



What should we expect from psychotherapy?



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HIGHLIGHTS

- Difference between empirically supported treatments and evidence-based practice.
- Ways we can close the gap between treatment and practice.
- There are times when therapy makes the patient worse.

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ABSTRACT

In addressing the very general question of what we should expect from psychotherapy, this article begins by discussing what constitutes relevant evidence on which to base the efficacy and effectiveness of psychotherapy. In this context, an important distinction is made between empirically supported treatments and evidence-based practice. Although there is evidence that psychotherapy does indeed work, there are also findings that there are times when our patients are harmed by our interventions. It is noted that the therapeutic alliance plays an extremely important role in the change process, and that ruptures in the alliance can contribute to our therapeutic failures. In pointing to directions for the future, modifications of how we investigate the outcome of treatment, as well as how to close the gap between research and practice, are offered.

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1. Introduction

Approaching the question of what we should expect from psychotherapy is somewhat of a daunting task—especially knowing where to start. Perhaps a good way to begin is by asking what *our patients* should expect when they seek out therapy. In the most general sense, patients come to us with the expectation that our professional

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services will provide them with a way of overcoming the difficulties they are experiencing. They enter therapy hoping to make their lives better. This may involve their desire to reduce such problematic symptoms as anxiety or depression, to improve their relationships with others, to become more effective at school or work, or to resolve other problematic life issues. Although their goals for therapy clearly vary, their expectations nonetheless involve the desire or hope that we as therapists will assist in achieving them.

This, of course, is a somewhat simplified picture, as there are times when patients' goals are unrealistic, or not the desired outcome that will provide them with the improvement in their life for which they have entered therapy. In such instances, it is up to us as skilled clinicians to help them recognize that an alternative goal is more likely to give them what they want. My own professional sensitivity to the establishment of goals began when I was a financially challenged graduate student, and needed to have my dental work done at a training clinic. Upon examining my teeth, the student suggested that my fillings should consist of gold inlays. When I asked him if the advantage would be that they would last longer, he replied: "No. But because you have such strong teeth, gold inlays would go well with them." This experience made an indelible impression on me, and whenever I work with patients to establish the goals for therapy, I make every attempt not to confuse my goals for them with what they want from therapy.

In considering what our patients need from therapy, we as their therapists should expect that the treatment that we offer will help, and not harm them. This article begins with the acknowledgement that we have evidence to support the efficacy and effectiveness of psychotherapy, but also the need to go beyond the findings from randomized controlled trials (RCTs). An important distinction is made between RCTs and evidence-based practice (EBP), and the role that the technique, the therapy relationship, and common principles play in the change process. Although there clearly exist data to demonstrate that therapy helps, there are also findings that instances exist where it does not, and even more troubling, where it may even create harm. This article discusses the importance of certain factors that may increase the likelihood that therapy will be successful, such as the role of the therapeutic alliance in therapy, and closes with some suggestions for future directions in research and for ways to help close the gap between research and practice.

2. The role of evidence in psychotherapy

Another way of responding to the question of what we should expect from psychotherapy is that there exists evidence that it indeed does work. Over six decades ago, [Eysenck \(1952\)](#) lamented that although the practice of psychotherapy had been in existence since the beginning of the 20th century, the effectiveness of treatment was based primarily on the therapist's say-so. His critique served as an important impetus for research on psychotherapy.

2.1. Psychotherapy outcome research

Research on the outcome of therapy can be thought of as having spanned three generations, starting in the 1950s, moving to the second generation in the 1960s and 1970s, with the third generation beginning in the 1980s.

In the [1950 Annual Review of Psychology](#), Snyder provided a summary of the research that had been done on psychotherapy outcome to date; he was able to summarize it within the confines of a single chapter. Shortly thereafter, as the field began to recognize the importance of obtaining evidence on whether therapy actually produced change, it did so by addressing the very general question: "Does psychotherapy work?" The therapy that was studied primarily consisted of psychodynamic treatment, the methodology lacked rigor and sophistication, and the specification of the therapy interventions and outcome was general and vague. Nonetheless as the first generation of therapy research, it set the stage for what was to come.

The second generation of outcome research took place during the 1960s and 1970s, and was directed toward addressing a more specific question, namely "Which specific interventions are more effective in dealing with which specific problems?" For the most part, the interventions consisted of different techniques associated with behavior therapy and cognitive-behavior therapy, and marked the beginnings of a greater methodological sophistication in outcome research. Behavior therapy had its roots in basic research, where it was assumed that the extrapolation of research findings from the laboratory could have important clinical implications for practice. As an additional benefit associated with this line of thinking, there came a methodological sophistication for conducting outcome research. With preliminary findings pointing to the promising impact of behavioral treatments, the NIMH began to provide funding for carrying out outcome research. In what eventually became an impressive array of different studies of behavior therapy, various clinical interventions, such as desensitization, relaxation, and role playing were applied to different target problems, such as phobias, anxiety and unassertiveness. This generation of research was also characterized by the use of therapy manuals, whereby behavior therapy techniques, which were clearly delineated, could specify clinical guidelines. Although there was an important methodological advance over the first generation, generation two of psychotherapy outcome research was limited by the fact that the participants in the studies consisted primarily of college students, with graduate students serving as therapists.

Psychotherapy outcome research moved into its third generation in the 1980s. Many of the methodological advances in the previous generation were retained and some improvements were made, such as the independent rating of whether therapists indeed followed the specific treatment manual. However, in line with the fact that the NIMH shifted its preferred research model to that used in the investigation of drugs, "target behaviors" became "DSM disorders" and "outcome research" became "randomized controlled trials" (RCTs). All of this was a portent of things to come, where biological psychiatry transformed what we had once thought of as "psychological problems" into "clinical disorders."

It was in the late 1970s that Morris Parloff, the head of the Clinical Research Branch of the NIMH, provided his very sage perspective on the pros and cons of what was then becoming RCTs. Although a very strong advocate of psychotherapy research, Parloff cautioned psychotherapy researchers and practitioners alike that along with pressures for empirical accountability came the dangers of arbitrary and poorly informed decisions by policymakers, who would be instrumental in setting guidelines to financially reimburse patients for psychotherapy. In his presidential address before the Society for Psychotherapy Research (SPR), he shared some of his concerns, stating:

From time to time, psychotherapy researchers have complained that their findings have not impacted sufficiently on the practitioner or on the policymaker. We have carped that our voices have not been heard in high councils and that our wisdom has gone unrecognized and unrequited by government's decision makers. I regret to inform you that those idyllic days are now gone. We can no longer be confident that our papers will be read only by fellow researchers. Policymakers are reading our records and the clinicians are listening. [[Parloff, 1979, p. 296](#)]

Parloff was concerned that although outcome research might provide useful evidence for the efficacy of treatment, it had its limits, as it did not always focus on what actually happens in clinical practice—a concern that was reiterated at a later point by others committed to the importance of therapy research (e.g., [Garfield, 1996](#); [Goldfried & Wolfe, 1996](#)).

In the early 1980s, I attended an NIMH-sponsored workshop on the use of cognitive-behavioral techniques for the treatment of anxiety disorders. The workshop was to be led by Parloff, who unfortunately was not able to attend because he had been called to testify before Congress to report on the effectiveness of psychotherapy. Congress wanted to explore the possibility that the NIMH might serve the

function that the US Food and Drug Administration (FDA) served in the certification of which medications should be approved for clinical use. This chilling realization that the practice of psychotherapy might need to be accountable to National Health Insurance that the federal government was hoping to institute came on the heels of Parloff's warning that policymakers were looking over the shoulders of both the therapy researcher and practitioner.

In an article entitled "Psychotherapy research evidence and reimbursement decisions: Bambi meets Godzilla," Parloff (1982) raised concerns that policymakers may not recognize the subtle issues and methodological compromises associated with psychotherapy research, and that in the final analysis "Research findings can be expected to exert all the impact of a quixotic Bambi planted firmly in the path of the onrushing Godzilla of cost-containment policies" (Parloff, 1982, p. 725). Observing that there was the beginning of a proliferation of numerous therapy interventions based on theoretical assumptions rather than empirical evidence, Parloff went on to argue for the importance of psychotherapy process research, pointing out that he was concerned that "in the absence of a firmer knowledge of the valid agents of change, an infinite number of redundant 'new' therapies may continue to be invented and presented for assessment by the outcome researcher" (p. 725). And while the NIMH had a period of time where they supported process research, which could increase the likelihood of developing more empirically based interventions, most of the support went to financing clinical trials.

At present, when we think about the evidence supporting the efficacy of therapy, we associate it with the findings of RCTs. With our current emphasis on the medical model that guides drugs research, it not only changed how we conduct research on psychotherapy, but also how we think about clinical problems. As noted earlier, no longer do our patients have problems in living, but rather have "clinical disorders." No longer are certain problematic issues in a person's life functionally related to other problematic difficulties, but rather there exists "comorbidity."

The limitations of RCTs in informing the practicing clinician have been discussed elsewhere (e.g., Garfield, 1996; Goldfried & Wolfe, 1996, 1998), and will not be reviewed in any detail. Suffice it to say, the limitations of generalizing to the real world of clinical practice involve the random assignment to treatment rather than basing the intervention on case formulation, a fixed number of sessions rather than having the number of sessions needed to bring about change for any given patient, and the use of theoretically "pure" interventions rather than being free to pursue intervention derived from other theoretical approaches. Indeed, Allen Francis, chair of DSM-IV – and also a practicing therapist – highlighted the clinical limitations associated with RCTs that are directed toward treating DSM-disorders. As a practicing clinician, Francis was clearly aware of the gap between RCTs and the practice of therapy:

Making a DSM-IV diagnosis is only the first step in a comprehensive evaluation. To formulate an adequate treatment plan, the clinician will invariably require considerable information about the person being evaluated beyond that required to make a DSM-IV diagnosis. [American Psychiatric Association, 1994, p. xxv]

If he is correct in his observation – and most practicing therapists are likely to agree that he is – one needs to take great care in unquestioningly generalizing the results of RCTs to clinical practice.

Roth and Fonagy (1996), in their careful review of the outcome literature, have similarly recognized the limits of RCTs. Reflecting a view held in the UK, they have pointed to some of the unintended consequences of specifying ESTs based on clinical trials:

As research evidence begins to be collated, there is a temptation to turn to these findings as though they provide a definitive answer, without noting the cautions researchers almost universally attach to them. Where payers yield to this temptation in the design of managed care programs and directives regarding first-line treatments, the

reaction of many clinicians is to become suspicious of moves toward (or demands for) evidence-based practice. This adversarial process threatens to set those paying for care against those providing it, and indeed, providers against researchers. In this context, there are clear perils along the path of applying research findings to clinical practice. On the one side, the risk that practitioners reject psychotherapy research out of hand; on the other, the possibility that purchasers embrace it uncritically, leading to a cookbook approach to planning.

[Roth & Fonagy, 1996, p. 40]

2.2. The importance of evidence beyond RCTs

Despite the limitations described above about the limitations of RCTs, the findings of such clinical trials have become the "gold standard" in determining which therapies have been proven to be efficacious. Thus an intervention for a given clinical disorder that has been demonstrated to be superior to a control intervention in two or more RCTs have reached the status of being an EST. Recognizing that the methodological constraints in conducting RCTs (e.g., fixed number of session, use of theoretically pure interventions) might eventually become clinical constraints, and that the evidence to be considered by third-party payers as constituting empirical support might be based solely on RCTs, an APA task force broadened the definition of what constitutes "evidence" in determining the clinical effectiveness of therapy (APA Presidential Task Force on Evidence-Based Practice, 2006). Although it was clearly acknowledged that RCTs were an important source of evidence, other sources of evidence were also seen as being important, as were such variables as patient characteristics and context, and clinical expertise. Interventions do not always work for all patients, and some therapists are better than others.

In addressing the issue of sources of "evidence" that can contribute to evidence-based practice, one may think of three general categories of research, each of which addresses a different question that is related to what we do clinically (Arkowitz, 1989). The question "Does therapy work?" is addressed by outcome research—now called "clinical trials." Numerous research designs have been used to answer this question, and most typically have involved comparing a given treatment for a given disorder to another condition (a different intervention or appropriate control condition) to determine how well it fares at the end of treatment. However, other research approaches are also clearly relevant, such as process research, which attempts to identify the mediators and moderators associated with successful outcome (e.g., degree of patient motivation and the presence of a good therapeutic alliance). This addresses the research question "How does successful therapy work?" Finally, there is a third type of relevant research – basic research on psychopathology (e.g., what we know about the nature of panic) and human functioning (e.g., the relationship between misattribution and problematic emotional reactions) – which deals with the question "What needs to be changed?" These latter two questions, each of which is essential to effective clinical practice, are not addressed by ESTs.

Although this broader view of what constitutes evidence that is relevant to the practice of therapy makes good clinical and empirical sense, it is distressing that many workers in the field have tended to equate the more comprehensive notion of evidence-based practice with manual-driven ESTs. These other sources of evidence clearly exist but are often ignored by those advocating the importance of evidence in the practice of therapy. Evidence on *if* change occurs, *how* it does, and *what* needs to be changed can come for a variety of different sources, including the findings on principles of therapeutic change (Castonguay & Beutler, 2006), consensus ratings made by expert clinicians on how to deal with certain clinical situations (Eubanks-Carter, Burckell, & Goldfried, 2010), clinicians' reports on those factors that help and hinder successful therapy (Castonguay, Boswell, Constantino, et al., 2010; Castonguay, Boswell, Zack, et al., 2010), and surveys of practicing

therapists on their clinical experience in using ESTs in clinical practice (Goldfried, 2011).

3. Does psychotherapy help or make things worse?

Six decades after Eysenck (1952) pointed out that there was no good evidence that psychotherapy had a positive impact on patients' lives, there has been the accumulation of a truly impressive body of research evidence to indicate that it indeed does. Extensive reviews of the research findings have appeared in the literature, and a presentation of these findings goes well beyond the purpose and scope of this article. Despite the plethora of findings that support the efficacy of therapy, numerous questions nonetheless remain about those important mediators and moderators that account for change when it occurs—and when it does not.

3.1. When therapy fails

At the same time that the research literature clearly attests to the efficacy of psychotherapy, there also exist findings that indicate that there are times when therapy fails to produce change (e.g., Foa & Emmelkamp, 1983), and can at times even make things worse (Castonguay et al., 2010; Henry, Schacht, & Strupp, 1986; Lilienfeld, 2007). Our recognition of the potentially harmful effects of therapy have existed for some time (e.g., Bergin, 1966), but perhaps for political, economic and professional reasons, the field has tended to deemphasize such findings. In writing about the failures of behavior therapy, Foa and Emmelkamp have acknowledged this general phenomenon: “Contact with clients has taught us that clinical practice is not as simple as that portrayed in textbooks.... It seems that once a technique was endorsed as effective, it became almost taboo to admit that sometimes the expected positive results were not obtained” (Foa & Emmelkamp, 1983, p. 3). The failure to find therapeutic change when using empirically supported treatments is especially seen when they are used to treat complex clinical cases (Ruscio & Holohan, 2006). This general tendency to place less emphasis on clinical failures is indeed unfortunate on many counts, not the least of which is that they can often tell us as much about the variables that contribute to the change process as do the successes. Fortunately, there has been an increase in attention to the fact that many patients continue to be symptomatic at the end of treatment (Dimidjian & Hollon, 2011; Goldfried, 2011).

It has been estimated that anywhere between five and 10% of patients not only fail to benefit from treatment, but also get worse (Lambert & Ogles, 2004). Although it is possible that these patients might have gotten worse in the absence of therapy, available research findings suggest two primary causes of this deterioration effect: the nature of the therapy alliance and the specific interventions that are used. It should be kept in mind that in research that has studied the relationship between the therapy alliance and outcome, the quality of the alliance is typically not experimentally manipulated. Although some early research that manipulated warmth of therapist interaction found that systematic desensitization administered by warm therapists was more effective in reducing phobias than therapists who were aloof (Morris & Suckerman, 1974), most of what we know about the alliance and outcome is correlational. And even though measures of the alliance are taken early in the therapy, it is still possible that they are a consequence of change that has already occurred (see Feeley, DeRubeis, & Gelfand, 1999). Although there have been debates in the literature as to whether the change process can be accounted for by the therapy relationship or the specific techniques that are employed, a case can be made that both the therapy alliance and the intervention procedure play a significant role in whether change occurs (Goldfried & Davila, 2005; Norcross, 2002). We will return to this issue shortly.

3.2. The importance of the therapy alliance

In defining the components of the therapy alliance, the conceptualization offered by Bordin (1979) has proved to be most useful. According to Bordin, the alliance is comprised of not only the bond between therapist and patient, but also the agreement on both the goals of therapy and the methods that will be used to reach these goals. The bond between therapist and patient is usually what we think of when we talk about the “therapy relationship.” It refers to the mutual liking of therapist and patient, the feeling by both that there is good communication, and the mutual willingness to work together clinically. Reports on the part of patients that “My therapist really understands and cares about me,” and feelings by the therapist that “I enjoy working with this patient” are typical indicators that a good bond exists. The remaining aspects of the therapy alliance involving the mutual agreement on goals and methods represent what may be thought of as the contractual working guideline that exists between therapist and patient. Thus the alliance represents the context in which the change process occurs for the implementation of intervention procedures, but also in itself possibly creating therapeutic change as well—especially in those cases where interpersonal difficulties might be part of the patient's problem.

There have been numerous studies examining the relationship between the therapy alliance and outcome, virtually all of which indicate that a positive alliance is indeed associated with successful outcome (Muran & Barber, 2010). As suggested earlier, a controversy has arisen as to whether or not the alliance is a predictor of outcome or merely a reflection of it, as much depends on when the measure of alliance is obtained. When obtained early in therapy (e.g., by the third session), it is likely to reflect a good working context within which therapy can proceed successfully. However, when gotten later in treatment, it may reflect the fact that the bond and agreement on goals and methods are the result of therapy having been successful.

Just as there is evidence that a good therapy alliance can contribute to successful treatment, so are there findings that indicate that strains or ruptures in the alliance can lead to failure (Muran & Barber, 2010). A landmark study by Henry et al. (1986) and Henry, Schacht, and Strupp (1990), carried out in the context of a manual-driven short-term psychodynamic therapy, dramatically illustrates this. In relating process to outcome, Henry and colleagues found that subtle forms of therapist frustration and hostility were associated with negative clinical outcomes. It is of particular interest that such frustration occurred when patients did not respond favorably to therapists' manual-dictated transference interpretations. Despite the patients' resistance to these interpretations as not ringing true, therapists persisted with them, perhaps because it was important for them to do so in the context of what the research protocol required them to do clinically.

It should be noted that such strains in the alliance are not restricted to psychodynamic therapy. Castonguay, Goldfried, Wiser, Raue, and Hayes (1996) found very much the same phenomenon in their study of cognitive therapy for depression. In examining the relationship between process and outcome, Castonguay and colleagues obtained an unexpected *negative* relationship between therapists' use of intrapersonal links (e.g., linking how patients' thoughts were linked to their emotional reactions)—clearly opposite to theoretical expectations. In conducting a further analysis of the therapy alliance across all cases, they found that the problem was not in the therapists' use of intrapersonal links, but rather in the use of them in instances where there was a rupture in the alliance. For example, there were cases where patients were unhappy with the therapy and were questioning the rationale, and instead of dealing with the alliance rupture, the therapists continued to make links between the patient's thoughts and feelings about the therapy.

3.3. Strains in the therapeutic alliance

The above examples of how strains in the alliance can lead to negative clinical outcomes may be thought of as artifacts of the fact that the

therapists were following a manual, knowing that how they behaved during the session was going to be rated for adherence to the manual, an important methodological condition in the research design. Still, it illustrates that the communication of the frustration with the patient can have an adverse effect—especially if patients grew up as being the object of such negative responses.

Although therapists are not inclined to openly discuss their frustrations and negative reactions to patients, they nonetheless are more prevalent than one might expect (Wolf, Goldfried, & Muran, 2013). Despite training and personal therapy, therapists were people before they were therapists, and at times continue react in ways that might not be all that therapeutic. There are times when we as therapists are aware of our negative emotional reaction to patients, but other times when there are only indirect indicators—such as when we are not looking forward to a session with the patient, or where we continually check the clock during a session. In discussing the therapists' negative reactions to the patient, Gelso and Hayes (2007) have linked it to countertransference, based on the therapist's personal issues. However, it can occur in clinical cases where the patient's behavior is seen as being particularly abhorrent (e.g., physically or sexually abusing one's children). And it may also happen in less obvious situations, such as when therapists become "frustrated" with lack of progress or the patient's resistance to the therapy.

As observed by Goldfried and Davison several years ago, although there is often the temptation to blame the patient when therapy does not progress as hoped or expected, "the client is never wrong" (Goldfried & Davison, 1976, p. 17). Clinical lore has it that therapists should deal with patients "where they're at." In discussing the importance of fulfilling patients' expectations, Sullivan once put it as follows:

The person who comes to the interview expecting a certain pattern of events which does not materialize will probably not return.... In other words, what a client is taught to expect is the thing that he should get—or, at least, any variation should very clearly depart from it in a rather carefully arranged way.

[Sullivan, 1954, p. 28]

Another way to think about this is that a therapist who is trying to guide patients to shift their thinking, feeling or behavior, often needs to progress gradually—first accepting where patients are "at," and then guiding them to what might be more beneficial for them. In essence, it is a balance between *following* (e.g., "That must have been hard for you") and *leading* (e.g., "You might want to consider telling him what you really wanted"). Some patients can be readily led (e.g., whereby the therapist *follows*, *leads*, *follows*, *leads*), whereas others might require more patience (e.g., *follow*, *follow*, *follow*, *lead*, *follow*, *follow*, *lead*, *follow*, *lead*).

The importance of therapists accepting their patients for where they are at has been advocated by professionals of all orientations. Two therapists, in particular, have indicated that their clinical ability for acceptance was very much influenced by their observation of how a horse whisperer trained wild horses. Lorna Benjamin (2001), a psychodynamic therapist, and Larry Beutler (2001), an experiential therapist, both independently related that their observations of how horses were trained had influenced their therapeutic practice. Benjamin reports that she learned "to take things slowly and with great patience," adding that "I also learned about the impossibility of controlling another creature. The most one can do is persuade and negotiate for mutual interests as you move with the other." (Benjamin, 2001, p. 29). This very same observation was similarly reported by Beutler as one of the major lessons he learned about how to be an effective therapist. As Beutler reports, "Patience is part of the key. Let things happen that happen. Let people find their own comfort. Allow them to learn through struggle. Don't rescue, just support" (Beutler, 2001, p. 215). In the absence of this, it is all too easy for us as therapists to become impatient. Although both Benjamin and

Beutler are probably best known for their research contributions, it is of considerable interest that their clinical practice has also been informed by their personal observations and experiences.

In considering the importance of therapists having patience in their clinical work, negative therapeutic results can readily be understood by the opposite of patience, namely *impatience*. When we display our impatience with a patient's progress in therapy, we all too often send the message that the patient is to blame for the therapeutic plateaus or reversals. This may be communicated subtly, such as in our tone of voice or facial expression. Indeed, some of our patients who are ultra-sensitive to criticism may be aware of such messages even before we are. A case in point has been discussed by Linehan (1993) in her work on treating borderline personality disorders. In her original attempts to use cognitive-behavior therapy in working with this population, Linehan found that, much to her confusion and dismay, her borderline patients interpreted her recommendations for intervention as an invalidation of who they were as individuals. Based on their early experiences of being criticized for being "too emotional," her borderline patients had developed an ultra-sensitivity to any messages that implied an invalidation—including suggested interventions that might make their lives better. In a clinical *tour de force*, Linehan developed an approach to therapy – dialectical behavior therapy – that placed a great emphasis on accepting and validating the patient just as they are, but being available to help them change when they felt ready to do so.

There is another aspect of acceptance that is relevant here, namely acceptance of the reality that there is only so much that therapy can do to help. Despite the advances in therapy that have been made in recent years, it is important to accept the fact that constitutional, physiological, and psychological diatheses can limit just how much progress can be made in therapy. For individuals who are constitutional introverts, it might be unrealistic to expect that therapy should be able to have them become as outgoing and socially comfortable as someone who was born that way. Similarly, it may be unrealistic to expect that a person who has had devastating losses or traumas early in life will become totally free of the effects of the past. Even with the best of therapy and the development of competencies in one's adult life, we cannot expect a total "recovery." To do so, may result in both therapist and patient ending up feeling like failures.

4. What contributes to change: the technique? The relationship? Something else?

In considering the question of what we should expect of psychotherapy, it is important to address the issue of our knowledge of what contributes to change. This falls in the realm of process research which, as noted in the previous section, deals with the question of *how* therapy works. Although it is beyond the scope of this paper to review the extensive research literature on psychotherapy process research, suffice it to say that in the most general sense, researchers and clinicians have pointed to two possible classes of active ingredients in the therapy change process: therapy *techniques* and the therapy *relationship*. Unfortunately the controversy in the field has often taken on an adversarial stance, questioning whether it is the technique or the relationship that is most responsible for change.

4.1. The technique versus the relationship

In 1995, the Society of Clinical Psychology, Division 12 of the APA, published a list of therapy procedures that were found to be efficacious in clinical trials (Task Force on Promotion and Dissemination of Psychological Procedures, 1995). These techniques, which were clearly delineated and manual-driven, were found to have empirical support in controlled research. Although the importance of the therapy relationship was not denied, it had secondary importance to the specific procedures that were studied. As a response to this specification of empirically supported treatments, the Psychotherapy

Division of APA, Division 29, established a task force to review the empirical literature that supported the way that the psychotherapy relationship contributed to change. The purpose of the task force – the results of which were summarized in *Psychotherapy Relationships That Work* – was not to negate the importance of technique, but rather to offer a more complete evidence-based explanation of the therapy change process (Norcross, 2002). Nonetheless, the tendency to pit technique against the relationship continues to exist.

The argument that the therapy relationship played a particularly significant role in the change process was originally put forth in the classic article by Rogers (1957), entitled “The necessary and sufficient conditions of therapeutic personality change.” In it he maintained that there was a natural tendency for people to grow psychologically, which could be facilitated by an accepting and genuine relationship with the therapist. Although Rogers did not explicitly indicate that this may be a learned phenomenon, he nonetheless explained that as patients continue to experience the acceptance on the part of the therapist, they eventually will develop a similar attitude toward themselves. In his historic debate with Rogers, Skinner was much more specific in indicating that learning was indeed involved in the change process (Rogers & Skinner, 1956). And in doing so, Skinner highlighted the importance of specific procedures that might facilitate this learning.

Although one may trace the current disagreement on the importance of the relationship or the technique to the different epistemological assumptions underlying this historical debate between Rogers and Skinner, it should also be emphasized that even advocates of therapy techniques have acknowledged the role of the therapy relationship. Writing about behavior therapy, Kanfer and Phillips (1970) emphasized that “the therapist may enhance or detract from the effectiveness of his behavioral techniques through the impact of his own personal and interactional characteristics” (p. 65). Goldfried and Davison (1976) devoted an entire chapter in their book *Clinical Behavior Therapy* to the importance of the therapy relationship, maintaining that “any behavior therapist who maintains that principles of learning and social influence are all one needs to know in order to bring about behavior change is out of contact with clinical reality” (p. 55).

In writing about the relative importance of both the relationship and the technique in the therapy change process, Goldfried and Davison (2005) argued for the synergy between the two. In making the case for the importance of both, they documented research findings to indicate that a good therapist–patient relationship increases the likelihood of the patient engaging in the therapeutic technique, and that the successful implementation of therapy techniques can function to enhance the therapeutic relationship. Conversely, problems with the therapy alliance have been demonstrated to undermine the efficacy of therapy techniques (Castonguay et al., 1996; Castonguay et al., 2010a,b).

At the interface between relationship and techniques is the *skill* with which the therapist is able to implement the technique. Not surprisingly, there are research findings to indicate that even with clearly delineated therapeutic interventions, some therapists are better than others. For example, in a manual-driven RCT on cognitive-behavior therapy for the treatment of panic, it was found that some therapists were more clinically effective than others. Interestingly enough, they did not score higher on ratings of adherence or competence in administering the procedure, but had more clinical experience (Huppert et al., 2001). Consistent with this are the findings of a survey of practicing therapists about their experience in using cognitive behavior therapy to treat panic disorder, where 36% indicated that the absence of a strong therapy alliance limited their clinical effectiveness (Goldfried, 2011). Finally, a recent meta-analysis on psychotherapy drop-rates found that experienced therapists had lower rates than inexperienced therapists (Swift & Greenberg, 2012).

However, I would suggest that the question of technique vs. the therapy relationship is not the basic issue we need to understand. Instead it is the general principles that underlie the therapeutic change process.

4.2. General principles of change

Although different therapeutic orientations use the therapy relationship in different ways, and also make use of different techniques in order to bring about change, it is useful to think about what goes on in therapy as a manifestation of more general principles of change. As stated elsewhere (Goldfried, 1980), therapeutic change principles may be thought of as occurring at a level of abstraction between the specific techniques that are used during a session, and the more general theoretical conceptualizations of why such techniques may be important. At the observable level, we have such techniques such as transference interpretations, behavior rehearsal, and two-chair interventions. Each of the specific therapeutic procedures is usually subsumed under a more general theoretical model, be it psychodynamic, cognitive-behavioral, or experiential. Somewhere between these two levels of abstraction one may find general principles of change that cut across these different theoretical approaches and the techniques they recommended. Thus common change principles can include (1) the facilitation of expectations that therapy can be helpful; (2) the establishment of an optimal therapeutic alliance; (3) facilitating the patient's awareness of those factors within themselves, others, and their environment that contribute to their problems; (4) the facilitation of corrective experiences; and (5) the encouragement of continued reality testing. These general principles do not require the adoption of any given theoretical orientation, and may be implemented with a variety of therapeutic techniques—regardless of their theoretical origin.

The idea that *positive expectations* play an important role in the change process was originally put forth by Frank (1961), who documented it not only within the therapeutic situation, but also within other methods of change (e.g., religious healing). Moreover, research findings have found the patients' motivation to change to be an essential component for any therapeutic approach (Prochaska & DiClemente, 2005), and that methods to enhance a patient's motivational state can positively impact on the willingness to change (Miller & Rollnick, 2002).

Like positive expectations and motivation to change, *the therapeutic alliance* has been viewed as being most essential to the change process. As indicated earlier, it goes beyond the therapeutic bond, and also includes the agreement of goals and methods on the part of both patient and therapist. Indeed, it exists as a most important context within which successful interventions can occur.

When patients enter into treatment, they are typically unaware of the factors that contribute to their problems, and at times even have misconceptions about the causes. A most important role of the therapist is to *help them to become better aware* of these determinants/dynamics, so that they may be better able to see connections between what they think and how they feel, how they feel and what they do, the impact that others made on them, and the impact that their actions make on others. In many respects, our role as therapists is to assist our patients in the redeployment of their attention, so that that may be better aware of the factors that interfere with their functioning.

Sometimes increasing patient awareness is sufficient, but quite often behavior change is needed as well. Some years ago, Alexander and French (1946) proposed that therapy helps to facilitate *corrective experiences*, whereby patients need to take the risk in changing what they do in the hopes of finding it to result in more positive consequences. Within a psychodynamic framework, this may be seen to occur within the therapeutic interaction. A more cognitive-behavioral approach often makes use of this principle by having patients behave differently between sessions.

It is rare, however, than a single corrective experience can eliminate the problem for which the patient came for help. More likely, there needs to be ongoing the corrective experiences, which are then processed cognitively within the therapy session. Much like the notion of working through, there is the use of increased awareness to help facilitate the behavioral risk taking, and having done so,

processing these experiences cognitively so as to further enhance awareness that the behavior pattern is more effective. In essence, this may be thought of as *ongoing reality testing*.

5. Where should we go from here?

In returning to the original question posed at the outset of this article of what we should expect of psychotherapy, it is clear that interventions must have an empirical underpinning. And although the findings from RCTs provide important information about the efficacy of our various interventions, and have allowed us to generate a list of empirically supported treatments, evidence-based practice casts a wider empirical net. Although clearly important, the findings from RCTs should not be swallowed whole, as they continue to reflect the gap that exists between research and practice.

5.1. Moving beyond RCTs

As indicated earlier, the research model for outcome research shifted in the 1980s, when the research design was modeled after the drug research paradigm. Thus instead of developing interventions for specific focal problems, such as unassertiveness, research funding required targeting a more heterogeneous DSM diagnosis (e.g., social phobia). Although there were other methodological improvements as we moved into this third generation of outcome research, such as ensuring that therapists adhered to the treatment manual, I would suggest that our research paradigm became less relevant to what practicing clinicians actually do in practice. As pointed out earlier, this shift in the treatment of mental disorders has not only changed how we approach research, but also how we think about clinical problems. Instead of thinking about anxiety in some ways being functionally related to depression (e.g., anxiety may prevent an individual from behaving in an effective way, which may then result in depression), we think in terms of “comorbidity.”

With the move toward emphasizing biological processes in psychological disorders, the NIMH has become less generous in their funding of clinical trials that involve psychological interventions. Although the shift in funding toward neuroscience has the potential for having an adverse affect on the investigation of the psychological processes associated with change, the reduction of funding for therapy research may nonetheless free us up from the constraints of needing to treat DSM diagnoses, allowing us to revisit our outcome research paradigm that focused on more specific clinical problems that practicing therapists are likely to see clinically (e.g., fear of intimacy, anger, perfectionism). In a sense, this crisis in funding may afford us the opportunity to conduct research on those issues that more accurately reflect the needs of the practicing clinician.

5.2. Closing the research-practice gap

Researchers have long lamented that the practicing clinician does not make use of the research findings they worked so hard to produce. For their part, the clinician has similarly argued that much of what researchers have studied have not addressed the questions that they confront in their practice. This gap between research and practice continues to exist, even in the face of external demands for empirical accountability. There undoubtedly are numerous reasons for this gap. Clinicians and researchers live in different professional worlds. Clinicians are concerned about referrals and insurance reimbursement and researchers are involved with publications and research grants, and there exist few forums where the two can interact.

Fortunately, there have been a few notable attempts to create forums in which clinicians and researchers could collaborate. Linda Sobell (1996), who was preparing to conduct a clinical trial on the treatment of addictions, recognized that it was important for the producers of research findings to meet the needs of the clinical consumers. The

impetus for her concern came from the Ministry of Health in Ontario, Canada, which was interested in having various agencies that show better accountability for meeting community needs, including outpatient treatment. Sobell approached the clinicians in her community that dealt with addictive behaviors, and involved them in the actual design of the intervention protocol, which mirrored the way such interventions actually occurred in clinical practice, namely having individualized flexibility, depending upon the progress made by clients during treatment. Sobell reported that it was a collaboration in which everyone benefited: “By adopting a new approach to the dissemination of my research... I have reached more agencies, more practitioners, and ultimately, more clients than in my 25 years in the field. The rewards of effective dissemination are immense for everyone.” (Sobell, 1996, p. 316). As a result of this experience, Mark Sobell has made such clinician–researcher collaboration his presidential initiative when he assumes the role of President of the Society of Clinical Psychology, Division 12 of the APA in 2013.

Another attempt to close the gap between practice and research consists of practice research networks, in which practicing therapists, in collaboration with researchers, have been able to identify important client, treatment and therapist factors that can help and hinder successful treatment (Castonguay et al., 2010a,b). Still another example involves the efforts of Eubanks-Carter et al. (2010), who compiled consensus information on how practicing therapists handled clinical situations involving adult patients' conflicts with their parents. Recognizing that ways of integrating research and practice might best begin in graduate school, suggestions for how to close the gap during clinical training have been outlined (Drabick & Goldfried, 2000; Hershenberg, Drabick, & Vivian, 2012). Finally, an effort to close the gap between research and practice is being made by the Society for the Exploration of Psychotherapy Integration (SEPI). SEPI was found in 1983 to foster collaborative dialogs among therapists of different orientations. Having had 30 years of experience of encouraging meaningful dialogs across theoretical orientations, SEPI has expanded its mission to facilitate collaborative interactions between clinicians and researchers. The goal is to enable clinicians to learn and utilize the findings of cutting-edge research, and for researchers to learn from the observations of clinicians working with the issues that arise in the actual practice of therapy. More can be learned about SEPI at its Web site (www.sepiweb.org).

As suggested above, researchers' ongoing attempts to disseminate research findings to the practicing clinician have met with limited success. For their part, practicing therapists have argued that much of the research literature does not address their clinical concerns. Another likely factor is that there appears to be an undercurrent of resentment on the part of practicing therapists, who lament that “... the standards and methods of clinical therapy will be set by those who do the least amount of clinical practice (Fensterheim & Raw, 1996, pp. 169–170). I would suggest that among the reasons for the clinical-research gap is also the fact that there has been a one-way bridge between the two, whereby researchers attempt to disseminate their findings to the clinician, and the voices of the practicing clinician typically go unheard. It is of particular interest that this state of affairs is less of an issue in the case of drug research, which has been the model for our contemporary approach to studying outcome. Once a drug has been shown to be efficacious in clinical trials, it is approved by the FDA for clinical use. However, there exists a mechanism in medicine whereby practicing physicians can report back to the FDA about their experiences—particularly the difficulties they encounter in making use of these empirically supported medications in actual practice.

In 2010, the Society of Clinical Psychology, Division 12 of the APA, began an initiative to build a two-way bridge between research and practice. Specifically, it established a mechanism whereby practicing clinicians could provide researchers with feedback about their clinical use of these empirically supported treatments. In thinking about clinical experience as being the context of discovery, the goal is to point to those

mediating, moderating, and contextual variables that were not necessarily studied in clinical trials, but which nonetheless are important for the effective application of these interventions in practice.

In sponsoring this two-way bridge initiative, the Society of Clinical Psychology appointed a diverse subcommittee to spearhead the effort, consisting of: Louis Castonguay, Marvin Goldfried, Jeffrey Magnavita, Michelle Newman, Linda Sobell, and Abraham Wolf. In the survey of practicing clinicians, which was internationally advertised and conducted online, therapists were asked to report on their experiences in the using CBT in the treatment of panic disorder — the only currently approved EST. Among the various questions asked, there was a request for information about certain key classes of variables that they found to undermine the clinical effectiveness of CBT in treating panic, including: the patients' symptoms related to panic; other patient problems or characteristics; patient expectations; patients' beliefs about panic; their motivation; the social system in which they were functioning; any problems and limitations associated with the intervention itself; and relevant therapy relationship issues. The preliminary findings associated with this survey can be found in a summary by Goldfried (2011), and in *the Clinical Psychologist*, the newsletter of the Society of Clinical Psychology (American Psychological Association (APA) Division 12 Committee on Building a Two-Way Bridge between Research and Practice, 2010; http://www.div12.org/tcp_journals/TCP_Fall2010.pdf#page=10).

This two-way bridge initiative has since received the co-sponsorship of the Psychotherapy Division of APA, Division 29. Recently completed surveys — the finding of which has yet to be reported — have looked at clinical experiences associated with the use of empirically supported treatments in dealing with social anxiety and general anxiety disorder. Future surveys will deal with other clinical problems, such as PTSD and OCD. It is hoped that this collaborative effort between clinicians and researchers will contribute to developing a response to the question of what we should expect from psychotherapy—interventions that have an empirical base and have been found to work in practice.

References

- Alexander, F., & French, T. (1946). *Psychoanalytic therapy: Principles and applications*. New York: Ronald Press.
- American Psychiatric Association (1994). *Diagnostic and statistical manual for mental disorders* (4th ed.). Washington, DC: Author.
- American Psychological Association (APA) Division 12 Committee on Building a Two-Way Bridge between Research and Practice (2010). Clinicians' experiences in using an empirically supported treatment (EST) for panic disorder: Results of a Survey. *The Clinical Psychologist*, 63, 10–20.
- APA Presidential Task Force on Evidence-Based Practice (2006). Evidence-based practice in psychology. *American Psychologist*, 61, 271–285.
- Arkowitz, H. (1989). The role of therapy in psychotherapy integration. *Journal of Integrative and Eclectic Psychotherapy*, 8, 8–16.
- Benjamin, L. S. (2001). A developmental history of a believer in history. In M. R. Goldfried (Ed.), *How therapists change: Personal and professional reflections* (pp. 19–35). Washington, DC: APA.
- Bergin, A. E. (1966). Some implications of psychotherapy research for therapeutic practice. *Journal of Abnormal Psychology*, 71, 235–246.
- Beutler, L. E. (2001). From experiential to eclectic psychotherapist. In M. R. Goldfried (Ed.), *How therapists change: Personal and professional reflections* (pp. 203–219). Washington, DC: APA.
- Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice*, 16, 25–260.
- Castonguay, L. G., & Beutler, L. E. (Eds.). (2006). *Principles of therapeutic change that work*. New York: Oxford University Press.
- Castonguay, L. G., Boswell, J. F., Constantino, M. J., Goldfried, M. R., & Hill, C. E. (2010a). Training implications of harmful effects of psychological treatments. *American Psychologist*, 65, 34–49.
- Castonguay, L. G., Boswell, J. F., Zack, S. E., Baker, S., Boutselis, M. A., Chiswick, N. R., et al. (2010b). Helpful and hindering events in psychotherapy: A practice research network study. *Psychotherapy: Theory, Research, Practice and Training*, 47, 327–345.
- Castonguay, L. G., Goldfried, M. R., Wisner, S. L., Raue, P. J., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology*, 64, 497–504.
- Dimidjian, S., & Hollon, S. D. (2011). What can be learned when empirically supported treatments fail? *Cognitive and Behavioral Practice*, 18, 303–305.
- Drabick, D. A., & Goldfried, M. R. (2000). Training the scientist–practitioner for the 21st century: Putting the bloom back on the rose. *Journal of Clinical Psychology*, 56, 327–340.
- Eubanks-Carter, C., Burckell, L. A., & Goldfried, M. R. (2010). Clinical consensus strategies for interpersonal problems between young adults and their parents. *Journal of Consulting and Clinical Psychology*, 78, 212–224.
- Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology*, 16, 319–324.
- Feeley, M., DeRubeis, R. J., & Gelfand, L. A. (1999). The temporal relation of adherence and alliance to symptom change in cognitive therapy for depression. *Journal of Consulting and Clinical Psychology*, 67, 578–582.
- Fensterheim, H., & Raw, S. D. (1996). Psychotherapy research is not psychotherapy practice. *Clinical Psychology: Science and Practice*, 3, 168–171.
- Foa, E. B., & Emmelkamp, P. M. G. (Eds.). (1983). *Failures in behavior therapy*. New York: John Wiley & Sons.
- Frank, J. D. (1961). *Persuasion and healing*. Baltimore: Johns Hopkins.
- Garfield, S. L. (1996). Same problems associated with “validated” forms of psychotherapy. *Clinical Psychology: Science and Practice*, 3, 218–229.
- Gelso, C. J., & Hayes, J. A. (2007). *Countertransference and the therapist's inner experience: Perils and possibilities*. Mahwah, NJ: Lawrence Erlbaum Associates. and practice. New York: Wiley.
- Goldfried, M. R. (1980). Toward the delineation of therapeutic change principles. *American Psychologist*, 35, 991–999.
- Goldfried, M. R. (2011). Generating research questions from clinical experience: Therapists' experience in using CBT for panic disorder. *The Behavior Therapist*, 34, 57–60.
- Goldfried, M. R., & Davila, J. (2005). The role of relationship and technique in therapeutic change. *Psychotherapy: Theory, Practice and Training*, 42, 421–430.
- Goldfried, M. R., & Davison, G. C. (1976). *Clinical behavior therapy*. New York: Holt, Rinehart & Winston.
- Goldfried, M. R., & Wolfe, B. E. (1996). Psychotherapy practice and research: Repairing a strained alliance. *American Psychologist*, 51, 1007–1016.
- Goldfried, M. R., & Wolfe, B. E. (1998). Toward a more clinically valid approach to therapy research. *Journal of Consulting and Clinical Psychology*, 66, 143–150.
- Henry, W. P., Schacht, T. E., & Strupp, H. H. (1986). Structural analysis of social behavior: Application to a study of interpersonal process in differential psychotherapeutic outcome. *Journal of Consulting and Clinical Psychology*, 54, 27–31.
- Henry, W. P., Schacht, T. E., & Strupp, H. H. (1990). Patient and therapist introject, interpersonal process and differential psychotherapy outcome. *Journal of Consulting and Clinical Psychology*, 58, 768–774.
- Hershenberg, R., Drabick, D. A. G., & Vivian, D. (2012). An opportunity to bridge the gap between clinical research and clinical practice: Implications for clinical training. *Psychotherapy*, 49, 123–134.
- Huppert, J. D., Buřka, L. F., Barlow, D. H., Gorman, J. M., Shear, M. K., & Woods, S. W. (2001). Therapist variables, and cognitive-behavioral therapy outcome on a multi-center trial for panic disorder. *Journal of Consulting and Clinical Psychology*, 69, 747–755.
- Kanfer, F. H., & Phillips, J. S. (1970). *Learning foundations of behavior therapy*. New York: Wiley.
- Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (pp. 139–193) (5th ed.). New York: Wiley.
- Lilienfeld, S. O. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science*, 2, 53–70.
- Linehan, M. (1993). *Cognitive treatment of borderline personality disorder*. New York: Guilford.
- Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people to change* (2nd ed.). New York: Guilford Press.
- Morris, R. J., & Suckerman, K. R. (1974). Therapist warmth as a factor in automated systematic desensitization. *Journal of Consulting and Clinical Psychology*, 42, 244–250.
- Muran, J. C., & Barber, J. P. (Eds.). (2010). *The therapeutic alliance: An evidence-based guide to practice*. New York: Guilford.
- Norcross, J. C. (Ed.). (2002). *Psychotherapy relationships that work*. New York: Oxford University Press.
- Parloff, M. B. (1979). Can psychotherapy research guide the policy maker? A little knowledge may be a dangerous thing. *American Psychologist*, 34, 296–306.
- Parloff, M. B. (1982). Psychotherapy research evidence and reimbursement decisions: Bambi meets Godzilla. *The American Journal of Psychiatry*, 139, 718–727.
- Prochaska, J. O., & DiClemente, C. C. (2005). The transtheoretical approach. In J. C. Norcross, & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 147–171) (2nd ed.). New York: Oxford University Press.
- Rogers, C. R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, 21, 95–103.
- Rogers, C. R., & Skinner, C. R. (1956). Some issues concerning the control of human behavior: A symposium. *Science*, 124, 1057–1066.
- Roth, A., & Fonagy, P. (1996). *What works for whom? A critical review of psychotherapy research*. New York: Guilford.
- Ruscio, A. M., & Holohan, D. R. (2006). Applying empirically supported treatments to complex cases: Ethical, empirical, and practical guidelines. *Clinical Psychology: Science and Practice*, 13, 146–162.
- Snyder, W. U. (1950). Clinical methods: Psychotherapy. *Annual Review of Psychology*, 1, 221–234.
- Sobell, L. C. (1996). Bridging the gap between scientists and practitioners: The challenge before us. *Behavior Therapy*, 27, 297–320.
- Sullivan, H. S. (1954). *The interpersonal theory of psychiatry*. New York: Norton.
- Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology*, 80, 547–559.
- Task Force on Promotion and Dissemination of Psychological Procedures (1995). Training in and dissemination of empirically-validated psychological treatment: Report and recommendations. *Clinical Psychologist*, 48, 3–23.
- Wolf, A., Goldfried, M. R., & Muran, J. C. (Eds.). (2013). *From frustration to compassion: Transforming negative reactions to clients*. Washington, DC: American Psychological Association.