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THERAPIST EFFECTS: INTEGRATION AND CONCLUSIONS

CLARA E. HILL AND LOUIS G. CASTONGUAY

After the previous chapters of this book were written, we held a meeting with a large number of the authors who contributed to them to determine what we know about therapist effects and what could be done to improve our understanding about them. Discussion was lively, given that the researchers involved varied in theoretical orientation, engagement in clinical practice, and preferred research methods (e.g., qualitative, quantitative). There were essentially two camps: those who believed that a phenomenon of therapist effects had been detected and established via sophisticated statistical methods, and those who were more cautious and skeptical about the state of our knowledge given the many methodological and clinical problems with the research to date.

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How and Why Are Some Therapists Better Than Others? Understanding Therapist Effects, L. G. Castonguay and C. E. Hill (Eds.)

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Bruce Wampold, one of the participants, noted that the discussion about therapist effects was heated because the topic is highly personal. Given that all present had spent many years in training to become therapists, most currently were therapists, and most also currently supervised therapists-in-training, it was challenging to grapple with the findings related to therapist effects. Despite the professional, if not existential, weight carried by these issues, all viewpoints were respectfully heard and valued.

In the final chapter of this volume, we integrate the perspectives aired during our meeting. Three questions were considered: How are therapist effects defined, and what is the evidence for therapist effects? What therapist variables might account for therapist effects? And what are the next steps in the research on therapist effects? Although we did not discuss them at our meeting, there are also clear implications for the research on therapist effects, which we address in this chapter as well.

THERAPIST EFFECTS

By definition, *therapist effects* are present when some therapists consistently achieve superior performance and others consistently achieve poorer performance than other therapists. Although therapist effects could emerge for many variables, we are most interested in therapist effects as reflected in changes in client mental health (e.g., symptom relief, interpersonal functioning, social role performance, well-being, quality of life), such that some therapists have better client outcomes (in terms of psychological improvement) than do others. Moreover, as Constantino, Boswell, Coyne, Kraus, and Castonguay (Chapter 3) summarized, therapists can have relative strengths and weaknesses in treating different types of mental health problems within their own caseloads.

Differences between therapists have been observed since the beginning of the field of psychotherapy. There has also been considerable research on therapist variables (see the review in Beutler et al., 2004). Yet, the recent surge of interest in this phenomenon is due to findings from sophisticated statistical analyses (e.g., hierarchical linear modeling [HLM]) involving large numbers of therapists and clients. HLM is particularly appropriate for psychotherapy research because it models how clients are nested within therapists. Nesting is especially important for understanding variables such as the alliance and outcome, as clients and therapists contribute to the effects. HLM allows for statistically disentangling clients' and therapists' contributions to the alliance, which then allows determination of how these two sources predict outcome.

As Barkham, Lutz, Lambert, and Saxon (Chapter 1) noted, a substantial body of research using HLM analyses has established that about 5% to

8% of the variability in client outcome is attributable to therapists. Although smaller than the proportion of variability attributable to clients, Barkham et al. suggested that this proportion is important statistically and clinically, indicating that some therapists are consistently better and some are consistently worse than others. These therapist effects appear to be most pronounced with clients who are more challenging and distressed relative to other more highly functioning clients.

Major caveats to these findings about therapist effects, however, are that our current knowledge about therapist effects is mainly based on specific populations, treatment approaches, measures, and methods. In other words, most of this research has been conducted in very large databases that typically involve either university counseling centers or managed care clients. Therefore, data may not be representative of clients seen in long-term psychotherapy. Relatedly, more data are available for short-term, manualized, and cognitive-behavioral treatments than for longer term insight-oriented treatments. In addition, most measures used to assess outcome involve client self-report of symptomatology, social role performance, and interpersonal functioning, whereas measures associated with depth psychology (e.g., defenses, character structure, meaning in life) have rarely been assessed (though, if these constructs can be reliably assessed, they can be examined for therapist effects). Finally, much of this research has not considered the complexity of the change process, such as the intertwining of therapist and client variables and the many moderators and mediators of change. We would note that this lack of inclusion of specific populations, treatment approaches, measures, and methods is not a fault of the statistical methods, which are indeed value neutral, but arise more because many of the complexities of the therapy situation have not been validly measured and included in analyses.

An additional caveat is that HLM-demonstrated therapist effects may reflect differences in therapists' ability or tendency to responsively "do the right thing at the right time," where the right thing varies with shifting client requirements, therapeutic approach, and other circumstances. In that case, variables that simply describe therapist characteristics and behaviors would not be expected to be predictive of outcomes. Variables that evaluate the therapists or the process (i.e., considering whether the actions and timing were appropriate) tend to be more successful in predicting outcome.

Hence, current results of therapist effects must be interpreted with caution given these caveats. With these caveats in mind, however, we can assert that we have considerable evidence about the role that therapists play in client improvement. Table 17.1 summarizes the findings about the outcome variance explained by therapist effects, as well as some of the clinical implications that have been derived from these results.

TABLE 17.1
Summary of Chapters in This Volume Describing the Current State of Empirical Literature
on Therapist Effects in Terms of Quantitative Findings and Methods

Chapter	Findings and methods	Clinical implications
1	Therapist effects explain between approximately 5% and 8% of client outcome variance; with higher effect sizes found in naturalistic studies than in randomized clinical trials. In general, most therapists seem to be equivalent in terms of therapeutic benefits experienced by their clients. However, 15% to 20% appear to be consistently and distinctively more effective, whereas 15% to 20% appear to be consistently and distinctively less effective than other therapists. Therapist effects also appear to be stronger with highly distressed or impaired clients.	Implications of these results include the need to focus on therapist effects early in treatment (to predict dropout and quick therapeutic change), to provide outcome monitoring and feedback during training (to foster therapeutic improvement and decrease deterioration), and to examine the work of exceptional therapists (to better predict and explain therapist effects).
2	Four variables have received empirical support in explaining why some therapists are better than others. First, strong evidence has been found for therapists' ability to establish a positive therapeutic alliance. More limited evidence exists for the other three variables: therapists' facilitative interpersonal skills, self-doubt, and engagement in deliberative practice. It is also important to note that several variables have not been found to be responsible for therapist effects: demographics (e.g., age, gender), self-reported interpersonal skills, theoretical orientation, experience, adherence to a treatment protocol, and rated competence performing a particular treatment.	As ways to increase their effectiveness, therapists should strive to become better at developing, maintaining, and repairing the alliance with clients. They should also make use of and enhance their verbal and emotional expressiveness, motivational skills (persuasiveness and hopefulness), warmth and empathic attitude, and problem focus. Moreover, they should adopt and/or maintain a sense of humility toward their ability to help their clients. When not working with clients, therapists should also repeatedly and consistently devote time to improve their work, such as thinking about difficult cases, preparing and reflecting on sessions, and attending training workshops.

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Despite the existence of therapist effects, little is known about why some therapists are more effective than others, or why some therapists are good at treating some clients but not others within their caseloads. It is important to uncover such determinants empirically within diverse outcome domains (e.g., depression, substance abuse). Two promising categories of such determinants that have received the most empirical support to date are (a) individual characteristics of the therapist (e.g., amount of deliberate practice) and (b) characteristics manifested in therapy sessions (e.g., alliance). Multilevel statistical modeling is the most appropriate method for disentangling between-therapists and within-therapist variability in psychotherapy processes and outcomes to isolate, predict (including in interaction with possible moderator variables), and explain (through the use of therapist-level mediational models) between-therapists effects on client outcomes.

The selection and training of therapists is crucial. Therapists should engage in deliberate practice and foster the alliance to enhance their clinical services.

THERAPIST VARIABLES THAT MIGHT ACCOUNT FOR THERAPIST EFFECTS

We have three sets of findings to consider here. The first set involves data about therapist variables collected prior to the development of HLM analyses, typically using simple correlational analyses and not considering that clients are nested within therapists. The second set includes data about therapist variables associated with therapist effects, in which clients' and therapists' contributions to outcomes are disentangled using HLM. The third set involves many potential candidates for therapist variables that have not yet been adequately tested as determinants of between-therapists effects with HLM analyses.

Data on Therapist Variables Prior to Hierarchical Linear Modeling Analyses

On the basis of decades of research on therapist variables, Norcross (2002, 2011) compiled considerable evidence about relationship (process) variables that have been linked to client outcomes. These results tend to be based on total correlational analyses of relationship variables in relation to client outcomes. As noted previously, these correlational analyses fail to disentangle within-therapist (between-clients) variability, between-therapists variability, or the interaction between within-therapist and between-therapists variability in the correlations between relationship variables and outcomes. In these reviews, Norcross demonstrated that there is evidence that the following therapist-related variables are related to positive outcomes: alliance, cohesion, empathy, goal consensus and collaboration, positive regard and affirmation, congruence/genuineness, collecting client feedback, repairing alliance ruptures, managing countertransference, self-disclosure, and relational interpretations.

Although no doubt was expressed at the meeting about the relationship between process variables (e.g., therapist empathy) and client outcome, some participants noted that research conducted on most of them thus far has not shown, statistically, that they are responsible for why some therapists are better than others (see Chapter 3). It should be noted, furthermore, that some therapist variables are difficult to include in HLM analyses because it is not frequency of the variable as much as timing and quality that matters, and these contextual considerations are much harder to measure and include in statistical analyses. A good example is therapist self-disclosure, as it is not frequency of self-disclosure that matters in terms of effectiveness as much as it is type, timing, quality, and context (see Pinto-Coelho, Hill, & Kivlighan, 2016, for an example of a mixed-methods study of self-disclosure).

Data About Therapist Variables From Multilevel Statistical Analyses

Wampold, Baldwin, Holtforth, and Imel (Chapter 2) and Constantino, Boswell, Coyne, Kraus, and Castonguay (Chapter 3) indicated that there is good evidence from several HLM analyses that therapist ability to establish a therapeutic alliance and demonstrate facilitative interpersonal skills accounts for differential therapist effectiveness. In addition, Wampold et al. cited more limited evidence (i.e., not yet enough studies from different research teams) for therapist self-doubt and engaging in deliberate practice. These findings reflect the current status of what we know, quantitatively, about what explains therapist effects—what accounts for the fact that some therapists are better and some are worse than others (these findings and some of their clinical implications are presented in Table 17.1). Importantly, though, work on therapist-level predictors of systematic differences in therapists' outcomes is just beginning. Not only do more variables need to be examined, but existing findings need to be replicated. Underscoring the need for replication, Constantino et al. pointed out that the therapist's contribution to alliance quality is variable across studies, meaning that alliance may not be a consistently good indicator of how more versus less effective therapists attain their personal effectiveness status.

In addition, several therapist variables—age, gender, race/ethnicity, theoretical orientation, experience, or professional degree—were noted by Wampold et al. (Chapter 2) as not predicting therapist effects in the HLM analyses, as similar to findings in non-HLM research (see Beutler et al., 2004). We hasten to say, however, that there is considerable controversy about the evidence related to some of these variables, particularly experience, given that cross-sectional studies and an intensive longitudinal study (Goldberg et al., 2016) found no effects of experience, and yet others (Hill, Spiegel, Hoffman, Kivlighan, & Gelso, in press) have noted major problems with the definition and measurement of experience.

Potential Therapist Variables That May Be Related to Therapist Effectiveness

Many additional therapist-level variables that are potential candidates for determining therapist effects are presented in chapters of this book. Evidence for these variables comes primarily from clinical practice and therapist training, as well as from research-based evidence not restricted to the paradigm of using client outcomes as the sole dependent variable or on the basis of analyses that isolate therapists' contribution, as is done with HLM. Table 17.2 shows a summary description for each chapter of how these respective therapist variables might be linked to therapist effects on adaptive

TABLE 17.2
Summary of Chapters in This Volume Presenting Factors Potentially Explaining Therapist Effects

Chapter	Therapist variables potentially associated with therapist effects	Implications for therapists
4	Therapist effects are due, in part, to therapists' ability to be appropriately responsive to clients' needs.	Within the framework of their theoretical orientation, personality, and skills, as well as in consideration of a wide range of contextual variables (e.g., client diagnostic, values, therapeutic progress, preceding events, history of the therapeutic relationship), effective therapists flexibly attune the choice, dose, manner of implementation, and timing of their interventions to fit clients' moment-to-moment needs. By optimizing their responsiveness, effective therapists foster good therapeutic process, which leads to positive outcome.
5	More effective therapists reach, maintain, and appropriately convey higher levels of presence (awareness of, openness to, and centered on their experience and the experience of their client) during therapy, allowing them to be more empathic than less effective therapists.	To improve their effectiveness, therapists should identify, before and during therapy sessions, factors that can signal and/or increase their difficulty to be fully present (e.g., distraction, preoccupation, intellectualization, anxiety). Considering a number of possible strategies (e.g., self-observation, self-trust, intentionality and mindfulness, meditation, management of anxiety and countertransference, improving one's own mental health), therapists should focus and sustain their attention to internal and interpersonal experiences taking place in the here and now of therapy.
6	Therapist effects can be explained, in part, by clinicians' ability to be aware of, regulate, and use their inner experience (e.g., affect, cognition) during therapy to help foster clients' change.	Therapists are likely to be more effective when they successfully communicate empathy, prizing, and genuineness to their clients. Therapist effectiveness may also be improved by a recognition, acceptance, regulation, tolerance (not acting out), and use of negative and positive reactions (e.g., hate and love) to better understand their clients and their relationships with others. Furthermore, therapists are likely to increase their effectiveness when they can manage their countertransference.

- 7 Therapist attachment characteristics contribute to therapist effects. Whereas therapist secure attachment has been linked with positive alliance, therapist insecure attachment has been associated with negative therapeutic process. Therapist secure attachment has also been related to positive outcome with highly distressed and impaired clients. Complementarity between client and therapist attachment styles may also explain differences in client outcomes.
- 8 The fact that some therapists are more (or less) effective than others may be in part due to the competent delivery of technical, relational, conceptual, and cultural skills. In particular, helping and facilitative interpersonal skills (e.g., empathy; alliance related skills; interventions aimed at increasing hope, expectation, insight, behavioral changes) are likely to account for some of the outcome variance observed between therapists. Rather than a single skill (or a whole set of them), however, the integration of skills and other variables may provide a better explanation of therapist effects. For example, adherence to techniques prescribed by treatment and the use of helping skills may have an indirect impact on outcome, given that their effect could be moderated or mediated by relationship variables (e.g., quality of alliance), therapist characteristics (e.g., allegiance, internalized hostility), and client variables (e.g., involvement in the treatment process).
- 9 Some therapists are better than others, in part because of their ability to work with clients from a wide range of cultures and their ability to address cultural issues in therapy.
- As a way to improve their effectiveness, therapists might raise awareness of their own attachment patterns and that of their clients. They can use this awareness to avoid engaging in negative processes, as well as to help clients modify maladaptive ways of regulating emotions and relating to others.
- To improve their effectiveness, therapists should strive to responsively and appropriately use technical, relational, conceptual, and cultural skills that they learn and deliberately practice. The competent delivery of technical and relational skills is likely to be enhanced if based on a comprehensive case formulation, used in response to immediate markers for interventions, and implemented with therapists' awareness of their own internal experience and cultural awareness. In addition to implementing these skills in an interpersonal facilitative way and culturally sensitive manner, therapists are likely to improve client outcomes by paying attention to the client response as a way to decide to pursue, modify, or refrain from continuing to use specific skills.
- When working with clients (irrespective of ethnicity, race, religion, gender, sexual orientation, age, or disability status), therapists may improve their effectiveness by integrating in their practice an attitude of humility and openness toward cultural issues (acknowledging and tolerating lack of specific knowledge), by creating or making use of opportunities to address cultural issues, by addressing these issues as comfortably as possible (as by avoiding or repairing cultural microaggressions).

(continues)

TABLE 17.2
Summary of Chapters in This Volume Presenting Factors Potentially Explaining Therapist Effects *(Continued)*

Chapter	Therapist variables potentially associated with therapist effects	Implications for therapists
10	The experience of negative emotional reactions on the part of therapists (e.g., frustration, anger) toward clients, and the ways such reactions are dealt with during sessions, could account for a portion of the observed therapist effects. By potentially impeding the therapeutic process, negative reactions might be particularly relevant in explaining why some therapists have worse outcomes than others.	To improve their effectiveness, therapists need to engage in a participant–observer stance during therapy (which includes self-awareness), control the expression of negative reactions they have toward clients (regulate and contain), and use helpful strategies to work with these internal and relational experiences. These strategies include a reattribution of the meaning of clients' behavior that may have triggered the negative reaction, as well as techniques to temper these reactions and to repair resulting alliance ruptures. When implemented successfully, these strategies may not only lead to a reduction of toxic interactions but may also provide the opportunity to correct client maladaptive interpersonal patterns that might, in part, be triggering such negative reactions.
11	The outcome of better therapists may be explained, in part, by what has been observed in experts, or top performers, in different domains such as sports, music, and chess. These observations include (a) automatization of basic skills, (b) superior abilities in complex skills such as information processing (intuitive and rational-analytic mode of thinking) and appropriate reactions to complex situations, (c) repeated and deliberate practice of these complex skills over a long period of time, and (d) use of feedback to acquire and improve these complex skills.	Therapists might improve their effectiveness by following guidelines for expertise and deliberate practice. During training, these include the definition of learning steps and provision of feedback. Over years of practice, these guidelines include the development of abilities to process clinical information (e.g., sharpening case formulation skills, using their intuitive and analytic modes of thinking), and the use of feedback obtained after sessions and observed during sessions.

- 12 Some therapists are more effective than others in part because they adopt, in their practice, creative and flexible ways of thinking and being that are akin to perspective and strategies of artists. Therapists are likely to increase their effectiveness, at least for some clients, if they develop a creative (artistic/literary) sensibility that allows them to be aware, open to, and work with different aspects of the clients' life (e.g., existential issues, meanings, emotions, multiple sides and states of self, humor, imagination, fantasies), needs (e.g., playfulness, intimacy, creative change), and ways of communicating and expressing themselves (e.g., narratives, body language, tone of voice). They can foster this creative sensibility by engaging in artistic activities or by being exposed to artistic work.
- 13 Therapist outcome differences in psychodynamic therapy for depression could partially be explained by the use of relationship-oriented interventions. As a way to improve their effectiveness when working with depressed clients, psychodynamic therapists should focus on client interpersonal functioning inside and outside therapy, such as helping clients to better understand how their difficulties in social relationships may contribute to their problems.
- 14 What, in part, may explain therapist effects in the treatment of generalized anxiety disorder is the extent to which therapists facilitate client activation of the mechanisms of change in the theoretical approach being implemented (at least in cognitive-behavioral and interpersonal/emotion-focused therapies). In particular, less effective therapists may miss opportunities to foster client engagement in targeted mechanisms, may interfere with such engagement, and/or may intervene in ways that are contrary with the mechanism of change targeted by the treatment. Ways by which therapists may improve their effectiveness include being cognizant and aware of mechanisms of change driving the successful implementation of the treatment used; responding with appropriate techniques to markers of interventions that are consistent with targeted mechanism of change; and using techniques in affiliative, noncontrolling, and responsive manners (including knowing when to stop using some techniques). Moreover, therapists should ensure that these interventions are activating the targeted mechanisms (e.g., emotional deepening) and not fostering processes that are in opposition to these mechanisms (e.g., using interpretation in ways that reinforce cognitive avoidance of emotions). In addition, therapists should correct technical and/or relational mistakes that may interfere with positive therapeutic process.
- (continues)*

TABLE 17.2
 Summary of Chapters in This Volume Presenting Factors Potentially Explaining Therapist Effects *(Continued)*

Chapter	Therapist variables potentially associated with therapist effects	Implications for therapists
15	Part of the therapist effects may be due to the use of humor in a manner that is responsive to the client's needs and view of humor, as well as consistent with the therapist's personality.	If it fits who they are, if the therapeutic relationship is strong, and if the client values humor, therapists may improve their effectiveness by using humor (often ironic or dry humor) in response to clients' discussing or demonstrating symptoms or problems. Used in a careful and responsive way, humor could reduce clients' anxiety, enhance the therapeutic climate and bond, and foster clients' acquisition of new perspectives. Humor can lead to increased distress if used when the relationship is weak, and/or in ways that make client feel uncared for, misunderstood, or confused.

treatment processes and outcomes, as well as implications for how therapists can improve their own effectiveness.

Some of these variables are traits or stable personality characteristics, such as therapist attachment style (Chapter 7); or creativity, openness, and flexibility (Chapter 12). The rest are situational variables that vary according to context, such as

- technical skills (Chapters 8 and 13);
- relational skills (Chapters 6 and 8);
- conceptual skills (Chapter 8);
- cultural awareness (Chapters 8 and 9);
- responsiveness to client needs (Chapter 4);
- attentiveness to inner experiences/emotional reactions (Chapters 6 and 10);
- presence (Chapter 5);
- automatization of basic skills, superior abilities in complex skills such as information processing and appropriate reactions to complex situations, deliberate practice of skills, use of feedback (Chapter 11);
- humor if used in a genuine manner and fits therapist's personality (Chapter 15); and
- fostering client engagement in treatment-related activities (Chapter 14).

Of course, there are many more potentially relevant therapist variables that were not addressed in the chapters in this book (e.g., use of immediacy, compassion, burnout, humility, curiosity, persuasiveness/confidence).

IMPLICATIONS OF THERAPIST EFFECTS

As mentioned previously, a number of clinical implications have been derived from the current research on therapist effects (see Table 17.1). Boswell, Kraus, Constantino, Bugatti, and Castonguay (Chapter 16) identified additional implications related to different facets of mental health practice; these implications and some of the challenges involved in implementing them are summarized in Table 17.3. For example, given that variability in therapist effectiveness on client outcomes (in relation to other therapists in general, and with regard to different types of outcomes in one's own caseload) can be detected with routine outcomes monitoring data, we can use such data to inform the referral of clients to the therapist who is most likely to be successful. Such evidence-informed matching might be especially important for low-functioning clients, or for specific types of outcomes, where the person of the

TABLE 17.3
Summary of Chapter in This Volume Describing Implications of Therapist
Effects on Different Facets of Mental Health Practice

Chapter	Implications for mental health practice
16	On the basis of monitoring of treatment outcomes, research has demonstrated that therapists show relatively stable patterns of effectiveness. Assessing therapist outcomes in routine practice settings can provide helpful information to identify therapist strengths and limitations across numerous clients, guide referral practices and case assignments, as well as to improve supervision and professional development during and after training. However, successful implementation of outcome monitoring requires paying attention to the various needs and concerns of several stakeholders in the mental health field (payers, clients, therapists, and trainers), as well as to several challenges to be expected in day-to-day clinical work (therapist engagement), training (socialization to outcome feedback), organization functioning (management and interpretation of outcome data), and policymaking (informing decision makers about empirical data on therapist effects).

therapist seems to have a more pronounced influence on treatment outcome. How exactly to disseminate information on therapist personal effectiveness, however, remains an open and empirical question.

In addition, if we can identify specific and consistent therapist-level *characteristics* that are responsible for differential between-therapists effectiveness, we could select students for therapist-training programs using those variables as criteria. Similarly, if we can identify specific and consistent therapist-level *behaviors* that are responsible for differential between-therapists effectiveness, we can implement targeted training on these actions for novice and experienced therapists (recalling that experience, as currently measured, does not explain differences in therapist effectiveness; Chapter 2).

Finally, awareness of therapist effects (relative to self and others) can help clinicians manage their own clinical services in a way that counteracts inherent bias and overestimation of general effectiveness. As it is a statistical impossibility that all therapists are above average, tracking and digesting outcome data seems useful. Of course, as Boswell et al. (Chapter 16) noted, many questions remain unanswered with regard to optimizing measurement-informed care.

NEXT STEPS IN RESEARCH ON THERAPIST EFFECTS

In the meeting, there was strong consensus about the next steps for research on therapist effects. In addition to advocating for the field to see therapists as a crucial focus of psychotherapy research (in addition to treatment

and client, see Chapter 1), perhaps the strongest sentiment was expressed for encouraging research using many paradigms. At this stage in research, we firmly believe that the use of multiple designs and methods is needed.

Discovery-oriented designs (e.g., consensual qualitative research, correlational process studies) and designs that seek verification (experimental designs) may be mutually beneficial toward advancing our understanding of therapist effects (which may be translated as bottom up and top down, respectively). For example, we could conduct qualitative analyses of clients who have seen many different therapists and ask about variables that they believe caused them to continue with some therapists rather than others. Or we can conduct studies of therapist use of different types of interventions, such as immediacy, in different contexts (e.g., Hill et al., 2014). Furthermore, we are most likely to find meaningful results if findings replicate across different methods.

In the context of experimental research that seeks verification, researchers can use sophisticated statistical designs such as HLM to test those variables that were identified in the context of discovery. Therefore, we strongly encourage researchers to add variables such as therapist humor, presence, and humility in HLM analyses. By including specific therapist variables in datasets with large numbers of therapists, each seeing large numbers of clients, we are most likely to verify the effects of specific variables, especially if we include many of the relevant moderator and mediator variables identified in the qualitative analyses. In other words, these HLM tests are not likely to be simple tests of straightforward or direct variables, but need to include clinical nuances. New designs and statistical methods also need to be developed to further enable researchers to include clinical nuances (e.g., context, timing, quality of interventions) and contextual factors (e.g., setting).

A special word needs to be said about developing and including measures that reflect more in-depth outcomes, such as those that are targeted in exploratory- or insight-oriented therapies (psychodynamic, humanistic) and/or long-term approaches. We do a disservice to the field if the only variables we include in investigations involve measures of symptom relief. Relatedly, we need to include more than just client self-report, given that therapists, external assessors, and significant others have important perspectives about client change (Chapter 10; see also Strupp & Hadley, 1977). We also need to be particularly attentive to negative changes and deterioration effects, given the realization that some therapists are indeed harmful (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010). Importantly, though, whatever the outcome and whoever the rater, the chapters in this volume remind us of the importance of determining if therapists systematically differ on particular variables (e.g., some therapists may be consistently more likely to foster a reduction in client use of defenses as rated by a

therapist or significant others). This outcome would be a therapist effect just the same as self-reported outcomes and would therefore require understanding its determinants.

Furthermore, as Constantino et al. (Chapter 3) discussed, we need to investigate therapist effects on process variables that consistently explain between-therapists differences on outcomes. And these relations may be complex. For example, we need to understand why some therapists foster alliances so competently, whereas others do not. It could be, for example, that therapists who use more immediacy promote better alliance formation, which then promotes better outcomes for those therapists. This would reflect a therapist-level mediational model, which Constantino et al. argued is an important next wave of therapist effects research. Similarly, it would be fruitful to examine therapist differences in responding competently and successfully to markers of change, some markers specific to particular orientations (e.g., Greenberg, 2015) and others common across approaches (e.g., Constantino, Boswell, Bernecker, & Castonguay, 2013; Messer, 1986). Finally, in conducting future research, it is important to remain aware of long-standing myths of uniformity, and search for differential therapist effectiveness within particular contexts (e.g., specific forms of therapy, particular types of clients, specific types of symptoms, dimensions of functioning, clients' concerns). We also need, of course, to be aware of possible myths related to differences (e.g., differences related to therapist theoretical orientation and sex) and change our thinking or design more valid research studies to better understand these variables.

We are excited about the advances in knowledge regarding therapist effects. We hope that continued research using sophisticated statistical analyses and qualitative methods, with attention to the complexities and nuances of the psychotherapy process, will help us understand why some therapists are better than others, which in turn may lead us to improve the effectiveness of psychotherapy.

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