What makes a master therapist?

BARRY DUNCAN

BARRY DUNCAN elaborates on four questions about becoming a 'master' therapist posed by Jeffrey Kottler and Jon Carlson for their forthcoming book, '*Becoming a Master Therapist*'. His answers, illustrated with clinical vignettes, integrate the latest research about what matters in effective psychotherapy to challenge the prevailing view that to be an accomplished psychotherapist one must be well-versed in evidence-based treatments. Psychotherapy is a relational endeavour, one wholly dependent on the participants and the quality of their interpersonal connection. After the client, the therapist is the most potent aspect of change in therapy, and in most respects *is* the therapy. Soliciting feedback engages clients in the collaborative monitoring of outcome, heightens hope for improvement, fits client preferences, maximises the alliance potential and client participation, and is itself a core feature of therapeutic change.

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

Recently, I was asked four questions about what I do, and who I am that makes my work effective (assuming it is) (Kottler & Carlson, in press). In this article, I elaborate on those questions, illustrate with client stories, and integrate my answers with the latest research about what makes psychotherapy effective.

Question one

What is it that you do, or who you are, that you believe is most important in contributing to your effectiveness as a master therapist, meaning a professional who produces consistently good outcomes and feels reasonably confident in your work?

First, I must say something about the term 'master therapist'. While your description makes sense, the notion itself is troublesome because it seems to connote that an elite group of 'masters' possess something that others do not. I don't have anything that others don't have or can't develop.

There are two parts to your question: *What I do* and *who I am*. What I do that is most important in contributing to my effectiveness is that I routinely measure outcome and the alliance via the *Partners for Change Outcome Management System* (PCOMS; Duncan, 2012) to ensure I don't leave either issue to chance. This allows me to deal directly and transparently with clients, involve them in all decisions that affect their care, and keep their perspectives as the centerpiece of everything I do. In addition, it serves as an early warning device that identifies clients who are not benefiting, so that the client and I can chart a different course that, in turn, encourages me to step outside my therapeutic business as usual, do things I have never done before and, therefore, continue to grow as a therapist.

Although it sounds like hyperbole, identifying clients who are not benefiting is the single most important thing a therapist can do to improve outcomes. Combining Lambert's *Outcome Questionnaire System* (Lambert & Shimokawa, 2011) and PCOMS (Duncan, 2012), nine RCTs now support this assertion (and two more are submitted). A recent meta-analysis of PCOMS studies (Lambert & Shimokawa, 2011) found that those in the feedback group had 3.5 times higher odds of experiencing reliable change, and less than half the odds of experiencing deterioration.[1]

Because of RCTs conducted at the Heart and Soul of Change Project (e.g., Anker, Duncan, & Sparks, 2009; Reese, Norsworthy, & Rowlands, 2009), PCOMS is a US Substance Abuse and Mental Health Administration designated evidence-based practice. It is different, however, to what is usually considered

1 Visit https://heartandsoulofchange.com for more information; the measures are free for individual use and available in 23 languages.

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evidence-based because feedback is a-theoretical and therefore additive to any therapeutic orientation, and applies to clients of all diagnostic categories (Duncan, 2012). It allows a therapist to be evidenced-based across all clients while simultaneously tailoring therapy to the individual client—evidence-based one client at a time (Duncan, in press).

Before I say what it is about me, let me remind the reader about the major factors that account for how people change in psychotherapy. Calculated from the often reported 0.80 effect size (ES) of therapy, the proportion of outcome attributable to treatment (14%) is depicted by the small black circle nested within the larger clear circle to the left in Figure 1.

The variance accounted for by client/life factors (86%), including unexplained and error variance is represented by the larger clear circle. Even a casual inspection reveals the disproportionate influence of what the client brings to therapy. As examples, persistence, faith, a supportive grandmother, depression, membership in a religious community, divorce, a new job, a chance encounter with a stranger, a crisis successfully managed all may be included. Although hard to research because of their idiosyncratic nature, these elements are the most powerful of the common factors—the client is the engine of change (Bohart & Tallman, 2010). If we don't recruit these unique client contributions to outcome, we are inclined to fail.

By the time I reached my internship I had experiences in two community mental health centres and a stint in the state hospital. The hospital experience lingered, leaving me with a bad taste in my mouth. Now, my charge was to help people stay out of the hospital, and I took that charge quite seriously.

One of my first clients was Peter. Peter sometimes said ominous things to other clients in the waiting room, or often spoke in a boisterous way about how the florescent lights controlled his thinking through a hole in his head. Actually, Peter was a terrific guy, but a man of little hope who lived in dread of returning to the state hospital. His behaviours were mostly distraction efforts from the tormenting voices that told him people were trying to kill him.

Peter's unfortunate routine was that he was terrorised by these voices until he started taking actions that would wind him up in the state hospital. He might empty his refrigerator for fear that someone had poisoned his food, or occasionally he would start threatening or menacing others, those he believed were trying to kill him. Once hospitalised, his medications were changed, usually increased in dose, and he essentially slept out the crisis.

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These cycles occurred about every four to six months and had so for the last eight years. Peter's 'treatment' brought with it tardive dyskinesia and about a hundred pounds of extra weight.

I felt profoundly sad for this young man, who was about the same age as me. I also felt completely helpless. I tried to apply strategies I learned from my supervisor about the voices, which were helpful to others, but not with Peter. I knew he was ramping up for another admission—he had already emptied his refrigerator and left the food on the kitchen floor.

Only because I had no clue about

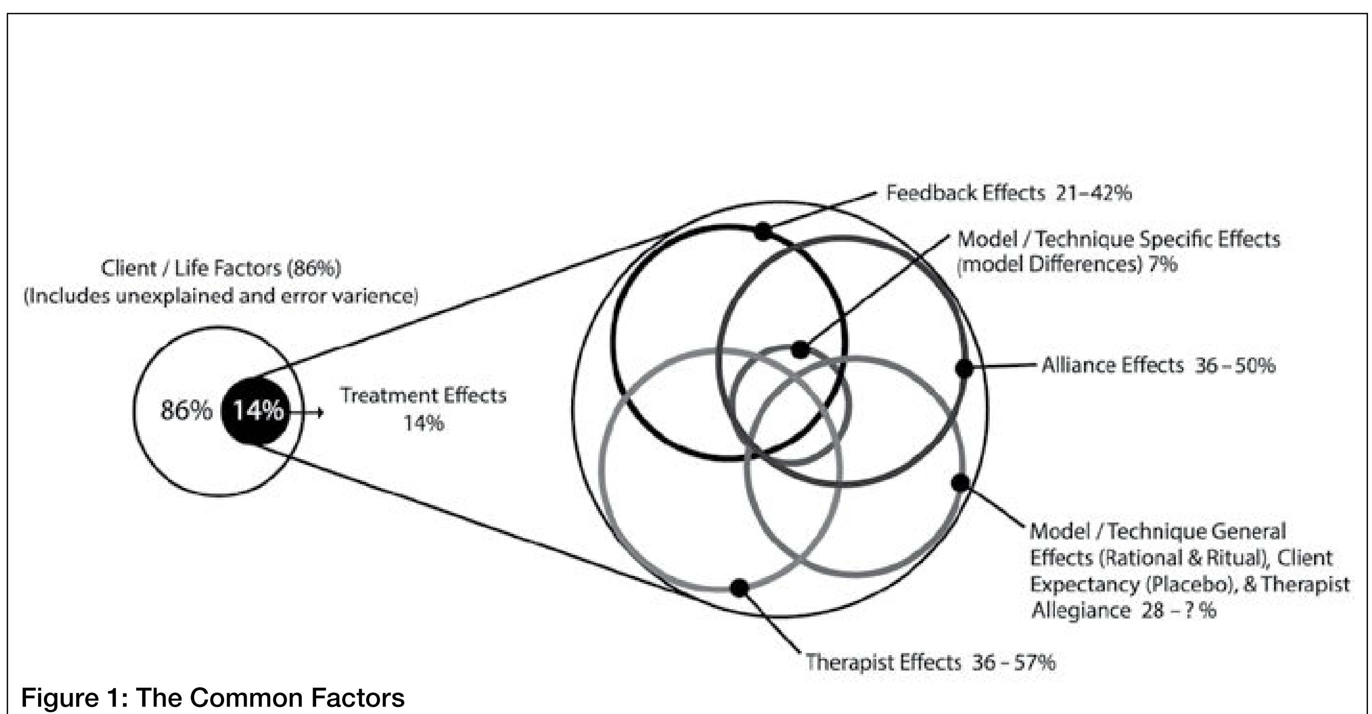

Figure 1: The Common Factors

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what to do, I asked Peter what he thought it would take to get a little relief—just a glimpse of a break from the torment of the voices and the revolving door hospitalisations. After a long pause, Peter said it would help if he could start riding his bike again, and told me about what his life was like before the bottom fell out. Peter had been a competitive cyclist in college. I heard the story of a young man away from home for the first time, overwhelmed by life, training day and night to keep his spot on the racing team, and topped off by falling in love for the first time. When the relationship ended, it was too much for Peter, and he was hospitalised, and then hospitalised again, and again, and so on until there was no more money or insurance—then the state hospitalisations ensued.

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

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

Returning to Figure 1, the large circle in the center expands the small black circle and represents the overlapping elements that form the 14% of variance attributable to therapy. Therapist effects represent the amount of variance attributable not to the model wielded, but rather to the person and character of the therapist.

A recent meta-analysis suggested that 5–7 percent of the overall variance is accounted for by therapist effects (Baldwin & Imel, 2013). Earlier estimates and a recent investigation by Owen, Duncan, Reese, Anker, and Sparks (in press), found the variance to be a little higher at 8 percent. Therefore, Figure 1 depicts a 5–8 percent range of overall variance or 36–57 percent[2] of the variance attributed to treatment; therapist factors, then, account for five to eight times more than model differences. Therapists, not their models, account for most of the changes noted in any treatment model.

What I bring to the therapeutic endeavour is that I am a 'true believer'. I have belief in the client, the power of relationship and psychotherapy as a vehicle for change, and I believe in my ability to be present, fully immersed, and dedicated to making a difference. The odds for change when you combine a resourceful client, a strong alliance, and a therapist who brings him/herself to the show, are worth betting on, certainly cause for hope, and responsible for my unswerving faith in psychotherapy as a healing endeavour.

Question two

What do you think is most important in identifying or defining an extraordinary therapist, one who stands out from her or his peers?

Therapists vary significantly in their ability to bring about positive outcomes. The big question, of course, is what separates the best from the rest. There is no mystery here. The answer is that tried and true, but taken for granted, old friend the therapeutic alliance. For example, Baldwin, Wampold, and Imel (2007) reported that therapist average alliance quality accounted for 97% of therapist variability. Owen et al. (in press) found that therapist average alliance quality accounted for 50% of the variability in outcomes attributed to therapists. In general, research suggests strongly that clients seen by therapists with higher average alliance ratings have better outcomes (Zuroff, Kelly, Leybman, Blatt, & Wampold, 2010).

Therapists, not their models, account for most change in any delivered treatment.

In the 1980s and 1990s, I used to direct a training institute. We consulted regularly with clinicians and agencies who felt stuck, and took turns being the therapist in the room with the client while the team and the primary counsellor watched behind a one-way mirror. It was the most enriching learning experience of my career. While all our team were very good, Greg Rusk stood out because of his remarkable ability to engage clients from all walks of life, facing all kinds of despair and destitution, in this thing we call psychotherapy.

The case of Peg

Peg is particularly memorable. She was referred to us by her psychiatrist and was taking two antidepressants as well as pain medication. Peg suffered severe pain from a fall in an elevator shaft two years prior, and had not been able to return to her job as a night cleaning person in a large office building. The therapist described her as 'profoundly depressed' and 'perpetually suicidal', and he wanted an opinion about ECT and involuntary hospitalisation because many changes in medications had been tried and she refused hospitalisation. In addition, the psychiatrist reported that Peg didn't make eye contact, gave barely audible one sentence replies to questions, and seemed to punctuate every utterance with *"I have no reason to live"*.

Greg greeted both Peg and her husband Wayne in the waiting room,

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

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and asked Peg if it was okay if Wayne joined them. True to form, Peg never looked up and responded in a low voice that it was okay. On the way back to the consultation room, Greg started chatting with Wayne about his 'Hooked on Fishing' hat, and Wayne shared that it was Peg who was the true fisherman of the family. They arrived in the therapy room, and Greg, while ushering Peg and Wayne to the couch, asked Peg if she remembered the first fish she ever caught. Peg looked Greg right in the eye, and told him the story of her first fish, a sun granny, and moreover, about her very special relationship with her father who taught her not only to fish, but also about life. She spoke of her father's death as a blessing after his horrible bout with cancer, which happened right after her accident, while Wayne added that many in Peg's family compared Peg's gentle parenting style and overall compassion to that of her father. Wayne proudly said that Peg was the rock of the family, and stood by him when he was struggling with alcohol.

It was a touching conversation, and Greg, visibly moved, commented on his heartfelt admiration for this couple as well as the difficulty of the situation. From there, it emerged that Peg felt useless to the family—she was unable to contribute financially and, more importantly, to parenting their two daughters. Wayne chimed in that both their daughters were honor roll students because of Peg. In essence, Greg said, no wonder Peg believed she had no reason to live given her identity had been stolen by the accident. From there, a lively discussion ensued about how Peg could recapture her usefulness and identity. The couple outlined ways Peg could start to contribute more to the family, which included a frank discussion about the merits of the medications and their effects on her ability to function. The beginnings of a plan surfaced, and most importantly, so did hope. This was Greg Rusk. He engaged people, even those who seemed impossible to engage, in meaningful conversations about how their lives could be better—the purpose of the alliance.

The alliance

Bordin (1979) defined the alliance with three interacting elements: 1) a relational bond; 2) agreement on the goals of therapy; and 3) agreement on the tasks of therapy. Horvath, Del Re, Flückiger, and Symonds (2011) examined 201 studies and found the correlation between the alliance and outcome to be .28, accounting for 7.5% of the overall variance. Putting this into perspective, the amount of change attributable to the alliance is over seven times that of specific model or technique.

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Based on the profound work of Carl Rogers (1957), the concepts of empathy, positive regard, and genuineness still represent the best way to understand the power of the relational bond. A recent meta-analysis of 57 studies looking at empathy and outcome (Elliott, Bohart, Watson, & Watson, 2011) found a significant relationship, an *r* of .31 (*r* is a different effect size stat than *d*; an *r* of .31 is a medium effect). Similarly, another idea championed by Rogers, unconditional positive regard, continues to demonstrate the centrality of the relationship to outcome. A recent meta-analysis of 18 studies examining positive regard and outcome found a significant relationship, an *r* of .27 (Farber & Doolin, 2011). Finally, there is congruence/genuineness. Kolden et al. (2011) meta-analysed 16 studies and found a significant relationship between congruence/genuineness and outcome, an *r* of .24. Lambert (2013) rightly notes that these relationship variable correlations are much higher than those of specific treatments and outcome.

The case of Maria

When Maria was six years old a gas furnace explosion killed both her father and sister. Her mother collapsed emotionally after the accident and spent most of her days in bed. Essentially, Maria had grown up without a parent, and partly as a result, had been sexually abused repeatedly by an uncle. By the time I saw Maria she was 35 and had been in therapy and taking antidepressants for most of her life. She held a responsible, but

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unsatisfying, job in a biotechnology company. Maria had tried to kill herself five times, leading to five psychiatric stays. She called her latest therapist eight or nine times a day, leaving agonised messages with the answering service, demanding to be called back. Perhaps because of her borderline diagnosis, Maria's demands were rarely, if ever, met by her therapist, which provoked Maria into escalating levels of distress and self-harming. She was headed toward another suicide attempt when her burnt-out therapist referred her, with a sense of relief, to me through an investigation I was involved in called the 'impossible case' project.

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

Then, after our sixth session, I went on a backpacking trip with my son Jesse, entrusting my colleagues to cover for me. After setting up camp the first night, I felt inexplicably worried about Maria. This was before cell phones. So I hiked four miles back to my truck in the darkness and drove to a pay phone in a nearby town to see how she was getting along. She was okay.

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

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

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

Maria taught me to honour the client's view of the alliance — she knew she needed a certain sort of contact to heal, and our time together gave her this contact. It was the affectionate container for our conversations that included discussions of what she wanted to change and how she could make it happen. Maria also taught me the power found in simple acts of human caring, in empathy and positive regard. Of course, I had no idea of the connection of my actions to her desires for a loving father. Within the limits of what I can manage ethically and personally, I have learned to provide as much human caring and non-possessive love as possible.

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

Perhaps the most important part of this collaboration is whether the favoured model of the therapist fits client sensibilities about change. Swift, Callahan, and Vollmer (2011) conducted a meta-analysis of 35 studies of client preference and found that clients who had their preferences honoured attained better outcomes ($d = .31$), and were less likely to drop out. Alliance skills are at play here: your interpersonal ability to explore the client's ideas, discuss options, collaboratively form a plan, and negotiate any changes when benefit to the client is not evident. Traditionally, the search has been for interventions that promote change by validating the therapist's favoured theory. Serving the alliance requires taking a different angle — the search for ideas that promote change by validating the client's view of what is helpful — the client's theory of change (Duncan & Moynihan, 1994). The litmus test of any chosen method is whether or not it engages the client in purposive work and makes a difference.

The alliance: One last word

We all have clients to whom we connect quickly. But what about those clients mandated by the courts or protective services, or who just don't want to be there? What about people who have never been in a good relationship or have been abused or traumatised? What about those who have lost hope? Well, the therapist's job, our job, is exactly the same regardless. As Greg Rusk illustrated, if we want anything good to happen, it all rests on a strong alliance — we have to engage the client in purposeful work, even those who don't want to be engaged.

It is hard work. We often think

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that 'therapeutic work' only applies to clients. It doesn't. We have to earn this thing called the alliance. We have to put ourselves out there with each and every person, each and every interaction, and each and every session. It is a daunting task, and one that is minimised perpetually in its importance and difficulty. It gets such little press compared to models and techniques, and is often relegated to statements like *'first gain rapport and then…'* or *'form a relationship and then…'* as if it is something we do effortlessly before the real intervention starts. The alliance is not the anesthesia to surgery. We don't offer Rogerian reflections to lull clients into complacency so we can stick the real intervention to them! Intervention is not therapy.

The case of Lisbeth

When Lisbeth was introduced to me in the waiting room, she told me to go f...k myself. I was doing a consult because this 16 yr-old was refusing to go to school and had assaulted five foster parents. Lisbeth was one angry adolescent and my initial thought was, *"Wouldn't it be sweet if she told me what she was angry about"*, because I knew there had to be good reason. In the opening moments, I asked Lisbeth what she thought would be most useful for us to talk about and she said, *"What I think of you is that you are a condescending bastard with no understanding of your clients whatsoever!"* Whew, she knew how to hit where it hurt! But slowly, and surely, I listened and didn't react to her, and maintained my conviction that if I understood her story, everything, especially her anger would make complete sense. For example, she told me how she refused medication in one of her many hospitalisations, and had threatened to break the kneecaps of the psychiatrist who attempted to force her to take meds. This stimulated possible replies about the inappropriateness of her violent tendencies ad nauseam. Instead, I commented simply that she didn't want to kill the psychiatrist after all, but only wanted to permanently impair her, a significant difference. In return, she gave me a slight smile, and enaged a bit more in conversation.

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

> ***…better outcomes can be expected when client and therapist agree on goals and the processes to achieve them.***

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

There is no more righteous anger than this kid felt. I said that, and we connected. And Lisbeth, via work with others who finally addressed her goal for therapy, completed school online and settled in with her foster parents. The therapy relationship is not always easy and demands a lot of us, but it is worth the effort, and perhaps why we became therapists in the first place.

Question three

What do most people, and even most professionals, not really understand about what it takes to be really accomplished in our field?

Although I often bash the idea of specific treatments for specific 'disorders', especially when they are mandated, there is nothing wrong with EBTs and it is useful to learn the ones relevant to your particular practice, as well as many explanations and rituals (a la Jerome Frank) for client distress. The truth is we don't know ahead of time what model or technique will be helpful with the client in our office now—a lot of uncertainty accompanies this work. To be accomplished is to embrace uncertainty. We long for the structured, the scripted, the predictable, the manualised, the 'sure fire' way to conduct a session—maybe not even to sequester success, but at times, just to get through, staring eye-to-eye with a person who is experiencing significant distress. Who can blame us? Uncertainty is endemic to our work as it is to life, and is therefore important to embrace if you want to get better at this work.

Uncertainty is the place of unlimited possibilities for change. It allows for the 'heretofore unsaid', the 'aha moments', and all the spontaneous ideas, connections, conclusions, plans, insights, resolves, and new identities that emerge when you put two people together in a room and call it psychotherapy.

The case of Rosa

Rosa, who was seven years old, had gone to live with her foster parents—her aunt and uncle, Margarita and Enrique—because the parental rights of her birth parents had been terminated. Both parents were addicts with long criminal records; the father was in jail, and the mother was still using. Rosa had been born with two strikes against her: parents missing in action and her development impaired by drugs.

Although much professional psychopathological gobbledygook accompanied her, it was safe to say that Rosa was a 'difficult' child—prone to tantrums that included kicking, biting, and throwing anything she could find. I began the session by asking Rosa if

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she was going to help me today and she immediately yelled, *"No!"* leaning back, with her arms folded across her chest. As I turned to speak with Enrique and Margarita, Rosa began having a tantrum in earnest—screaming and flailing around, kicking me in the process.

With Rosa's tantrum escalating, Margarita, who had first tried to soothe her, dropped a bombshell. In a disarmingly quiet voice, she announced she didn't think she could continue foster-parenting Rosa. The tension in the room escalated immediately; the only sound was Rosa's yelling, which had become more or less rote at that point. I felt as if I had been kicked in the gut. I had expected to be helping foster parents contain and nurture a tough child. Now it felt like I was participating in a tragedy in the making. Here was a couple, trying their best to do the right thing by taking in a troubled kid with nowhere else to go, but who seemed ready to give up.

The situation was obviously wrenching for Margarita and Enrique, but was potentially catastrophic for Rosa. In this rural setting, they were her last hope, not only of living with family, but of living nearby at all, since the closest foster-care placement was at least 100 miles away. I contemplated Rosa's life unfolding in foster care with strangers who would encounter the same difficulties and likely come to the same impasse—resulting in a nightmare of ongoing placements.

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

Margarita continued explaining why she couldn't go on, speaking softly while tears rolled down her cheeks. Not only did she feel she couldn't handle Rosa, she also worried about the child's attachment to her. As Margarita expressed her doubts in a near whisper, Enrique's eyes began to tear up and a feeling of despair permeated the room. Enter uncertainty. At that moment, I felt helpless to prevent a terrible ending to an already bad story and didn't have a clue about what to do. Meanwhile, Margarita began caressing Rosa's head gently and speaking softly to her—the Spanish equivalent of *'there, there, little one'*—until the little girl started to calm down. With her tantrum at an end, Rosa turned to face Margarita, and then reached up and wiped the tears from her aunt's face. *"Don't cry, Auntie,"* she said warmly, *"don't cry"*.

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

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

By now, the tension and despair present a few moments before had evaporated. The decision to discontinue foster parenting, born of hopelessness, had lost its stranglehold, though nothing had been said explicitly. Now all smiles and bubbly, Rosa was bouncing up and down in her chair. Somewhat out of the blue, Margarita announced she was going to stick with Rosa. *"Great"*, I said quietly. Then, as the full meaning of what she had said washed over me, I repeated it a bit louder, and a third time with enthusiasm—*"Great!"* I asked Margarita if anything in particular had helped her come to this decision. She answered that, although she had always known it, she realised in our session even more that there was a wonderful, loving child inside Rosa, and that she, Margarita, just had to be patient and take things one day at a time. The session had helped her see the attachment that was already there.

The session included that intimate space in which we connect with people and their pain in a way that somehow opens the path from what is, to what can be.

I felt the joy of that moment then, and I still do.

Follow-up revealed this family stayed together. Margarita never again lost her resolve to stick with Rosa. In addition, many of Rosa's more troubling behaviours fell away, perhaps as a result of having stability in her life for the first time

The session included that intimate space in which we connect with people and their pain in a way that somehow opens the path from what is, to what can be. My heartfelt appreciation of both the despair of the circumstance and their sincere desire to help this child, combined with the fortuitous 'attachment' experience, generated new resolve for Margarita and Enrique. This session taught me, once again, that anything is possible. Just when things seemed the most hopeless, when both the family and I were surely down for the count and needed only to accept the inevitable, something meaningful emerged that changed everything—including me.

Uncertainty stokes the flames of such occurrences. Good therapy capitalises on these opportunities. The tolerance for uncertainty, however, requires faith—faith in the client, faith

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in yourself, and faith in psychotherapy.

The second thing that is understated in doing good work is perhaps the most difficult skill for therapists to master—the ability to keep sessions focused and not get lost in the sometimes confusing, and nearly always complex, ways that clients unfold their stories. Switching from one important topic to another without thematic connection or relevance to the way the client is experiencing life between sessions is almost a guaranteed recipe for failure. But to address this is not easy. It can require therapists to step up their activity and steer the conversation toward ensuring some meaningful difference is accomplished in the day-to-day life of the client.

It doesn't have to be heavy-handed and it can, of course, be collaborative. I ask clients whether they think it is better for us to continue talking about the topic at hand, or whether we should return to what they are most concerned about. I also ask if it is okay if I return us to task from time to time. It can be a challenge to follow the client's lead while simultaneously never losing sight of where the client wants to go—to balance being empathic to the sometimes overwhelming presentation of topics and concerns, with ensuring these topics and concerns are tied to making a meaningful difference in the client's experience of life. It is easier to meander across a myriad of worthwhile topics and legitimate concerns, and not connect the conversation to what the client will do between sessions. The unfortunate result is a therapy that represents an ongoing commentary of the client's life and never leads to any real change.

Measuring outcomes through a method such as PCOMS can really help with this process. Monitoring benefit enables the focus to start and remain on what the client would like to see happen. It helps the therapist stay on task, and take charge of channelling the conversation and complexities of clients' life toward something tangible that will make a difference.

Question four

What advice would you give someone who aspires to be a master therapist?

First, measure your outcomes to improve your effectiveness and track your development. There is strong evidence that therapists are not good judges of their own performance. It is not that we are stupid, it's simply impossible to assess our effectiveness without a quantitative reference point. PCOMS is one feasible method available to cut through the ambiguity of therapy and discern your clinical development without falling prey to wishful thinking. The systematic collection of outcome feedback will not only improve your outcomes by identifying that pool of clients who are not responding so you can collaboratively forge new directions, it also allows you to track your effectiveness/development over time and implement proactive strategies to improve your outcomes. Regarding these strategies, I recommend you start with your engagement, relationship, and alliance skills. The alliance is our craft. Practice it well. At some point the craft becomes art. Tracking outcome and the alliance enables your proactive efforts to improve without: guesswork; leaving your growth to chance; or, waiting for the platitudes about experience being the best teacher to manifest.

Second, treasure the clients who do not respond to your therapeutic 'business as usual'. Clients provide the opportunity for constant learning, but tracking outcomes takes the notion that 'the client is the best teacher' to a more immediately practical level. Tracking outcomes with clients not only focuses us more precisely on the here-and-now of sessions, it provides an 'in vivo' training ground to expand our theoretical and technical repertoires. From our openness to client reactions and reflections, and our authentic search for new possibilities, we step out of our comfort zone and do things we have never done before. Tracking outcomes enables your clients—especially those who are not responding well to your 'usual fare'—to teach you how to work better.

Finally, I will outline the lessons I learned from my first client in my initial placement in graduate school at a state hospital which, in many ways, charted my course as a therapist.

The case of Tina

Tina was like a lot of the clients: young, poor, disenfranchised, heavily medicated, and in the revolving door of hospitalisations—and at the ripe old age of 22, she was called a 'chronic schizophrenic'. I gathered up my *Weschler Adult Intelligence Scale-Revised*, the first battery of tests I was attempting to gain competence with, and was on my merry but nervous way to the assessment office, a stark, run-down room in a long-past-its-prime, barrack-style building that reeked of cleaning fluids overused to cover up some other worse smell, the institutional stench. But on the way I couldn't help but notice all the looks I was getting—a smirk from an orderly, a wink from a nurse, and funny-looking smiles from nearly everyone else. My curiosity piqued, I was just about to ask what was going on when the chief psychologist put his hand on my shoulder and said, *"Barry, you might want to leave the door open"*.

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

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

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"Sure", and put her clothes back on. And although Tina struggled with the testing and clearly was not enjoying herself, she completed it.

I was so genuinely appreciative of Tina's help that I told her she really pulled me through my first real assessment. She smiled proudly, and ultimately smiled at me every time she saw me from then on. I wound up getting to know Tina pretty well and often reminded her how she helped me, which she enjoyed immensely. The more I got to know Tina and realised that her actions, stemming from horrific abuse, were attempts to take control of situations in which she felt powerless, the angrier I became about her being used as a rite of passage for the psychology trainees—a practice that I stopped.

I will never forget the lessons Tina taught me in the beginning of my psychotherapy journey: authenticity matters and, when in doubt or in need of help, ask the client because you are in this thing together.

In retrospect, Tina's lessons were a precursor for the development of PCOMS. Client feedback enables a transparent process that solicits the client's help in ensuring a positive outcome. An inspection of Figure 1 shows that feedback overlaps and affects all the factors—it is the tie that binds them together. Soliciting feedback engages clients in the collaborative monitoring of outcome, heightens hope for improvement, fits client preferences, maximises the alliance potential and client participation, and is itself a core feature of therapeutic change.

Wherever you are, Tina thanks for charting my course toward the power of real partnerships with clients.

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