

## RESEARCH INTO PRACTICE

### How and Why Some Therapists Are Better Than Others: Empirical Evidence and Clinical Applications from a Christian Perspective

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There has been a recent resurgence of interest in and attention to therapist factors, as well as client and relationship variables related to effective counseling and psychotherapy, with technique or specific treatment variables receiving more critical scrutiny (e.g., Castonguay & Hill, 2017; Norcross, 2011; but see also Nathan & Gorman, 2015). Based on empirical research as well as the opinions of expert or master therapists, the emphasis has emerged again on the critical importance of therapist factors for producing positive client outcomes in counseling and psychotherapy (e.g., see Kottler & Carlson, 2014). It has been repeatedly pointed out that techniques or specific treatments account for only a small variance of therapeutic outcomes, with larger variances found for client variables and relationship as well as therapist variables (Elkins, 2015; see also Baldwin & Imel, 2013; Duncan, Miller, Wampold, & Hubble, 2010; Lambert, 2013).

The present article will briefly review and summarize the latest empirical research on therapist effects in particular, as published in a recent and important book, *How and Why Are Some Therapists Better Than Others?* Understanding Therapist Effects edited by Castonguay and Hill (2017). The article will also provide a Christian perspective.

With regard to therapist effects in the process and outcome of counseling and psychotherapy, the empirical research has shown that some therapists produce excellent therapeutic outcomes with their clients, while others have poor or mediocre client outcomes. How and why some therapists are

better than others, focusing on understanding therapist effects, are topics covered in 15 key chapters in Castonguay and Hill (2017). Two more chapters at the end provide implications of therapist effects for routine practice, policy, and training, and an integrated summary and conclusions on therapist effects.

Barkham, Lutz, Lambert, and Saxon (2017) provide the following definition or description of therapist effects: "The term *therapist effects* encompasses conceptual, clinical, and statistical phenomena that refer to 'the contribution that can be attributed to therapists when evaluating the efficacy of a psychological intervention' (Lutz & Barkham, 2015, pg. 1)...Therapist effects refer to the contribution made to the outcome variance that can be apportioned to therapists rather than to other variables, primarily the client." (pg. 14).

### Therapist Effects: Integrated Summary and Conclusions

Hill and Castonguay (2017) in the final chapter 17 of their edited book (Castonguay & Hill, 2017) provided a very helpful integrated summary of the 15 key chapters and some conclusions, which I will briefly review (see pp.328-329, 332-336):

### Therapist Effects: Empirical Evidence

1. About 5% to 8% of client outcome variance can be explained by therapist effects, more so in naturalistic studies than in randomized or controlled clinical trials. About 15% to 20% of therapists seem to be more effective, and 15% to 20% of other therapists to be less effective. Therapist effects appear to be more significant with more highly disturbed clients. **Clinical implications** include attending to therapist effects early in treatment (to predict dropout and rapid therapeutic change), providing outcome monitoring and feedback (to facilitate therapeutic progress and reduce deterioration), and learning from the work of exceptional therapists.
2. The following four variables in particular have received empirical support for explaining therapist effects: strong evidence for therapists' ability to form a positive therapeutic alliance with clients, and more limited

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evidence for therapists' facilitative interpersonal skills, professional self-doubt, and engagement in deliberative practice of therapy skills outside of treatment sessions with clients. Several other variables have not been found to be related to therapist effects (e.g., demographics such as age and gender, self-reported interpersonal skills, theoretical orientation, therapist experience, adherence to a treatment manual or protocol, and rated therapist competence in executing a specific treatment). **Clinical implications** include therapists trying to become better at developing, maintaining, and repairing the therapeutic alliance with clients; using and improving their verbal and emotional expressiveness, warmth and empathy, motivational skills of persuasiveness and hopefulness, and problem focus; having a sense or stance of humility about their ability to help their clients; and taking time to improve in their therapeutic work by reflecting on tough cases and sessions and attending training seminars and workshops.

3. We still know little about why some therapists are better than others and why some therapists do well with some clients and not others. Diverse outcome domains such as treating depression and substance abuse should also be studied for possible different therapist effects. However, empirical support has been found for amount of deliberative practice as an individual characteristic of the therapist, and the therapeutic alliance as a characteristic present in therapy sessions, as significant determinants of therapist effects. **Clinical implications** include the need for therapists to be involved in deliberate practice outside of therapy sessions, and to work on enhancing the therapeutic alliance with their clients to provide more effective therapy.

### Factors Potentially Explaining Therapist Effects

4. The therapist's ability to be flexibly and appropriately responsive to clients' needs at a particular time may be a significant part of therapist effects. **Clinical implications** include the need for therapists to be sensitive and flexible in appropriately responding to clients' needs moment-to-moment, adjusting the choice, dose, style of implementation and timing of their clinical interventions with particular clients.

5. More effective therapists may be more present with their clients, with higher levels of awareness of their own experience and their client's experience in session, and deeper levels of empathy than less effective therapists. **Clinical implications** include the need for therapists to be aware of factors that can hinder their being more fully present with their clients in the here-and-now of the therapy session (e.g., preoccupation, distractions, intellectualization, anxiety), and to use appropriate strategies to help them focus and maintain attention to both internal and interpersonal experiences taking place in the therapy session (e.g., by self-observation, mindfulness and intentionality, meditation, management of counter-transference and anxiety, enhancing one's own mental health).
6. Therapist effects are partly due to therapists' ability to be aware of, modulate, and constructively use their internal experience (feelings and thoughts) in a therapy session to facilitate clients' therapeutic change. **Clinical implications** include the need for therapists to effectively communicate empathy, prizing, and genuineness to their clients; appropriately manage and use both negative and positive reactions to the client to further understand them and their relationships with others; and to manage their own counter-transference well.
7. Therapist effects are also related to therapists' attachment styles. Therapist secure attachment is related to positive therapeutic alliance with the client, whereas therapist insecure attachment is linked with negative therapeutic process. Therapist secure attachment is also associated with positive outcomes with highly disturbed or impaired clients. **Clinical implications** include the need for therapists to be more aware of their own attachment patterns as well as the attachment patterns of their clients, and to use this awareness to help their clients and themselves to avoid or change negative and maladaptive ways of managing feelings and interacting with others.
8. More effective therapists are usually more competent in providing technical, relational, conceptual, and cultural skills in sessions with their clients, particularly helping and facilitative interpersonal skills such as empathy, fostering a good therapeutic alliance,

and interventions for increasing hope, insight, expectation, and behavioral changes. However, relationship variables (e.g., quality of alliance), client variables (e.g., degree of involvement with the therapeutic process), and therapist variables (e.g., allegiance, hostility that is internalized) all affect the eventual therapeutic outcome.

**Clinical implications** include the need for therapists to develop their technical, relational, conceptual, and cultural skills and to use them in a sensitive and empathic way with particular clients, using a good case formulation with each client, and to attend to clients' responses or reactions in session in order to better decide to continue or stop using specific skills or interventions.

9. Some therapists are better than others partly because they are able to work well with diverse clients from a wide range of cultures, and they effectively and sensitively address cultural issues in therapy. **Clinical implications** include the need for therapists to have humility and openness with clients from diverse cultures and backgrounds (irrespective of ethnicity, race, gender, age, religion, sexual orientation, or disability status) with appropriate sensitivity in dealing with cultural issues, and avoiding or repairing cultural microaggressions.
10. More effective therapists seem to better manage the experience of negative emotional reactions they may have (e.g., anger, frustration) toward clients, being able to contain them and constructively use them to help their clients become more aware of their maladaptive interpersonal patterns and to modify them. **Clinical implications** include the need for therapists to be aware of their own negative emotional reactions to their clients and to appropriately manage or contain them, and even use them to help their clients become more aware of how they may trigger negative reactions in others in their lives and how to modify maladaptive interpersonal behaviors.
11. More effective therapists may be engaging in similar processes that have been observed in experts or top performers in other domains such as music, sports, and chess. These observed processes include: automatization of basic skills, superior abilities in complex skills (e.g., information processing and appropriate responses to

complex situations), deliberate and repeated practice of these complex skills over the long haul, and use of feedback to develop these complex skills. **Clinical implications** include the need for therapists to engage in deliberate practice of essential therapy skills over years of practice and training, and to obtain feedback from trainers and supervisors, and also from clients themselves.

12. Some therapists are more effective than others partly because they practice in flexible and creative ways, much like artists do. **Clinical implications** include therapists developing a creative sensibility that enables them to openly work with various aspects of their clients' lives, needs, and ways of expressing themselves and communicating. Such creative sensibility can be enhanced in therapists if they get involved in artistic activities and exposed to artistic work.
13. Therapist effects in psychodynamic therapy for depression may be partly due to the use of relationship-oriented interventions. **Clinical implications** include the need for psychodynamic therapists to focus on the interpersonal functioning of clients both inside and outside therapy, and helping clients to more clearly see how their difficulties in social relationships may be contributing to their problems.
14. Therapist outcome differences in the treatment of generalized anxiety disorder may be partly due to how much therapists facilitate client activation of the change mechanisms specific to a theoretical approach being used (e.g., cognitive-behavioral and interpersonal/emotion-focused therapies). Less effective therapists may not be as involved in helping clients to engage in targeted mechanisms of change, or may interfere with such engagement, or even intervene in ways that are contrary to the change mechanisms targeted by the treatment. **Clinical implications** include the need for therapists to be aware of how their actions are facilitating or hindering clients' engagement in mechanisms of change targeted by the specific intervention they are using with their clients. Therapists should also correct any relational or technical mistakes that may be getting in the way of positive therapeutic process or progress.
15. Therapist effects may be partly due to their use of humor in a sensitive way that is

responsive to the client's needs and view of humor, and that is also consistent with the personality of the therapist. **Clinical implications** include therapists learning to use humor if they are comfortable with this, and if the client values humor, in the context of a good and strong therapeutic relationship, in response to the client discussing or manifesting problems or symptoms. The sensitive and appropriate use of humor can help reduce clients' anxiety, deepen the therapeutic bond, and enable clients to adopt new perspectives. However, humor can be misused if clients feel misunderstood, confused, or uncared for, in the context of an already weak therapeutic relationship, and therefore can lead to greater distress in the client.

In addition to the clinical implications of therapist effects already mentioned, Hill and Castonguay (2017) also emphasized the need for and usefulness of routine outcomes monitoring data to help determine more consistent and specific therapist-level characteristics as well as behaviors responsible for differential between-therapists effectiveness (pp. 337-338), with implications for mental health practice and the training of clinicians and therapists. Prescott, Maeschalck, and Miller (2017) have recently edited a helpful book on feedback-informed treatment in clinical practice that focuses on how clinicians can gather such real-time input or feedback from clients through structured but flexible measures (e.g. the Outcome Rating Scale and the Session Rating Scale) that identify what is working and what is not working in therapy and how to more effectively meet the needs of clients (see also Lambert, 2010). Hill and Castonguay concluded: "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" (p. 340).

More recently, Erikson, Janis, Bailey, Cattani and Pedersen (2017) found that therapists at higher levels of training, including becoming licensed to practice, showed the same amount or less change in client distress compared to when they were at earlier levels of training.

Furthermore, the rate of change in clients either remained the same across different levels of training or slightly slowed. Training itself may therefore not be a significant factor in therapist effectiveness. In another more recent study, Zuroff et al. (2017) reported that differences in therapist effectiveness in therapists practicing interpersonal therapy for depression are partly explained by therapists' capacity to elicit and maintain autonomous motivation in their clients by providing high levels of warmth in the therapeutic relationship.

### On Being a Master Therapist

In another helpful book focusing on being a master therapist or exceptional and excellent practitioners (and not just good or competent), Kottler and Carlson (2014) provided several characteristics and behaviors of such master therapists or extraordinary practitioners, based on both empirical research findings as well as interviews with 77 master therapists, including a few healers from other spiritual and indigenous traditions outside of contemporary Western psychotherapy. They first reviewed what we know or think we know about excellence in the practice of therapy based on empirical evidence obtained through research studies in the following areas: what clients bring to the table, personal attributes of the therapist, the importance of knowing stuff, it's the relationship, and wondering what things mean (see pp. 25-34). Then, based on their interviews with the master therapists, they listed the following as what famous therapists appear to have in common: they aspire to greatness; they work harder than others; failures and mistakes provide valuable feedback to improve performance; passion reigns supreme (they love their work); flexibility and innovation define their thinking and their work; they found their own voice; their ideas evolved over time, followed by their developing practice; and their clients were their best teachers (pp. 38-44).

Kottler and Carlson (2014) also listed the following as important facets of mastery: deep compassion and caring; sophisticated interpersonal skills; remaining fully present in therapeutic encounters; having a high level of domain and subdomain-specific knowledge; being clear-headed and honest with clients; being honest with oneself in acknowledging mistakes; processing feedback; and who we are as human beings is just as critical (p. xi).

They discussed the following attributes of excellence in clinical practice: responsiveness to cultural and individual differences of our clients but also a deep understanding of commonalities that connect all human experience; expression of non-demanding, platonic *love* that is the very essence of what we do as therapists; producing consistent and reliable positive outcomes in therapy, but going beyond what is known with an exceptional level of originality and creativity as deep thinkers and innovators; feeling a commitment to something much greater than only their clients, and therefore getting actively involved in advocacy both locally and globally; and realizing that we all fall short of mastery no matter how much effort we put in, and accepting we are all “works in progress,” simply doing the best that we can (pp. xi-xii).

Kottler and Carlson (2014) have focused on being a master therapist or extraordinary practitioner, and in so doing are also emphasizing the importance and value of psychotherapy and counseling as a human and humane, loving endeavor. Elkins (2015) has similarly described the human elements of psychotherapy in a nonmedical model of emotional healing that puts common factors, especially human factors at the center and techniques or modalities at the periphery of helping and healing relationships. Woolfolk (2015) has also strongly advocated for the value of psychotherapy as the talking cure in an age of clinical science that tends to overemphasize technique.

### **A Christian Perspective on Therapist Effects and Being a Master Therapist**

It is interesting that Kottler and Carlson (2014) asserted that non-demanding, platonic love is the very essence of what we do as therapists in psychotherapy. From a biblical perspective, it is agape love, God's divine love that is even deeper and more complete (1 Cor. 13), that fills us and moves us. By the power and presence of the Holy Spirit who produces the fruit of agape love (Gal. 5:22, 23), we are called to genuinely care for our clients and to love God and our neighbor as ourselves (Mark 12: 30, 31). Technique, while important, especially in the treatment of some disorders (e.g., behavioral and cognitive methods for treating panic, phobias, compulsions, childhood aggression and psychotic behaviors; Lambert, 2013, pp. 205-206), is not the

most crucial factor influencing therapeutic outcomes. Other factors like client factors and relationship factors, or common factors, may be more important. The emphasis on therapist effects and the person of the therapist resonates with the biblical emphasis on character or personhood in Christ, becoming more like him (Rom. 8:29). However, qualities like humility, healthy and holy brokenness, weakness, and servanthood are also emphasized in Scripture (see Tan, 2006). We need therefore to be careful of an unsanctified ambition or aspiration to be great, or to be a great therapist or master therapist, who consistently excels and outshines other “lesser” therapists. While God wants us to do our best in whatever endeavor or work we are called to (Col. 3:23), so God is glorified (1 Cor. 10:31), we should not confuse this with a prideful superiority type of striving to be great or “perfect” or even “excellent.” Jeremiah 45:5 warns us to not seek great things for ourselves.

We can learn from therapists who consistently do better than other therapists or from so-called master therapists, but we need to be careful about simplistically embracing all of their characteristics or behaviors, especially the one about aspiring to greatness. From a Christian, biblical perspective, we follow Jesus and learn to humbly and lovingly become more like him, and to serve him and others with agape love and humility. His grace is sufficient for us and his power or strength is made perfect in our weakness and brokenness (2 Cor. 12: 9, 10). Ultimately, it is the Holy Spirit who transforms and empowers us, with his spiritual gifts, to effectively minister to others as therapists in helping and healing relationships with our clients, based on agape love and truth (see Tan, 2011, pp. 363-367).

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