMMARY

1. Much effort has been expended to develop evidence-based interventions with patients diagnosed with PTSD and comorbid disorders- - what are called “Acronym Therapies.
2. Exposure-based interventions such as Direct Therapy Exposure and Cognitive Processing Therapy have been endorsed as being most effective.
3. Meta-analytic studies of various so-called “evidence-based” therapies for PTSD patients versus bona-fide comparison groups that were intended to succeed have raised questions about the differential effectiveness of various treatments.
4. Both dismantling and specificity-based studies have questioned the mechanisms of change on those interventions.
5. Common to all these “Acronym” therapies are a set of Core Psychotherapeutic tasks with the most central being the nature and quality of the therapeutic alliance which accounts for the largest proportion of treatment outcome variance.
6. The impact of the therapeutic alliance on treatment outcome is strengthened when ongoing, real-time session-by-session feedback is solicited from patients and used by the psychotherapist to identify potential failures and dropout risk and to alter treatment accordingly.
7. Other core psychotherapeutic tasks beside establishing, maintaining and monitoring therapeutic alliance include psychoeducation, nurturing hope by means of collaborative goal-setting and bolstering resilience, teaching coping skills and building in generalization procedures.
8. Key ingredients in the development of a therapeutic alliance include empathy, trust, respect and a caring attitude. Table 1 provides a list of psychotherapeutic methods to enhance the therapeutic alliance and treatment outcomes.
9. A constructive narrative perspective of the therapeutic alliance highlights how to help traumatized/victimized patients develop “healing stories” with redemptive endings that engender hope, self-efficacy and help move trauma patients (some 20-30% of victimized individuals) to the 70-80% of resilient individuals.
10. The therapeutic alliance provides patients with an opportunity to share, reframe, and develop the courage to reexpose, reexperience, reengage and review their lives so traumatic events are incorporated into a coherent narrative and a personal account.

ⁱ DTE-Direct Therapy Exposure; VRE- Virtual Reality Exposure; CPT- Cognitive Processing Therapy; EMDR-Eye Movement Desensitization and Reprocessing; SIT- Stress Inoculation Training; AMT- Anxiety Management Training; MBSR- Mindfulness Based Stress Reduction; MAGT- Mindfulness and Acceptance Group Therapy; ACT- Acceptance and Commitment Therapy; CR- Cognitive Restructuring; TF-CBT- Trauma Focused Cognitive Behavior Therapy; DBT- Dialectical Behavior Therapy; CP- Counting Procedures; CMT- Compassion Mindfulness Training; IPT- Interpersonal Therapy; IRT- Imagery Rehearsal Therapy.

ⁱⁱ SS- Seeking Safety Treatment; TARGET- Trauma Adaptive Recovery Education and Therapy; STAIR-MPE- Skills Training in Affective and Interpersonal Regulation Followed by Modified Prolonged Exposure.

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