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Answering the Call: Qualitative Analysis of an Exceptional Therapist

Lourenço Saud Moniz Botelho

Orientador de Dissertação:

Professor Doutor Daniel Cunha Monteiro de Sousa

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Abstract

Objective: Psychotherapy, when delivered in the form of virtually any bona fide psychotherapeutic treatment, is effective (Lambert, 2013). However, there are still significant challenges to psychotherapeutic effectiveness and no measurable improvement in the effectiveness of psychotherapy has occurred in the last 30 years (Wampold & Imel, 2015). Superior outcome studies adopt the premiss that, in order to understand the processes that lead to better psychotherapeutic results, it is necessary to study therapists with superior outcomes (Hansen, Lambert & Vlass, 2015a). However, there is little investigation regarding the process that leads to the existence of therapists with superior outcomes and what characterizes their therapeutic approach (Tracey et al., 2014; Chow et al., 2015). Therefore, the aim of this investigation is to detail the clinical way of being and in-session approach of a therapist with superior outcomes.

Method: An exceptional therapist with superior outcomes as presented in the *Outcome Questionnaire 45* (Lambert, Burlingame, et al., 1996; Umphress, Lambert, Smart, Barlow, & Clouse, 1997) was selected, and three of her patient's full treatments, consisting of two sessions of two patients and one session of another patient, were transcribed and subsequently qualitatively analysed using the grounded theory approach (Glaser & Strauss, 1965).

Results: Two core categories composed of three sub-categories for the former and 4 sub-categories for the later were found. The categories were developed in light of the therapeutic actions that best supported each other and the therapist's overall approach. The therapist was found to carry out therapeutic actions that allow for a consistent approach that is both unique to herself and adaptable to each patient.

Conclusions: This exceptional therapist's approach is composed by a combination of her intuitive, empathetic, and genuine nature, theoretical orientation, and balanced use of techniques.

Keywords: Master therapists; Therapeutic Expertise; Superior Outcomes; Supershrink; Grounded Theory

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Introduction

The matter of psychotherapy's legitimacy has been around since the beginning stages of its practice (Scott, 1909). We currently know that not only is psychotherapy effective, but all bona fide therapies are equally efficacious (Smith & Glass, 1977; Wampold et al., 1997; Wampold, 2001; Benish, Imel & Wampold, 2007; Miller, Wampold & Varhely, 2008; Wampold, Miller & Fleming, 2009; Lambert, 2013). If psychotherapy is indeed effective and all bona fide therapies have earned their legitimacy, what might be at the basis of psychological treatment?

Following Rosenweig's (1936) dodo bird effect which stated that benefits from therapy accrue from factors common to diverse methods of psychotherapy, Wampold and Imel (2015) suggested an evidence-based model that would conceptualize the transversal mechanisms to any therapeutic process. The authors called it the Contextual Model. The basic premise is that the benefits of psychotherapy accrue through social processes and that the relationship is the bedrock of psychotherapeutic effectiveness (Wampold & Imel, 2015). For the Contextual Model, the therapist is key because it is recognized that how the treatment is delivered is critical to the success of therapy (Wampold & Imel, 2015).

Having established the effectiveness of all therapies and a credible model for this fact, we must also come to terms with a sobering truth: *No measurable improvement in the effectiveness of psychotherapy has occurred in the last 30 years* (Miller, Hubble & Duncan, 2008; Wampold & Imel, 2015). What does seem to improve is therapist's confidence in their abilities (Miller et al., 2007). Some studies have shown that the least effective therapists believe they are as good as the most effective and that average clinicians overestimate their outcomes in the order of 65% (Chow, 2014; Hiatt & Hargrave, 1995; Walfish, McAlister, O'Donnell, & Lambert, 2012). Before delving more deeply into this, let us first consider what other challenges we've yet to overcome:

- The Dropout rates. A metanalysis by Swift and Greenberg (2012) composed of 669 studies revealed a dropout rate of 19.2%, which translates to one in every five clients abandoning treatment with no significant therapeutic gains.
- The negative effects of therapy. A significant number of patients conclude therapy in a state worse than that with which they initiated it (Barlow, 2010).
- Therapists seem to consistently overestimate their efficacy. A study by Walfish, McAlister, O' Donnell and Lambert (2012) revealed that out of 129 mental health specialists, 25%

believed to be in the 90th percentile of efficacy and none evaluated him/herself below average.

- The average therapist is ineffective in recognizing clients in clinical deterioration (Hatfield, McCullough, Frantz & Krieger, 2009) and evaluating the state of the therapeutic relationship (Haartman, Joos, Orlinsky & Zeek, 2014).

As it seems, the common denominator in the contextual model as well as most of the challenges we now face seem to be factors related to the therapist him/herself, also known as therapist effects. Johns et al., (2019), define the therapist effect as the total outcome variance attributable to the variability between therapists. To measure therapist effects is, in some regard, an attempt to answer the question of how important the person of the therapist truly is, in terms of therapeutic outcome. Intuitive as it may seem, this question has been subjected to relatively little investigation. Beutler (1997) has even named therapist effects "the neglected variable".

The existing studies posit therapist effects as ranging from 3% to 7%, with most resulting in 5%. This number becomes considerably more important when compared to the 1% variance attributable to treatment differences (Wampold & Imel, 2015). In other words, *who* delivers the treatment is far more important than *what* treatment is being delivered. We also know that clients seen by the most effective therapists show three times as much change as other clients (Brown, Lambert, Jones & Minami., 2005) and improve at a rate at least 50% higher and drop out at a rate at least 50% lower than those of average clients (Miller, Hubble & Duncan, 2007). Okiishi et al (2003) note that therapists whose clients showed the fastest rate of improvement had an average rate of change 10 times greater than the mean of the sample. These results are in line with Castonguay and Hill's (2017) conclusion that 15% to 20% of therapists have discernibly better outcomes and 15% to 20% have discernibly worse outcomes. In short, some clinicians are markedly better than others.

As Castonguay and Hill (2017) have asserted "…to help build a more accurate science of the psychological therapies, we need to have a greater understanding of the phenomenon of variability and how it affects therapists and the outcomes of their clients in therapy". However, we seem to know more about what doesn't account for this fact than what does:

- The difference in outcome is not related to age, sex, or therapeutic orientation (Brown, et al., 2006; Wampold & Brown, 2005; Anderson et al., 2009).

- Many therapists seem to not have their efficacy improve with years of experience, and some might even see their efficacy slightly decline over time (Brown, Lambert, Jones & Minami, 2005).
- Professional therapists and therapists that are in training/supervision frequently reach similar clinical results (Nyman, Nafziger & Smith, 2010; Budge et al., 2012).
- The use of and adhesion to manualized interventions does not dissipate the differences in clinical effectiveness between therapists (Webb, DeRubeis, Barber, 2010; Owen, 2014).

What is even more worrisome is concluding that, when it comes to improving outcomes, the time, money, and effort spent by millions of therapists worldwide has apparently no palpable effect at a statistical level (Miller, Hubble & Chow, 2017). Clinicians do not necessarily improve with time, training, and experience. How then, might therapists be provided with specific ways with which to improve their effectiveness? One field of investigation that attempts to answer this question is the study of therapists with superior outcomes, that is, who they are, what they do and how they do it (Erickson et al., 2006; Chow et al., 2015).

Therapists with superior outcomes have also been referred to as “supershrinks” or “master therapists”. However, superior outcomes is not the only way to define an exceptional therapist and there is still considerable debate over the definition of an expert therapist. Depending on the author, expertise may be understood in terms of (a) reputation, degree attainment, professional distinction, and experience, (b) skill, competence, or adherence to a prescribed standard of performance, (d) clinical accuracy, or (d) outcomes, that is, success with clients (Tracey, Wampold, Goodyear & Lichtenberg., 2015). There are various benefits and limitations for each definition (Tracey, Wampold, Goodyear & Lichtenberg., 2015; Hill et al., 2017; Reese, 2017). For its practicality, mensurable nature and flexibility regarding individual therapeutic style, Goodyear et al (2017) seem to have the most apt definition, stating that: “Experts are those for whom there is evidence of improvement over time and who demonstrate superior performance as measured by something that is both agreed on and important, specifically client outcomes”. An understandable critique of studying master therapists whose title was derived from outcomes is that outcomes facilitated by a therapist will encompass not only those actions that are observable in the therapy room but also those qualities that are embodied in the person of the therapist (Jennings & Skovholt, 2016). However, another considerable advantage to this definition is that it provides a solution for the

previously mentioned challenge that many therapists think themselves as having superior results than they truly do. Defining expert therapists in terms of client outcome also allows investigators to more effectively find and study expert therapists and extrapolate conclusions from their superior results, thereby further understanding the processes that lead to therapeutic improvement (Hansen, Lambert & Vlass, 2015a).

However, it is still unclear what is the making of master therapists. In fact, many so called expert therapists do not even know exactly what makes them exceptionally effective (Miller, Hubble & Duncan., 2007). These authors would later come to suggest three key components for expertise, working together to form the "cycle of excellence": determining bassline level of effectiveness; obtaining systematic, ongoing, formal feedback (which can enhance performance by as much as 65%) and engaging in deliberate practice (Miller, Hubble, Chow & Seidel, 2013). Miller, Hubble and Duncan (2007) have attributed special importance to the act of following up on feedback, as expert physicians seem to "need to know whether they were right" even when there is no extrinsic motivation (often monetary compensation) to do so.

Experts do seem to be the hardest and smartest workers. As Chow et al. (2015) have found, the most effective 25% of therapists spent, on average, 2.8 times more hours per week engaged in deliberate practice activities. This is in line with Ericsson and Lehmann's (1996) assertion that expertise is more closely attributable to training than raw talent.

One of the most surprising findings is that a major difference between "master" and median therapists is that the former are more likely to ask for and receive *negative feedback* about the quality of their work and their contribution to the alliance. Quite surprisingly, the best clinicians consistently achieve lower scores on standardized alliance scores at the onset of therapy, which allows them to address potential problems in the therapeutic relationship, whereas median therapists might only find these problems later when the risk of dropout is greater (Miller, Hubble & Duncan., 2007).

Caspar (2017) states that experience is required to acquire expertise, but experience does not equal nor does itself lead to expertise. The author theorizes that the mastery of skills is important as it free resources needed for expert information processing and, applying this concept to psychotherapy, asserts that experienced therapists will process information more intuitively than novices, without sacrificing rational thinking.

Focusing their research on therapeutic actions withing the therapeutic setting, Sperry and Carlson (2014) asserted that what differentiates master therapists from others is their ability to enhance the therapeutic alliance, enhance positive expectations and client motivation, increase client awareness, facilitate corrective experiences, identify patterns, and focus treatment. Master therapists then facilitate first, second and third order change. The authors also mention that, for master therapists, the first session is the most important. Whereas most therapists will follow a structured questioning focused format, "master therapists" focus on developing a deep connection and understanding of the client as well as effecting some level of change during the first session (Sperry & Carlson, 2014).

As "supershrink" studies find several factors that seem to be correlated with exceptional therapists, one potential way to deepen our understanding could be learning from comparative case studies. Werbart, Annevall and Hillblom (2019) had an interesting study design comparing three successful therapies to three unsuccessful ones. Their findings were that, in successful therapies, both patient and therapist had an early common understanding of presenting problems and what could be helpful; therapists experienced good comprehension of the patient's difficulties early on, and presented, from the beginning, a clear picture of their ways of being. Successful therapists also described an early staging of the patients' problems, which together they could work on, and focused on patient's fears and expectations. These therapists also fostered a confident, supportive, collaborative, and challenging therapeutic relationship. Also of great interest is that in all successful cases, therapists provided a clear picture of their therapeutic work.

Several master therapist studies seem to be derived from peer nominated criteria and many of which have been developed by Jennings and Skovholt (2016), who sought to comprise master therapist studies from around the world. An interesting Canadian study comprised of 9 participants (three men and six women) were all practicing psychotherapists and acknowledged by peers as masters of couples therapy. The number of years they had practiced ranged from 16 to 38 years, with a mean of 25 years of practice. The goal of the qualitative study was to inductively examine the characteristics of therapists acknowledged to be masters of couples therapy. The themes that emerged were derived from both from the perspective of the master couple therapists and from the perspective of the therapists who nominated them. Participants described a remarkable level of commitment in three main areas related to their practice: a commitment to personal development and self (these therapists were actively engaged in maintaining their emotional health and openly

embraced experiences that enhanced their own growth and self-awareness), a commitment to professional development (one particular therapists, when asked to describe characteristics of a less effective therapist, responded “someone who was not willing to go the extra mile in terms of developing themselves”) and commitment to relationships (participants have a deep awareness for the unique aspects of the alliance in couple therapy and tailor their interventions accordingly and display personal qualities that appear to facilitate the development of strong relationships). Participants also revealed that their own previous experiences (both general life experiences and previous professional experiences) impact their current practice (Jennings & Skovholt, 2016). It would be interesting to find if these areas found in couples therapy would be transversal to other therapeutic approaches.

Another study done by Jennings and Skovholt (2016) sought to detail the personal characteristics and therapy practices of expert psychotherapists practicing in Singapore. The master therapists (5 men, 4 women) ranged in age from 40 to 59 years ($M = 50.56$ years, $SD = 6.19$). Their number of years practicing psychotherapy ranged from 10 to 34 years ($M = 18.44$ years, $SD = 7.06$). The interview data indicated that Singaporean master therapists possess numerous characteristics in the following four categories: Personal Characteristics (empathy, non-judgement, respectful); Developmental Influences (experience, self-awareness, humility, self-doubt); Approach to Practice (balance between support and challenge, flexible therapeutic stance, empowerment based approach, primacy of the therapeutic alliance, comfortable addressing spirituality, embraces working in a multicultural context); and Ongoing Professional Growth (professional development practices, benefits of teaching others).

Peer nominated studies, however, have a disadvantage best described by (Hill et al., 2017): “We often have information about therapists based on our experiences with them as supervisors, friends, and colleagues, but we have no empirical evidence about the similarity in their behaviour across personal and clinical interactions.” In this regard, outcome studies have the added benefit of empirically quantifying standardized and statistically grounded therapeutic results.

Current investigation on this field, perhaps due to its limited amount, is yet to reach a consensus. Clearly, if such consensus is at all possible to be found, more in depth “supershrink” studies are necessary (Hansen, Lambert & Vlass, 2015b). And these studies hold great value. As Miller, Hubble and Duncan (2007) have highlighted, should “supershrink” talents prove transferable, the implications for training, certification and service delivery would be staggering.

One phenomenon that has been associated with “supershrinks”, found within the large variety of individual responses to treatment is that of “sudden gains” (Hansen, Lambert & Vlass, 2015a). Several methods have been employed to measure this phenomenon, such as the therapist’s rating that the client had little to no psychopathology by the end of the second session (Stewart et al., 1998), finding a 50% improvement over two sessions (Beckham, 1989; Renaud, Axelson & Birmaher, 1999) or in terms of the most extreme 10% of client sessions (Finch, Lambert & Schaalje, 2001). Though this phenomenon seems slightly mysterious, it is by no means rare. Studies on this matter report 39% to 50% (Tang and DeRubeis, 1999a; Gaynor et al., 2003; Hardy et al., 2005) of patients meeting the criteria for sudden gains and as much as 50% to 65% of total change happening during sudden gains periods (Gaynor et al., 2003; Hardy et al., 2005). Finally, patients who experience sudden gains tend to maintain their treatment responses when measured during follow up periods (Gaynor et al., 2003; Hardy et al., 2005). Keeping in mind the sobering fact that no therapeutic improvement has been proven in the last 30 years, phenomena such as sudden gains may be precisely the kind of paradigm shift capable of stimulating further scientific development.

Within the field of sudden gains and out of the few existing “supershrink” studies, Hansen, Lambert and Vlass’s (2015a) published one of the most recent and complete studies available. In it, Erigoni Vlass (or Eri, as the psychotherapist was referred to in said study) was titled as a “supershrink” after a full year (2009-2010) of her clients was analysed in the Outcome Questionnaire 45 (Lambert, Burlingame, et al., 1996; Umphress, Lambert, Smart, Barlow, & Clouse, 1997). In short, the OQ-45 is a measure of mental health functioning, which has been found to have adequate psychometric properties (Lambert et al., 2011). The OQ-45 is able to detect true changes in psychopathology, in that multiple items change when individuals receive treatment, and these items tend to remain constant without treatment (Vermeersch, Lambert, & Burlingame, 2000).

In Lambert and Vlass’s (2015a) study, out of Eri’s 248 clients, 85 were found to have completed three or more sessions of therapy. Of these 85, 43 (51%) were found to have experienced sudden gains (blue cases), and 6 (7%) experienced sudden losses (red cases). Thus, Eri had over five times the expected rate of sudden gains in her caseload, and about a third less of the expected rate of sudden losses—in sum, her results for sudden gains and sudden losses were statistically exceptional and she could be characterized as a "supershrink." In terms of Eri’s overall

caseload (N=248), her status of "supershrink" is again confirmed, with over 4.3 times the number of clients in the top 10% of response, and only 0.70 times the number of clients expected in the bottom 10% of response.

Having chosen five blue and five red cases, with a clinical cut-off point on the OQ-45 of 63/64, the average intake for blue cases was 111.4, which is "extremely high" at the 99.7th percentile, and an average "still quite high" 92 for red cases, in the 98.6th percentile. For post treatment, Blues had a "statistically significant" drop of 73.8 points into the non-clinical domain and the Reds a non-significant 8.4 points to 83.6, which is still in the clinical domain. Between their final session and a two year follow up, both blue and red cases remained, on average, at a similar level of distress, suggesting stable long term therapy effects (Hansen, Lambert & Vlass, 2015a). Four out of five blue cases achieved their sudden gains in session 2, with the last patient having such gains in session 4. To explain such results, the authors present the following explanation: "The client descriptions of their therapeutic relationship with Eri portray a therapist with charisma, with the ability to make a strong, immediate connection, with a clear and persuasive plan for change based on both medical and psychological principles, and with an expectation of quick change. In line with this, her techniques are designed to empower clients to find their own solutions, and her pragmatic approach does not require lengthy treatment. Thus, Eri provides her clients a holistic, top-down view of their psychopathology within the first session, so that they have a working rubric to organize their symptoms and seek to find solutions in a timely period." (Hansen, Lambert & Vlass, 2015a).

Hansen, Lambert and Vlass (2015a) have presented us with a greatly detailed investigation of a "supershrink", with the admitted limitations of having a small sample size, the possibility of conflating correlation and causation and the retrospective nature of the study. Though a direct causation could not be established with such study design, these authors do offer a uniquely practical perspective on therapist expertise. Indeed, this study dives deep in the uncharted waters of "supershrinkdom". After this publishment, the authors subsequently published a following article titled "Calling for More Case Studies of Exceptional and Efficient Psychotherapists" wherein they answer to some constructive criticism (see Laska & Federman, 2015; Pereira & Barkham, 2015) and state that they hope this work has sparked the curiosity of other researchers and that they are able to build upon it (Hansen, Lambert & Vlass, 2015b.)

Study Objective

In this paper, I intend to answer these authors' call. Having established Erigoni Vlass as a person deserving of the "supershrink" title, capable of effecting great therapeutic change in a short time, and in the spirit of superior outcome investigation, the present study will attempt to dive deeper still, by qualitatively analysing the first and only two sessions and one and only session of three different patients. As demonstrated previously, superior outcomes have been associated with deliberate practice, feedback mechanisms and several therapist factors, but it is still not clear how they contribute and what is the process that allows for the existence of a therapist with superior outcomes. Therefore, it seems necessary that more in-depth studies are carried out to gain further understanding of therapeutic effectiveness in a more concrete sense. Which leads to the investigative question: What clinical way of being and specific actions, carried out in session, characterize a therapist with exceptional outcomes' clinical approach?

Method

Design

In order to explore the fluid, interacting and dynamic nature of a therapeutic treatment, to "see the world from the participant's perspective" and derive the intention and meaning underlying every therapeutic intervention, as well as to closely explore an area not yet thoroughly researched, the chosen method was that of qualitative analysis (Corbin & Strauss, 2015). The specific form of qualitative analysis was Grounded Theory (Glaser & Strauss, 1967).

Grounded theory is a form of qualitative research developed by Glaser and Strauss (1967) for the purpose of constructing theory grounded in data. These authors aimed to move qualitative inquiry beyond descriptive studies into the realm of explanatory theoretical frameworks, thereby providing abstract, conceptual understandings of the studied phenomena (Charmaz, 2006). The procedures can be used to uncover the beliefs and meanings that underlie action, to examine rational as well as nonrational aspects of behaviour, and to demonstrate how logic and emotion combine to influence how persons respond to events or handle problems through action and interaction (Corbin & Strauss, 2015). For the purpose of developing a comprehensive understanding of this therapist's approach, remaining at a descriptive level of analysis would be insufficient. Simply noting what actions were undertaken without also understanding how and why

they were carried out, that is, integrating them into a larger framework of the therapist's overall clinical approach and personality, would not achieve a desirable level of significance.

This method has unique characteristics which fit the nature of this study. First, the concepts out of which the theory is constructed are derived from data collected during the research process and not chosen prior to beginning the research (Corbin & Strauss, 2015). This focus on deriving concepts from the data collected during the research process and not from prior literature was fundamental if the analysis was to remain as true as possible to the therapist's intended purposes and intentions. As such, another defining component of Grounded Theory is constructing the literature review *after* collecting data. I attempted to remain true to this point, to a possible extent.

Secondly, in grounded theory, research analysis and data collection are interrelated. After initial data are collected, the researcher analyses that data, and the concepts derived from the analysis form the basis for the subsequent data collection. Data collection and analysis continue in an ongoing cycle throughout the research process (Corbin & Strauss, 2015). This cyclical nature of Grounded Theory was necessary in order to grow more familiarized with the therapist and grasp the meaning and intention of her therapeutic actions, which had to be derived from an integral perspective that took into account the differences and similarities of the same therapeutic actions applied to different patients. This is known, in Grounded Theory literature, as *constant comparisons*.

In doing constant comparisons, data are broken down into manageable pieces with each piece compared for similarities and differences. Data that are similar in nature (referring to something conceptually similar but not necessarily a repeat of the same action or incident) are grouped together under the same conceptual heading. Through further analysis, concepts are grouped together by the researcher to form categories (sometimes referred to as themes). Each category is developed in terms of its properties and dimensions, and eventually the different categories are integrated around a core category. The core category describes in a few words what the researcher identifies as the major theme of the study. Taken together, the core category and other categories provide the structure of the theory. The properties and dimensions of each category fill in the structure by providing the detail (Corbin & Strauss, 2015). This method of constant comparisons was what allowed the derivation of meaning and intent, in the form of core categories, from descriptive coding of therapeutic actions.

Participants

The therapist whose work was qualitatively analysed in this study is Erigoni Vlass, more specifically, two of Eri's interviews with two patients and one interview of another patient.

Erigoni Vlass, as defined in her website, is a registered Clinical Psychologist with extensive post graduate qualifications and professional experience. Eri has a special interest in treating anxiety and depression in both children and adults and has worked with people who have suffered work injury, post-traumatic stress, cancer and drug and alcohol dependence. Eri has devised and presented courses on attachment and sexuality and is an accredited Positive Parenting facilitator. Eri is a member of the Australian Member of Australian Psychological Society (APS), APS Clinical College, the Australian Association of Cognitive and Behavioural Therapy (AACBT) and Australian Society of Hypnosis.

In a previous study, Eri has also detailed some information regarding herself: *"I am very vigilant with self-care. I maintain a healthy lifestyle exercising every day, eating healthy foods, and getting adequate sleep. I practice mindfulness meditation. During treatment sessions I am very focused on the person I am working with and no matter how difficult the presenting problem or the underlying problem for that matter, I know that I will be able to respond appropriately. I have had extensive clinical experience over the past twenty years working in areas such a post-natal depression, sexual health, child and adolescent anxiety, trauma, drug, and alcohol, eating disorders, bereavement and loss, sleep disorders, anxiety and depression, family therapy and parenting. As a member of the Australian Psychological Society, we are required to complete 30 hours of professional development a year, which means that we attend conferences workshops and engage in peer supervision."* (Hansen, Lambert & Vlass, 2015b).

Vlass's method and approach is described in full in the original study (Hansen, Lambert & Vlass, 2015a). In short, Vlass is an "active problem solver" who is "always open to new possibilities to improve patient outcome while gathering data on the client's response to treatment" and as having "an eclectic, holistic, and highly individualistic approach to the client and the therapy process that begins in the first session. Moreover, she holds at the forefront of her mind the principle that clients are largely in control of their own change processes, and she values this autonomy and independence" (Hansen, Lambert & Vlass, 2015a). Lastly, Vlass combines two complementary theories, that of Cognitive Behavioural Therapy (CBT; Beck, 1993) for identifying and challenging irrational beliefs, and Compassionate Mind Training (CMT; Gilbert & Procter,

2006), an intervention aimed at alleviating high levels of shame and self-criticism (Hansen, Lambert & Vlass, 2015a).

In terms of Unique Therapist Qualities, patients from a previous study have commented on factors related to the therapist's personality and approach that they considered helpful, using adjectives such as "lovely, very welcoming, soothing, compassionate, non-judgemental, open and welcoming" and feeling "ease of connecting", "easy rapport", "comfortable", "understood", "supported" as well as "validation" and "reassurance" (Hansen, Lambert & Vlass, 2015a).

The patients who underwent the therapy sessions which will be analysed were undergoing therapy under a different therapist who is a collaborator of Erigoni Vlass. They were asked if they wanted to receive a short therapeutic intervention by Eri, to which they agreed. These sessions took place in Seattle. Most all information regarding the patients has not been disclosed for confidentiality purposes. Therefore, only a short characterization is possible. All clients are females of working age. Client 1 is originally from China and has been living in Seattle for 6 years. Client 2 is Korean and was adopted and raised by an American family from infancy and Client 3 is American born.

Procedure

For this study I was provided with the recordings and transcripts from two sessions and a single session from the patients mentioned above, respectively. Subsequently, the audio recordings were listened to, in full, and any necessary corrections were made to the initial transcripts. Then, the transcripts were coded and analysed according to the procedures suggested in Grounded Theory, namely that of constant comparisons as described above. The coding was divided into two main phases: an initial phase involving naming each line or segment of data and a second phase where categories were developed at higher abstraction levels (Charmaz, 2006). In the initial phase, the intent was to have the codes be as descriptive as possible to reduce investigative bias. In the second phase, a higher level of abstraction was achieved by identifying the most apparent intent in each therapeutic action and the potential influence of each action in the patient's recovery. An example of this was deriving the abstract category "*Fostering Agency, Collaboration and Developing Resources"* from descriptive codes such as *"Asking client to identify emotions regarding (men admiring her body)"* as this action promotes the patient's agency in the therapeutic process and helps the patient develop resources to better identify her emotions in future situations.

Some codes required two levels of abstraction to develop into a fully comprehensive category. An example of this was having as an initial descriptive code *"Identifying client's behaviour (avoidance) in response to emotion (guilt)"* develop into a more general code *"Identifying Behaviours and Relating them to Life Experiences/Family Members/Symptoms and Complaints"* and finally the abstract category *"Offering a Credible Narrative/Rationale for Suffering/for Improvement".* The coding also relied on the audio recordings and considered full sequences of dialog between therapist and patient, so that the codes would reflect the therapist's intention as accurately as possible.

The final categories were achieved after multiple coding sessions for each transcript with constant comparisons between and within each case, resulting in two main categories and seven sub-categories.

Results

Core Categories	Sub-Categories
1. Keeping a natural, fluid rhythm during the session while balancing directive exploration, frequent associations, and interpretations with a sense of support, empathy and understanding.	1.1 Rhythm and Fluidity
	1.2 Exploration
	1.3 Creating a Safe, Supportive and Understanding Atmosphere
2. Fostering a sense of agency, mutual collaboration and positive expectation while co-constructing a Credible Narrative/Rationale for Suffering/for Improvement to be used in hypnosis.	2.1 Fostering Agency, Collaboration and Developing Resources
	2.2 Fostering Positive Expectation
	2.3 Offering a Credible Rationale for Suffering/for Improvement
	2.4 Hypnosis

Core Category 1: *Keeping a natural, fluid rhythm during the session while balancing directive exploration, frequent associations, and interpretations with a sense of support, empathy and understanding.*

Keeping in mind that each patient has one to two sessions with Eri, it is fundamental that enough meaningful and relevant information is properly collected. Therefore, Eri must direct the session in such a way that the patient addresses meaningful life history as well as several points that will fit Eri's particular therapeutic style of identifying anxiety inducing events, fears, emotions, and subsequent behaviours, which are necessary for the following hypnosis. This is possible due to Eri's directed questions, frequent interpretations and associations and slight interjections which motivate the patients to further their speech. Concurrently, Eri allows the patient enough freedom to navigate their own self-exploration while providing subtle cues to keep the patient focused on what seems most relevant as well as a constant and genuine reassurance, empathy, and support.

1.1 **Rhythm and Fluidity:** This code refers to actions undertaken by Eri to maintain fluidity and directiveness in the session, which allow for rapid gathering of information. Most commonly Eri uses reflections, but also clarifications, short validations, and bullet point summaries of identified behaviours/issues/fears/emotions.

> P: Uh, we don't have the best relationship. They're not the best parents. I mean, they are in the fact that they do financially support me when I first came here. They pay for my tuition and everything but…
>
> T: Financially you get help but not emotionally. *(Eri keeps* **Rhythm and Fluidity** *by quickly clarifying the client's speech.)*
>
> -
>
> T: And sometimes we do that. But remember, that you actually have had a pretty difficult upbringing. You've developed these fears which are very, very entrenched. So, there's a fear of betrayal, fear of repeating history, fear of making the wrong decision, fear of hurting your boyfriend too, because you don't want to hurt him. And you could see how much your father hurt your mother. *(Eri keeps* **Rhythm and Fluidity** *by quickly summarizing the fears identified up to that point of the session, keeping the patient organized.)*

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T: Emotions! You know the amygdala? *(Eri stimulates* **Rhythm and Fluidity** *by showing genuine excitement in the patient's knowledge and participation.)*

P: Yes!

T: Excellent! How did you know? *(Eri consistently uses encouraging adjectives such as "Excellent". They also serve to create a safe and supporting atmosphere.)*

P: From reading and I also have a masters in community health. I took physiology and I had some anatomy.

T: Oh! Excellent! *(The energy and enthusiasm brought on by Eri motivates the client, which allows for a fast yet friendly pace in the conversation.)*

1.2 **Exploration:** Exploratory questions to better learn and understand meaningful information about the client, her relationships, her emotions, life history and complaints. This information might be purposefully sought out by Eri or brought up by the patient.

P: …Ever since then, my boyfriend, I feel the same level of love from him. I feel like he's the only one out there in this world that makes me feel that I am not orphaned or… like there's someone caring about me, you know…

T: What about your parents? *(***Exploration:** *Eri gets hint from patient of an absence of secure and loving parental figures and chooses this moment to explore the patient's relationship with her parents.)*

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P: No. And I would say I was emotionally abused by them.

T: Yes? *(***Exploration:** *Eri incentivizes the client to develop a relevant theme. Parental relationships are usually given much attention in Eri's consultations.)*

P: Oh, you want to hear…

T: Emotional abuse? *(***Exploration**: *Eri echoes the client's words to incentivize her again.)*

1.3 **Creating a Safe, Supportive and Understanding Atmosphere:** Eri consistently validates and supports her patients, especially in moments when they are addressing difficult situations. Eri

will also show genuine excitement in the patient's progress, not only through words but in her tone of voice as well.

P: Yes. And my dad would constantly cheat on my mom with different women and then my mom would… one time she dragged us along to catch him in bed…

T: So, my goodness, that must have been really hard for you! As a child, you would actually go with your mother? To try and catch him out? *(***Creating a Safe, Supportive and Understanding Atmosphere:** *Eri provides empathetic validation before continuing the Exploration.)*

P: Yeah. I've known that he would cheat on her ever since I was ten or something. My mom is not the best mom either. Like she can't have her life in order and that means she can't take care of us either.

T: Absolutely! Absolutely! So, your mother was preoccupied with your father all the time? *(***Creating a Safe, Supportive and Understanding Atmosphere:** *Eri provides empathetic validation before continuing the* **Exploration***.)*

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P: Thank you for acknowledging me. I have felt [?] for a long time.

T: I'm sure you have. *(***Creating a Safe, Supportive and Understanding Atmosphere:** *Eri provides empathetic validation.)*

P: Like it was me, like there was something wrong with me.

T: I guess, when you are abandoned as very tiny, tiny baby, I think that is understandable. The subsequent experiences that you had. The thing is that you know yourself that you are able to discriminate and can actually see what is right and what isn't. That is a wonderful ability that you have. That's a strength that you have. And it has probably kept you very safe. I mean, given the circumstances, given your life, you actually are surviving, you have survived so well. And there's been just one instance of sexual assault, one instance. Aside from that, you've kept yourself safe. And you've only actually been in relationships where there is love. I think that is admirable. *(***Creating a Safe, Supportive and Understanding Atmosphere:** *Eri validates the patient's feelings by relating them to her early childhood experiences and subsequently highlights the patient's own resources and capabilities.)*

Main Category 2: *Fostering a sense of agency, mutual collaboration and positive expectation while co-constructing a Credible Narrative/Rationale for Suffering/for Improvement to be used in hypnosis.*

At the beginning of each session, Eri offers a considerable amount of psychoeducation, namely regarding sleep habits, physiological stress responses and a summary of the cognitive behavioural model of emotions. Eri also consistently explains how she works as a therapist and what both her and the patient are attempting to accomplish, which allows the patient to have more agency in the therapeutic process. Psychoeducation also empowers patients with the knowledge to make better decisions for their own psychological wellbeing beyond the therapeutic setting.

While the necessary information for hypnosis is being collected, Eri constantly motivates her patients to have an active role in their own improvement, often asking them to identify their own fears, emotions, and behaviours. She will also directly ask what the best words are to describe each of these phenomena.

Eri is quite open to the possibility of not having completely grasped the patient's narrative at any given moment, often using interpretations, associations, and reformulations as a scaffolding, which the patient has enough freedom to shape of simply refute, to which Eri is open and flexible, thereby building a shared understanding of the patient's world. Lastly, she repeatedly fosters positive expectation, often using the patient's own resources to do so.

2.1 **Fostering Agency, Collaboration and Developing Resources:** Eri consistently finds moments to foster agency in the patient, motivating them to have an active and collaborative role in the therapeutic process; in their own healing; in being more compassionate toward themselves and in past actions and future endeavours. The noticeable focus on providing psychoeducation on psychological and physiological principals seems to purposefully provide tools which the patient can use for their own therapeutic benefit. Eri will also foster agency by positive reinforcement or actively inviting the patients' collaboration in the therapeutic process, thereby creating a collaborative atmosphere with the shared purpose of helping patients to better understand themselves and heal.

T: So that's a safety behaviour, emotional torture?

P: Not me torturing myself but the situation tortures me.

T: Yeah, but you are actually creating a situation where the situation is torturing you. You are responsible for that torture, aren't you? You can choose not to torture yourself, that is your choice. *(***Fostering Agency, Collaboration and Developing Resources:** *Eri empowers the client by referring to the agency in her choices and developing resources by helping the patient be more mindful of her behaviours.)*

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T: What other fears. So, we've got fear of abandonment and fear of abandoning others. We've got these fears. Do you have a fear of intimacy? *(***Fostering Agency, Collaboration and Developing Resources:** *Eri asks the patient to identify her own fears.)*

P: I don't think so, I think I am just afraid that I'm not good at relationships or somehow, I'm not loveable or not marriage material.

T: Is it a fear of not being lovable? *(***Fostering Agency, Collaboration and Developing Resources:** *Eri respects the patient's input and continues exchanging ideas with her in a collaborative way,)*

-

P: I have always struggled but it has improved a lot especially lately, but I've always been afraid to speak up for myself in every area of my life but especially in relationships. That I fear I have a pattern of accepting just good enough. That this is a good enough relationship, good enough guy.

T: Is it alright for me to have written "fear that your body was your only worthy attribute?". *(***Fostering Agency, Collaboration and Developing Resources:** *Eri asks the patient what the best words are to describe her fear, showing sensibility for the situation and valuing the patient's role.)*

-

T: So, the way that you have managed these fears is to be clinging in relationships, panicking at the end of the relationships, rescuing others and fiercely independent? Is there any other safety behaviours that you have?

P: Any what?

T: Safety behaviours. Safety behaviours are the way we actually manage our fears. Through abandonment, understandably, you would be clinging and then panicky at the end of the

relationships and then rescue others. *(***Fostering Agency, Collaboration and Developing Resources:** *Eri provides useful psychoeducation for the therapeutic session, so that the patient can have a more active role.)*

-

T: Ok, so! Is there something that you would like to work with me on? Because the way that I work is I do-- I can go through, we can look at some historicals-- is there specific problem that you would like to work on that I can actually do--Tony, did he told you the fact that I record a session with a hypnosis? Did he tell you?

P: Nooo! He didn't tell me that! [excited]

T: No? Well, you can tell me about specific problems that you're having so we could look at the historicals, the key fears, the way you have managed those fears. Because we avoid a lot, ok? And then there's the unintended consequences of that. But then, we're looking at triggering events, something that triggers off emotion in you. Then what happens is that we start to-- because we're going in a downward spiral of negative thinking, what happens is that it becomes a vicious cycle of thinking, going round and round and round, circles, circles, circles. That all leads to a set behaviour which is avoidance, some people drink, smoke, do all sort of things. So, is there anything that you would like to work on? *(***Fostering Agency, Collaboration and Developing Resources:** *Eri explains her approach as a therapist and what is the purpose of the work they are about to embark in together).*

-

T: Good! Excellent! You're doing very well here. Actually, giving me a lot of information here. Lot of information. Yes. *(***Fostering Agency, Collaboration and Developing Resources:** *Eri provides positive reinforcement for the patient's role in the therapeutic process.)*

2.2 **Fostering Positive Expectation:** This code refers to any action undertaken by Eri to create hopeful expectations for future improvement, for which she might refer to the client's agency and newfound resources or to actions taken within the therapeutic setting, such as hypnosis or compassionate mind training.

T: It is really interesting that you obviously, that you are very employable because you are applying for these jobs, you've got both jobs. Very employable, that's very positive, isn't it? The thing is that these days, we actually work for a company for four or five years and we have the opportunity to move somewhere else. We get the experience, it is not the end of the world, is it? It is a bit different to the decision of marrying because you are Christian, and you want that to be forever. Whereas a job, in five years' time, you might decide to go to another start-up. *(***Fostering Positive Expectation:** *Eri refers to the patient's resources or capabilities, such as being employable, to foster positive expectations for her future.)*

P: Totally. It's not permanent.

T: Yes. You can think in those terms like, "I've made my decision now, it is actually, knowing that in five years' time, if I am not happy and I am so employable, here I am I've got two jobs. I've got offered two jobs here so it should not be a problem in the future.

P: Mm-hmm. Yeah but. But that's the major theme this year.

T: Yes, yes, yes, yeah. The thing is that this is the technique that you are going to be training yourself when we talk about compassionate thinking. You are now going to be able to train yourself to be able to manage these emotions when these emotion surface, being able to raise these emotions rather than react to them because as soon as you feel guilt and regret, you are going into a spiral of negative thinking. "I should have done this, I should have done that", that mental torture. *(***Fostering Positive Expectation:** *Eri now fosters positive expectation in relation to the therapeutic benefits and resources the patient will gain and subsequently use for her identified difficulties.)*

2.3 **Offering a Credible Rationale for Suffering/for Improvement:** This code refers to any interpretation, association or explanation offered by the therapist in order to promote a better understanding of self for the patient as well as the mutual creation of a narrative more conducive of growth and improvement, often offering more positive alternative views on past events or current ways of thinking. The better understanding of self is characterized by the identification of the origin of fears, emotions, behaviours, key issues, and challenging life situations.

The basic structure of this rationale is based on connecting past to present, that is, early and likely familial relationships modelling current loving and professional relationships, key issues

spawning fears and other emotions and said fears subsequently modelling behaviour and generating anxiety in a patient's life.

Though the established connections are unique to each patient's life, the rationale works as a sort of blueprint that Eri follows, directing the patient when necessary while allowing for maximum agency during the session. Having gathered sufficient or perhaps most all meaningful data, Eri then submits the patient to hypnosis.

P: Yes, like verbally. My dad would say, "You're so selfish!", "You have no heart, no love, no friends, no family!", things like that.

T: So, he was very, very, very critical of you. *(***Offering a Credible Rationale for Suffering/for Improvement:** *The therapist identifies a behaviour from her father which will later fit in the narrative/rationale as origin of behaviours/fears/emotions.)*

P: Yes.

T: And are you self-critical? *(***Offering a Credible Rationale for Suffering/for Improvement:** *Eri indirectly offers an association between a behaviour the client had experienced at a young age, from her parent, with a behaviour she might act out currently.)*

P: Yeah, very.

T: So, you learned from him.

P: Yes. And my dad would constantly cheat on my mom with different women and then my mom would… one time she dragged us along to catch him in bed…

T: So, my goodness, that must have been really hard for you! As a child, you would actually go with your mother? To try and catch him out?

P: Yeah. I've known that he would cheat on her ever since I was ten or something. My mom is not the best mom either. Like she can't have her life in order and that mean she can't take care of us either.

T: Absolutely! Absolutely! So, your mother was preoccupied with your father all the time?

P: Pretty much with her own stuff. Eventually, like my dad almost drove her crazy.

(…)

T: That brings a lot of [P starts crying] I will put this next to you [hands tissues] Oh, my gosh! That must have so hard for you!

P: Yeah…

T: So, you've got a fear of betrayal, don't you? *(***Offering a Credible Narrative/Rationale for Suffering/for Improvement:** *Eri then identifies a potential fear that may have originated from the patient's childhood experiences and early parental relationships.)*

P: I do. That's the key factor that I look in a future spouse. I have no tolerance for cheating. For others, they might have some wiggle room. For me, you cheat once and then you're out.

T: So, that's really your issue. *(***Offering a Credible Narrative/Rationale for Suffering/for Improvement:** *From exploring past experiences, the therapist and the patient have come to understand a current issue, connecting past to present.)*

P: Yeah…

2.4 **Hypnosis:** Hypnosis is the culmination of Eri's work, where all the information gathered will now be used to ensure that the cooperatively built rationale is assimilated by the client. To then provide healing, Eri trains the patient in compassionate mind-training. To do so, Eri provides preparation for the hypnosis, putting the patient in a state of deep relaxation and heightened suggestibility.

T: "You are listening to the sound of my voice, that's all you're focusing on. That's all you want to hear, the sound of my voice."

Then, Eri begins asking the patient to think of the identified trigger event (an event which triggered anxiety for the patient), and the emotions brought on by this event, which were identified with the patient's cooperation throughout the session.

T: "When you are thinking about the time when you were making the decision to leave the start-up and commence with Microsoft and you know that you are feeling guilty, regretful, anxious, scared, insecure and ambivalent and unsure."

Eri reenforces the benefits the patient will gain, creating positive expectations for improvement:

T: "And after you're away from this relaxed state, you are going to feel very good because you are going to remember everything and use what you hear and use it for you. Once again, you learned to use what I tell you and use it every day. And whenever you feel guilty, regretful, anxious, scared, unsure, ambivalent or any other distressing emotion you experience."

Eri then begins psychoeducation on Compassionate Mind Training:

> T: "The hope for this session is for you to train yourself in what we call compassionate thinking. As you know, from the handouts, compassion is comprised of many qualities of empathy, sympathy, forgiveness, acceptance, tolerance, and warmth. It is those qualities that of compassion which you will train yourself to use at those moment where you are feeling guilty, regretful, anxious, scared, unsure and ambivalent."
>
> T: "(…) we know from studies, and we know from research that when we show compassion towards ourselves (…) what happens is that we actually disengage the alarm system, the fight flight response (…) and reengage the prefrontal cortex. The prefrontal cortex is a rational brain and when we are functioning from the prefrontal we achieve state of calm, state of non-reactivity and of course that's what you want to train yourself to do. You want to train yourself to actually achieve that state of calm (…) when we're actually in a calm and non-reactive state we actually make the right decisions (…)"

Eri then addresses the trigger event, referencing the exact words chosen in cooperation with the client:

> T: "(…) Making that decision to leave start-up and commence Microsoft actually is the trigger event which triggers off those feelings of guilt regret, anxiety, fear, ambivalence. What's been happening is that when those emotions surface, what you have been doing is you're going into a downward spiral down of negative thinking. Focusing on the external threat (…) thinking about what the start-up would be thinking about you and then go internally, in your internal thoughts. You are thinking, as far as the start-up is concerned, they probably thought that you actually betrayed them, you took advantage of them. The thinking that they wouldn't hire you again because you are not loyal enough. And internally, saying to yourself, "Did I make the right decision? I screwed the start-up company, I shouldn't have taken the Microsoft job. I should have stayed with the start-up" And that all leads you to continue to be self-critical with that obsessive thinking, that internal torture. You can see that downward spiral of negative thinking is counterproductive, totally counterproductive and that is why you now want to intervene at that moment where those distressing emotions are surfacing."
>
> T: "(…) What you will be saying to yourself is, "I have every good reason to feel guilty, I have every good reason to feel regretful, I have every good reason to feel anxious, I have

every reason to be feeling scared, I have every good reason to feel unsure, I have every good reason to feel ambivalent and it is absolutely normal and okay for me to be feeling guilty, regretful, anxious, scared, unsure and ambivalent."

Eri then addresses the identified fears:

T: "(…) In that state of calm, that non-reactive calm state then you can challenge the fears that bringing up emotions."

T: "We look at your fears and I think that there is definitely a fear of hurting others. Of course, in this instance there was that fear of hurting those people you've worked with at start-up and of course there is also the fear of hurting your boyfriend as well for a different decision that you are making. There is also that fear of betrayal but also a fear of betraying others as well because you know how damaging it is to be betrayed or to betray others given your family history."

T: "There is a fear of not being good enough because of how critical your father was of you."

Eri then shows the patient how to use her own resources to challenge her fears:

T: "Let us go through those fears and challenge those fears because you are now in a calm state. There is a fear of hurting others, I guess in this life where we need to make decisions which may require that we do hurt others but that is just part of who we are and part of life. You are not doing it purposely. It is not like a betrayal. You actually are making a decision for your own future and for your own well-being. That is in many ways just a fear because there is no way you would hurt someone purposely."

T: "You can see that these fears that you have which are unappealing those emotions which surface when you're making decision, these fears are irrational fears. You can now let go of being self-critical, you can train yourself in being compassionate. This emotional torture, when you achieve a state of calm, you will achieve that state of calm by being able to manage those distressing emotions which surface, then you will be able to let go of that emotional torture. You won't experience that."

She then addresses the behaviours:

T: "And also, avoidance behaviours. Rather than avoiding, you will be able to manage any emotions which are surfacing, which are causing you to avoid and when you achieve that state of balance and calm, then there is no need to avoid because you will be able to

challenge whoever or whatever you are trying to avoid or maybe, you know, solve the problem that you are trying to avoid. Then there is no need to use that set of behaviours."

Throughout this process, Eri repeatedly creates reassurance and positive expectations:

T: "You can see that the value of being able to manage distressing emotions. As we said, whenever you feel like guilty, regretful, anxious, scared, unsure, ambivalent you will be able to manage these emotions and be able to show that empathy, acceptance, tolerance, warmth, forgiveness towards yourself and those emotions and you will achieve a state of calm. In that state of calm, you will be able to challenge the fears that are underpinning these emotions and understand that those fears are just fears."

Eri then finishes the hypnosis and briefly discusses how the patient is feeling before finishing the session.

Discussion

The objective of this study was to learn and detail the clinical way of being and in-session approach of a therapist with superior outcomes.

In short, Eri's effectiveness seems to be related to three major factors: Eri's personality and individual way of being, a specific theoretical orientation characterized by a combination of CBT, Compassionate Mind Training, psychoeducation, and Hypnosis and a balanced use of techniques designed to optimize the time spent in therapy, and which carry over the therapeutic work into the patient's life.

Regarding Eri's way of being, there is a genuine desire to help improve each patient's life, most noticeable in her enthusiasm for the patients' progress and empathy for their suffering. Eri is also very likeable as a person, as one of the former patient's states: "When I first met Tony, I think it took me a little bit to open up to him. And I instantly have a positive opinion of you, but it is just hard, I do not have anything that I specifically want to talk about." Even though this is each patient's first time seeing Eri, all seem to easily open up to her. This seems to be mostly related to Eri's gentle and compassionate nature, self-confidence, and approachable communication style, all of which help establish a trusting relationship with her patients. Also noticeable is Eri's intuition in identifying patient's thoughts, feelings and forming connections in their narrative. The role of Eri's intuition is in line with Caspar's (2017) assertion that experienced therapists are able to

process information intuitively without sacrificing rational thinking, which would suggest that Eri's experience does play an important role in her therapeutic success.

Each theoretical orientation seems to play a major role in Eri's therapeutic style. Psychoeducation forms the groundwork that ensures patients understand the therapeutic work being done, allowing them to have an active and collaborative role. It also helps making sure this work is carried over into the patients' life by creating a greater sense of self understanding, and the knowledge to conscientiously make healthier decisions for their psychological wellbeing. The CBT helps guide the consultation and forms the basis for the mutually constructed narrative for patients' suffering. Compassionate Mind Training is mostly related to the "healing" aspect of the process, as offering compassion, and teaching self-compassion helps break down the vicious circle identified with the CBT, that is, anxiety inducing events causing negative emotion, followed by the downward spiral of negative thinking that reenforces anxiety (Gilbert, 2009). This is one of the main tools developed in therapy that are crucial to be carried over into the patients' life. Finally, the hypnosis seems to act as the cement that secures this newfound knowledge and the patients' own previously identified psychological tools into the patients' repertoire of psychological resources.

The findings of this study are consistent with the premise of the Contextual Model (Wampold & Imel, 2015), in that Eri does seem to form an initial bond easily and rapidly with her clients and makes use of every pathway mentioned in the model's premise. The first pathway, regarding the real relationship between therapist and client is mentioned in the first abstract category, in that it involves the presence of a genuine and empathetic therapist, both being qualities that stand out in Eri's way of being. Secondly, the use of psychoeducation and positive expectations stood out as a fundamental part of Eri's work as well as the co-construction of a credible rationale for suffering and improvement, and the use of the client's agency and collaboration, which make up the second pathway (Wampold & Imel, 2015). The third pathway, conceptualized as the change resulting from carrying out treatment actions is most evident in Eri's use of hypnosis. Most importantly, as Wampold and Imel (2015) stated, the therapist is key in that *how* the treatment is delivered is critical to the success of therapy. For this matter, the two main categories achieved were *natural*: *Keeping a natural, fluid rhythm during the session while balancing directive exploration, frequent associations, and interpretations with a sense of support, empathy and understanding* and *Fostering a sense of agency, mutual collaboration and positive*

expectation while co-constructing a Credible Narrative/Rationale for Suffering/for Improvement to be used in hypnosis.

The way in which Eri's seems to intuitively make use of each of these techniques and approaches is balanced and effective. Considering the short time in which Eri works, the overuse of a single one of these techniques could potentially result in a decrease in effectiveness. If we considered, speculatively, that Eri were to keep a high pace with frequent interpretations and associations in the consultation without simultaneously establishing a supportive and empathetic atmosphere, the patients might feel overwhelmed and less inclined to share as much meaningful information. Or, if Eri were to gather information to fit her theoretical framework without simultaneously fostering agency and collaboration, the patient might not actually feel emotionally invested, nor as motivated to be part of the therapeutic process and would not learn as much useful information regarding agency and emotional self-regulation to achieve the same long-term therapeutic benefit. Also, the application of all of these techniques in such a shot time window would not be possible without a theoretical framework that could be structured enough to be effective with most all patients but flexible enough to fit any patient's narrative. This flexibility is also related to Eri's personality and her respect and appreciation of each patient's input. Even with a framework in mind, Eri allows each patient enough freedom in session to navigate meaningful subjects and areas they find relevant, which Eri subsequently validates. This, in turn, is related to Eri's present, genuine, intuitive and empathetic way of being.

Very interestingly, these results are quite similar to Werbart, Annevall and Hillblom's (2019) regarding the makings of a successful therapy, especially in the importance attributed to the first session. Their findings that, in successful therapies, both patient and therapist had an early common understanding of presenting problems and what could be helpful, and that therapists experienced good comprehension of the patient's difficulties early on, and presented, from the beginning, a clear picture of their ways of being, are deeply related to Eri's collaborative, intuitive, and genuine nature. Werbart, Annevall and Hillblom (2019) have also found that successful therapists described an early staging of the patients' problems, which together they could work on, and focused on patient's fears and expectations, quite similar to codes used in the present study, such as the co-construction of a credible rationale, fostering collaboration, identifying fears, and fostering positive expectations. Successful therapists also fostered a confident, supportive, collaborative, and challenging therapeutic relationship, all of which, to the exception of

challenging, have been detailed in Eri's work. Though admittedly, there are times when Eri does challenge her patients, such as when she demonstrates one of her patient's agency in maladaptive behaviours. Also of great interest is that in *all successful cases*, therapists provided a clear picture of their therapeutic work, which is a great focus of Eri and has been described in the present study as well.

Regarding the question of what makes a "supershrink" it seems both Miller, Hubble and Duncan (2007) and Sperry and Carlson (2014) have been warranted some level of truth in their findings regarding the makings of a "supershrink". As the former authors suggest, what greatly separates "supershrinks" from their peers is the number of times corrective feedback is sought, successfully obtained, and acted on (Miller, Hubble & Duncan, 2007). Though Eri hasn't specifically asked for feedback relative to the therapeutic process itself in these transcriptions, she does use the OQ-45 and asks for and openly accept patients' input while co-constructing the therapeutic rationale. The latter authors, who also focused their research on therapeutic actions carried out in session, suggest that what differentiates master therapists from others is their ability to enhance the therapeutic alliance, enhance positive expectations and client motivation, increase client awareness, facilitate corrective experiences, identify patterns, and focus treatment. All of which, to some extent, can be seen in Eri's work.

Most interesting and pertinent is the importance Sperry and Carlson (2014) also attribute to the first session, seeing as though in this study the first session makes up for half or even all the therapeutic process. As these authors state, master therapists focus on developing a deep connection and understanding as well as effecting some level of change in the first session. Eri focuses on exactly that, organically establishing said connection and opting for questions more pertinent to the clients' current discourse over any specific questioning format. She can also be seen to motivate the three levels of change. The first order change (assisting clients in making small changes and reducing symptoms) is most visible in Eri's previous study (Hansen, Lambert & Vlass, 2015a) wherein her clients commonly attain sudden gains, which are characterized by sudden symptomatic improvement. The second order change, assisting clients in changing maladaptive patterns to more adaptive ones can be seen particularly during hypnosis, as she uses Compassionate Mind Training to effect said change. Lastly, as Eri's previous study suggests (Hansen, Lambert & Vlass, 2015a), her clients have also been shown to retain clinical levels in a

two year follow up period, which would support the possibility that participants achieved third order change and have become able to change patterns for their own (Sperry & Carlson, 2014).

Jennings and Skovholt (2016)'s Canadian couples therapy study reported commitment to personal development, maintaining emotional health and a commitment to professional development, all of which Eri mentions specifically in her self-description. This would suggest that these actions are not only transversal to different therapeutic approaches but might even be generalizable to other therapists.

In regard to my previous question of how therapists might be provided with specific ways with which to improve their effectiveness, the actions that have been confirmed, by the present study, to be fundamental in successful or even expert level therapies are: Establishing a connection and a productive therapeutic alliance early on; to co-construct a credible rationale for the patient's issues and to offer specific ways to improve; to educate on the necessary information for the clients to have an active and collaborative part in their therapy, to enhance positive expectations (Sperry & Carlson, 2014; Wamplod & Imel, 2015; Werbart, Annevall & Hillblom, 2019). What Eri adds to this literature is how organically she utilizes her chosen bona fide theoretical framework and techniques that not only support each other but the framework itself.

Finally, an expert therapist seems to be a genuine, hard-working, empathetic, intuitive person. Above all else, if there is a specific quality that stands out in Eri, it is a genuine desire to aid others in their healing.

Limitations

This study's qualitative nature leads, by default, to the interaction between investigator and research material, inevitably leading to some level of investigative bias. Though this bias was attempted to be reduced by the use of line-by-line coding of a descriptive nature, the subsequent abstractions will ultimately have led to the valuing of some therapeutic actions over others. Also, in an attempt to find the deeper meaning behind some of Eri's actions in therapy, it is entirely possibly that my deductions have not accurately met the therapist's intentions. To reduce such bias, it would be recommendable to work directly with the case study subject, in this case, to work closely with the studied master therapist to capture more accurately his or her thoughts, feelings and intentions with each action.

Furthermore, this investigation sought to study the actions of a master therapist with consistently superior results, demonstrable by the Outcome Questionnaire 45. This method of evaluating the expertise of therapists has been subjected to criticism itself (Caspar, 2017). Furthermore, there is no data regarding the therapeutic outcome of the patients whose sessions were analysed in this paper. It would be very interesting and beneficial for future case studies to analyse confirmed successful therapies and confirmed unsuccessful ones from the same master therapist to attain greater knowledge regarding both therapist, patient and dyad factors that positively and negatively impact the therapeutic work.

Another limitation is related to this study's sample size and variability, which may not be generalizable to a larger population. This study's demographic is composed of three women in working age and could potentially benefit from a larger sample, perhaps including both men and women and different age groups, exhibiting a broader scope of Eri's capabilities as well as her technique selection. Though it is quite fortunate that the patients do have different backgrounds (Chinese living in Seattle for 6 years, Korean adopted and raised by American family from infancy, American born).

Lastly, while this is Eri's first encounter with these patients, all of them were already undergoing therapy with another therapist and their experience as patients might allow them more openness to therapeutic interventions than first time patients. On the same note, it is possible that when the original therapist of these patients offered them the option to undergo a two-session therapy with Eri, he may have fostered positive expectation for her as an exceptional therapist. This may also have led the patients to come into therapy with an enhanced sense of positive expectation and therapist credibility.

Conclusion

Qualitative investigations of therapists with superior outcomes are still few and far between. The present investigation sought to contribute to this area. These studies, being of a qualitative nature, allow us to learn more on the complex phenomenon of a therapeutic encounter, specifically a masterful one. However, this study detailed simply one of many possible combinations of a master therapist's individual personality, approach, and caseload. As other

studies of this nature have presented us already, there are many factors associated with masterful therapy, but we still don't know enough about how these may be applied to each individual therapist. For that reason, the present investigation was not particularly focused on finding generalizable factors that could be tried out by other therapists, so much as it sought to create a comprehensive and detailed scheme of one particularly successful therapist. With the combined investigation of Eri's previous study and this one, there is information pertaining to her personality and individual factors and habits that play a role in therapy, combined theoretical approach, client's feedback on therapeutic alliance factors and now, in session practical approach displaying how all the previous mentions come together and become realized. When combined, this information forms a fully comprehensive scheme (or as comprehensive as the limitations will allow for) of a particular master therapist. This scheme, and others like it, could one day be part of a large metanalysis. As more and more of these metanalysis are produced, the information will hopefully become more generalizable and applicable to different therapists, and perhaps become part of some form of educational program that can finally combine tried and true master level therapeutic practices with each therapist's specific personality and way of being.

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Annexes

Annex 1: Full Introduction

The Effectiveness of Psychotherapy

The matter of psychotherapy's legitimacy has been around since the beginning stages of its practice (see Scott, 1909). Perhaps one of the most notorious events in the history of this subject takes form in a debate between two psychologists, dating back to the 1950's. "The figures fail to support the hypothesis that psychotherapy facilitates recovery from neurotic disorder" states Eysenck (1952). Eysenck's conclusion exhibited the apparent ineffectiveness of psychotherapy, prompting an article published in 1963 by H. H. Struup, defending the therapeutic process itself, though admitting to the difficulty of its measurement. Eysenck met this challenge with another publishment, in which he states, "In reply, I would like to suggest that Strupp's review is, in a lawyer's phrase, irrelevant, incompetent and immaterial" (Eysenck, 1964, p. 97).

Given the lack of controlled studies regarding the practice of psychotherapy at the time, it is not entirely surprising that such debates would arise. Thankfully, this argument, and others like it, spawned a great deal of outcome research, which Wampold (2013) ascribed as the "good" in his humorous analogy of the famous western "The Good, the Bad and the Ugly". By the middle of the 1970's, hundreds of studies had been published regarding the question of whether psychotherapeutic treatment would produce benefits in excess that would not have occurred without it (Wampold, 2013). One of which, a metanalysis published by Smith and Glass (1977), was of particular importance in settling this debate. This metanalysis, consisting of an impressive 400 controlled evaluations found convincing evidence that psychotherapy was, indeed, effective. After coding and statistical analysis, it was found that, on average, the typical therapy client is better off than 75% of untreated individuals. These results, though challenged by Eysenck (1978) himself, were corroborated (see Andrews & Harvey, 1981; Landman & Dawes, 1982).

Lipsey and Wilson (1993) formed one of the largest and most comprehensive studies done in this area, comprised of 302 metanalysis. This extensive investigation again corroborated the overall effectiveness of psychotherapy: "What we conclude from this broad review of meta-analytic evidence is that well-developed psychological, educational, and behavioural treatments

generally have meaningful positive effects on the intended outcome variables." (Lipsey & Wilson, 1993).

Later studies would only come to further support psychotherapy's efficacious effect. Wampold (2001) states that about 80% of those receiving psychotherapy will have mental health status superior to those receiving no treatment. Also, psychotherapy appears to be as effective as medication for many mental disorders, as well as having longer lasting effects (Wampold, 2007). Lambert (2013) states that the estimated general success rate in treated persons is 67% compared with that of 33% for untreated persons over the same period. The individual will also make larger gains than similar individuals on waitlists, or who receive placebo treatments, and will maintain their gains at follow ups 2 to 3 years after treatment (Lambert, 2013). In this very article, Lambert (2013) also mentions that it does not generally matter which kind of psychotherapy is offered as long as it is a bona fide theory driven intervention.

Eysenck and Struup's argument would appear to have been settled. Though, at the time, the usage of the term "psychotherapy" was referred to regarding that of psychoanalytic orientation and it seems these authors were arguing over different theoretical orientations of psychology, namely psychoanalytic and behavioural therapy. Psychotherapy does, indeed, work. Though, is there a difference in efficacy between theoretical orientations?

The Dodo Bird Conjecture

Lambert's (2013) aforementioned statement regarding the overall efficacy of bona fide psychotherapies is by no means new information.

The most recognized hypothesis to provide an answer for this question was presented by Rosenzweig (1936), who proposed that the efficacy of psychotherapy was related not to the specific techniques of each theoretical orientation of psychotherapy but to "factors common to diverse methods of psychotherapy". The author postulated these may be unverbalized factors, such as catharsis and certain traits of the therapist himself and the consistency with which the therapeutic ideology was applied (Rosenzweig, 1936). Rosenzweig (1936) presented this notion borrowing the line from the Dodo bird of Alice in Wonderland "everyone has won, and all must have prizes". At its conception, the Dodo bird effect was received quite negatively and discredited for an extended period (Wampold, 1997). As Rachman and Wilson (1980) stated, the conviction that regardless of the nature of one's problem, one may seek any form of therapy is, in their own

words, “absurd”. However, the last decades of investigation have continuously supported the Dodo Bird conjecture.

Smith and Glass’s (1977) metanalysis found “virtually no difference in effectiveness” between the class of all behavioural therapies (systematic desensitization, behaviour modification) and the nonbehavioral therapies (Rogerian, psychodynamic, rationalemotive, transactional analysis, etc.). Wampold et al (1997) constructed a metanalysis based on comparisons between treatments gathered from 6 journals. This analysis contained rigorous inclusion criterion, wherein the corpus of studies reviewed was limited to only those studies that directly compared two or more treatments. Treatments were not classified into general types, and only bona fide psychotherapies (defined by the authors as those that were delivered by trained therapists and were based on psychological principles, were offered to the psychotherapy community as viable treatments, or contained specified components) were considered. The results demonstrated that the distribution of effect sizes produced by comparing two bona fide psychotherapeutic treatments was consistent with the hypothesis that the true difference is zero. As stated by Wampold et al (1997) “In all, the findings are entirely consistent with the Dodo bird conjecture.”

Additional metanalysis have shown bona fide psychotherapies to wield similar efficacy in treating PTSD (Benish, Imel & Wampold, 2007), youth disorders (Miller, Wampold & Varhely, 2008) and alcohol use disorders (Wampold, Miller & Fleming, 2009).

If psychotherapy is indeed effective and all bona fide therapies have earned their prizes, what might be at the basis of psychological treatment?

The Contextual Model

To synthesize the investigation made thus far regarding therapeutic effectiveness, Wampold and Imel (2015) suggested an evidence-based model that would conceptualize the transversal mechanisms to any therapeutic process. Wampold and Imel (2015) called it the Contextual Model. The basic premise is that the benefits of psychotherapy accrue through social processes and that the relationship is the bedrock of psychotherapeutic effectiveness (Wampold & Imel, 2015). In its current version, it elaborates on the three pathways that purportedly explain the benefits of psychotherapy. Before the three pathways can be employed, the therapist and client must create an initial bond. After which, the first pathway is the “real” relationship between therapist and patient, which implies the presence of an empathetic and genuine therapist. That

presence has a therapeutic effect in and of itself (Wampold & Imel, 2015). This will then create a second process of change. Trough explanation and treatment actions, expectations about therapy are created. As Wampold and Imel (2015) argue, an important function of psychological interventions is the co-construction of a credible rationale that would explain the essence of the clients' problems to him, as well as the actions that will lead him to improvement. Lastly, the third pathway involves change as a result of carrying out treatment actions, that is, implementing the actions previously agreed upon (Wampold & Imel, 2015).

Wampold and Imel (2015) believe that these three pathways are interdependent and that the most effective therapists make use of all of them. For the Contextual Model, the therapist is key because it is recognized that how the treatment is delivered is critical to the success of therapy (Wampold and Imel, 2015).

Having established the effectiveness of all therapies and a plausible explanation for this fact, we must also come to terms with a sobering truth: *No measurable improvement in the effectiveness of psychotherapy has occurred in the last 30 years* (Miller, Hubble & Duncan, 2008; Wampold & Imel, 2015). What does seem to improve is therapist's confidence in their abilities (Miller et al., 2007). Some studies have shown that the least effective therapists believe they are as good as the most effective and that average clinicians overestimate their outcomes in the order of 65% (Chow, 2014; Hiatt & Hargrave, 1995; Walfish, McAlister, O'Donnell, & Lambert, 2012). Before delving more deeply into this, let us first consider what other challenges we've yet to overcome.

Contemporary Challenges

- The Dropout rates. A metanalysis by Swift and Greenberg (2012) composed 669 studies revealed a dropout rate of 19.2%, which translates to one in every five clients abandoning treatment with no significant therapeutic gains. This event seems to be significantly correlated with variables pertaining to the therapeutic alliance and not with the theoretical orientation utilized (Roos & Werbart, 2013; Swift & Greenberg, 2014).
- The negative effects of therapy. A significant number of patients conclude therapy in a state worse than that with which they initiated it (Barlow, 2010). The percentage of negative effects is even worse when related to psychological interventions for children (15-23%) (Warren, Nelson & Burlingame, 2009).

- Therapists seem to consistently overestimate their efficacy. A 2012 study by Walfish, McAlister, O' Donnell and Lambert revealed that out of 129 mental health specialists, 25% believed to be in the 90th percentile of efficacy and none evaluated him/herself below average.
- The average therapist is ineffective in recognizing clients in clinical deterioration (Hatfield, McCullough, Frantz & Krieger, 2009) and evaluating the state of the therapeutic relationship (Haartman, Joos, Orlinsky & Zeek, 2014). A 2007 metanalysis by Tryon, Blackwell and Hammel revealed that the therapeutic alliance evaluations made by both the therapists and their respective clients only correlated by 36%. Therapists and patients also tend to vary in the importance attributed to different aspects of the therapeutic process (Bachelor, 2011; Timulak, 2010).

As it seems, the common denominator in the contextual model as well as most of the challenges we now face seem to be factors related to the therapist him/herself. Given that treatment differences bare a small significance, and that therapeutic effectiveness has seen little improvement in the past decades, perhaps it is time to turn our attention in a different direction, the lesser travelled road of therapist effect investigation.

Therapist Effects

Johns et al., (2019), define the therapist effect as the total outcome variance attributable to the variability between therapists. A therapist effect of 5%, for example, signifies that 5% of the variance in patients' outcome can be attributed to the variability between therapists (Johns et al., 2019). To measure therapist effects is, in some regard, an attempt to answer the question of how important the person of the therapist truly is, in terms of therapy outcome. Intuitive as it may seem, this question has been subjected to relatively little investigation. Beutler (1997) has even named therapist effects "the neglected variable".

One of the first meta-analysis to investigate this subject was published by Crits-Cristoph et al, (1991), wherein the authors attempted to examine factors that could account for the differences in therapist efficacy evidenced in psychotherapy outcome studies. The study revealed that the average treatment group exhibited a therapist effect of 8.6% of the outcome variance (Crits-Cristoph et al., 1991).

Baldwin and Imel (2013) have provided a summary for therapist effect literature, analysing 46 random effect studies, 29 on which were efficacy studies and 17 were naturalistic. The efficacy studies wielded a therapist effect of approximately 3% and the naturalistic 7%. According to Johns' et al (2019), this difference could be explained by therapist effects being supressed in trials due to tight inclusion criteria, manualization, close supervision of therapists and other factors. Considering the heterogeneity in Baldwin and Imel (2013) study results, John's et al (2019) sought to update and refine the previous authors' review as well as understand whether patient severity is a key determinant in the extent to which therapist effects are present. The authors included 46 studies, 1,281 therapists and 14,519 patients and found that approximately 5% of the variance in outcomes was attributable to the therapist. Although some of the evaluated studies would confirm that therapist effects grew with patient severity, more investigation would be required for this to be more than an observation (John's et al., 2019). Saxon and Barkham (2012) similarly reported that 7% of the variability in outcomes was due to the therapists.

It appears therapist effects range from 3% to 7%, with most studies resulting in 5%. This number becomes considerably more important when compared to the 1% variance attributable to treatment differences (Wampold & Imel, 2015). In other words, *who* delivers the treatment is far more important than *what* treatment is being delivered.

For a more practical example, in Saxon and Barkham's (2012) study, the investigators examined the outcome of 119 therapists and 10,786 patients in the UK's National Health Service primary care counselling and psychological therapy and found that 19 out of these 119 therapists had "below average" results. Thus, if the 1947 combined patients of these therapists had received treatment from better therapists, an additional 265 patients would have recovered (Saxon & Barkham, 2012). The authors also stated that some therapists were reported to be consistently more than twice as effective as others (Saxon & Barkham, 2012).

Clients seen by the most effective therapists show three times as much change as other clients (Brown, Lambert, Jones & Minami., 2005) and improve at a rate at least 50% higher and drop out at a rate at least 50% lower than those of average clients (Miller, Hubble & Duncan, 2007). These results are in line with Castonguay and Hill's (2017) conclusion that 15% to 20% of therapists have discernibly better outcomes and 15% to 20% have discernibly worse outcomes. Okiishi et al (2003) note that out of a sample of 1841 clients seen by 91 therapists of a 2.5-year period, therapists whose clients showed the fastest rate of improvement had an average rate of

change 10 times greater than the mean of the sample. In short, some clinicians are markedly better than others.

Though the exact number for therapist effect is still undetermined, the person of the therapist has been proven to have a palpable difference in outcome and therapeutic success.

Therefore, as John's et al (2019) have stated, it may be more profitable to determine why there are differences between therapist effects rather than determine a single point estimate for therapist effects. As Castonguay and Hill (2017) have asserted "…to help build a more accurate science of the psychological therapies, we need to have a greater understanding of the phenomenon of variability and how it affects therapists and the outcomes of their clients in therapy". However, we seem to know more about what doesn't account for this fact than what does:

- The difference in outcome is not related to age, sex, or therapeutic orientation (Brown, et al., 2006; Wampold & Brown, 2005; Anderson et al., 2009).
- Many therapists seem to not have their efficacy improve with years of experience, and some might even see their efficacy slightly decline over time. One of the largest studies done thus far in this matter analysed the results obtained by 281 therapists and their respective 10812 clients, concluding that years of experience, as a variable, was not predictive of therapeutic outcome (Brown, Lambert, Jones & Minami, 2005). More recently, a study composed of 170 therapists with a combined number of over 6.500 clients, evaluated over the course of 5 years, reported a decline in efficacy unrelated to patient severity, number of sessions or any of the previously mentioned therapist factors (age, years of experience, theoretical orientation) (Goldberg, Miller, Nielsen, Rousmaniere, Whipple & Hoyt, 2016).
- Professional therapists and therapists that are in training/supervision frequently reach similar clinical results (Nyman, Nafziger & Smith, 2010; Budge et al., 2012).
- The use of and adhesion to manualized interventions does not dissipate the differences in clinical effectiveness between therapists (Webb, DeRubeis, Barber, 2010; Owen, 2014).

What is even more worrisome is concluding that, when it comes to improving outcomes, the time, money, and effort spent by millions of therapists worldwide has apparently no palpable effect at a statistical level (Miller, Hubble & Chow, 2017). Clinicians do not necessarily improve with time, training, and experience. Tracey et al. (2015) posit that this lack of growth in expertise

is attributable to "the lack of information available to individual therapists regarding the outcomes of their interventions, the lack of adequate models about how psychotherapy produces benefits, and the difficulty of using the information that does exist to improve one's performance over time." This statement is equitable to the principles of deliberate practice.

Deliberate Practice

The concept of deliberate practice refers to therapists who spend more time reflecting on patient feedback, identifying the faults in their performance, seeking support from other therapists, and developing, rehearsing, executing, and evaluating plans with the purpose of improving their professional ability (Erickson, 2009). Though even this explanation has been subjected to controversy. While Erickson's (2009) explanation ties closely with actions and behaviours accessible to most therapists, some studies contradict this premise, associating effectiveness with genetic and psychological characteristics such as IQ (Ackerman, 2014; Hambrick et al., 2014). Macnamara, Hambrick and Oswald's (2014) metanalysis concluded that the suggested effect of deliberate practice explains 1%-26% of the variability in therapeutic performance in professionals of several fields. Other authors assert that the amount of time therapists spend in activities intended to improve their ability is a significant predictor of effectiveness, though exactly how that time should be spent is still thought to be highly individualized to each therapists' needs (Chow et al., 2015). It seems time and experience must be deliberately and consistently drawn upon if there is to be any improvement (Bennett-Levy, 2019).

Though deliberate practice shows great promise, even being regarded as the closest avenue to expertise (Ericsson, 2009), some authors have argued that the mechanisms of change in psychotherapy have not been so clearly understood that a training program containing deliberate practice could be designed (Cantonguay & Hill, 2017). The authors also state that a major problem in this area is the lack of a prescriptive model for what comprises expert performance in psychotherapy and a lack of individualized models, the argument for the latter being that training individualization motivates learners who'll then derive greater benefit from deliberate practice.

All the previous investigation is clear in one aspect above all- the field of therapist effects is complex and still in its beginning stages of investigation. Even with so many factors being repeatedly associated with effective therapists, it is still not perfectly clear how they might

influence the therapeutic process. How then, might therapists be provided with specific ways with which to improve their effectiveness?

One field of investigation that attempts to answer this question is the study of therapists with superior outcomes, that is, who they are, what they do and how they do it (Erickson et al., 2006; Chow et al., 2015).

SuperShrinks

Ricks (1974) compared two therapists who treated emotionally disturbed adolescents. For the first therapist, four out of fifteen (27%) patients went on to develop adult schizophrenia. For the second therapist, this happened to eleven out of thirteen (85%) patients. Given the ability of the former therapist, the adolescents started to refer to him as "supershrink" (Ricks, 1974). Since Rick's study, however, little has been done to deepen the understanding of supershrinks (Miller, Hubble & Duncan, 2007).

The terms "supershrink" or "master therapists" have been broadly applied to define therapists with consistently superior results both in therapeutic effectiveness and length, to some controversy (Tracey, Wampold, Goodyear & Lichtenberg., 2015). Firstly, there is still considerable debate over the definition of an expert therapist. Depending on the author, expertise may be understood in terms of (a) reputation, degree attainment, professional distinction, and experience, (b) skill, competence, or adherence to a prescribed standard of performance, (d) clinical accuracy, or (d) outcomes, that is, success with clients (Tracey, Wampold, Goodyear & Lichtenberg., 2015).

Some authors seem to find more potential in outcome-oriented definitions (see Reese, 2017), for improving accountability and quality assurance as well as providing a possibility for training. Furthermore, feedback on outcome provides the therapist with an opportunity to identify if he or she is being effective with the client and, within supervision, may help to find the reasons why therapy is being helpful or not (Reese, 2017). For its practicality, mensurable nature and flexibility regarding individual therapeutic style, Goodyear et al (2017) seem to have the most apt definition, stating that: "Experts are those for whom there is evidence of improvement over time and who demonstrate superior performance as measured by something that is both agreed on and important, specifically client outcomes". This definition also provides a solution for the previously mentioned challenge that many therapists think themselves as having superior results than they

truly do. Furthermore, feedback systems have been gaining increased credibility, as recent investigations shows that the usage of feedback systems can, in the best-case scenario, double the number of clients attaining significant improvements, half the number of dropouts, reduce the risk of clinical deterioration by a third and the length of therapy by two thirds (Lambert, 2015; Miller et al., 2015).

Defining expert therapists in terms of client outcome also allows investigators to more effectively find and study expert therapists, extrapolate conclusions from their superior results to further understand the processes that lead to therapeutic improvement (Hansen, Lambert & Vlass, 2015a).

However, it is still unclear what is the making of a supershrink. In fact, many so called expert therapists do not even know exactly what makes them exceptionally effective (Miller, Hubble & Duncan., 2007). These authors would later come to suggest three key components for expertise, working together to form the "cycle of excellence": determining bassline level of effectiveness; obtaining systematic, ongoing, formal feedback (which can enhance performance by as much as 65%) and engaging in deliberate practice (Miller, Hubble, Chow & Seidel, 2013). Miller, Hubble and Duncan (2007) have attributed special importance to the act of following up on feedback, as expert physicians seem to "need to know whether they were right" even when there is no extrinsic motivation (often monetary compensation) to do so.

Experts do seem to be the hardest and smartest workers. As Chow et al. (2015) have found, the most effective 25% of therapists spent, on average, 2.8 times more hours per week engaged in deliberate practice activities. This is in line with Ericsson and Lehmann's (1996) assertion that "measures of basic mental capacities are not valid predictors of attainment of expert performance in a domain" and that "systematic differences between experts and less proficient individuals nearly always reflect attributes acquired by the experts during their lengthy training." In other words, expertise is more closely attributable to training than raw talent.

One of the most surprising findings is that a major difference between master and median therapists is that the former are more likely to ask for and receive *negative feedback* about the quality of their work and their contribution to the alliance. Quite surprisingly, the best clinicians consistently achieve lower scores on standardized alliance scores at the onset of therapy, which allows them to address potential problems in the therapeutic relationship, whereas median

therapists might only find these problems later when the risk of dropout is greater (Miller, Hubble & Duncan., 2007).

While Sperry and Carlson (2014) agree that experts are “voracious learners”, they differ from the previous authors in their conclusions of therapeutic expertise. Focusing their research on therapeutic actions withing the therapeutic setting, Sperry and Carlson (2014) asserted that what differentiates master therapists from others is their ability to enhance the therapeutic alliance, enhance positive expectations and client motivation, increase client awareness, facilitate corrective experiences, identify patterns, and focus treatment. Master therapists then facilitate first, second and third order change. The first order is assisting clients in making small changes, reducing symptoms, or achieving stability; second order change is assisting the client in changing a maladaptive pattern to a more adaptive pattern and third order referring to clients changing patterns on their own (Sperry & Carlson, 2014). The authors also mention that, for master therapists, the first session is the most important. Whereas most therapists will follow a structured questioning focused format, master therapists focus on developing a deep connection and understanding of the client as well as effecting some level of change during the first session (Sperry & Carlson, 2014).

Caspar (2017) states that experience is required to acquire expertise, but experience does not equal nor does itself lead to expertise. The author theorizes that the mastery of skills is important as it free resources needed for expert information processing and, applying this concept to psychotherapy, asserts that experienced therapists will process information more intuitively than novices, without sacrificing rational thinking.

Castonguay and Hill (2017) claim is that therapeutic success is tied to the ability to form alliances across patients, having a sophisticated set of interpersonal skills that are revealed in challenging moments, expressing professional self-doubt, and practicing psychotherapeutic skills outside of delivering treatment to patients. The extent to which these characteristics are influenced by patients themselves is still relatively unclear.

As with therapist effects, supershrink studies find several factors that seem to be correlated with exceptional therapists. One way to deepen our understanding could be learning from case studies.

Werbart, Annevall and Hillblom (2019) had an interesting study design where they compared three successful therapies to three unsuccessful ones. Their findings were that, in successful therapies, both patient and therapist had an early common understanding of presenting

problems and what could be helpful; therapists experienced good comprehension of the patient's difficulties early on, and presented, from the beginning, a clear picture of their ways of being. Successful therapists also described an early staging of the patients' problems, which together they could work on, and focused on patient's fears and expectations. They also fostered a confident, supportive, collaborative, and challenging therapeutic relationship. Also of great interest is that in all successful cases, therapists provided a clear picture of their therapeutic work.

Current investigation on this field, perhaps due to its limited amount, is yet to reach a consensus. Clearly, if such consensus is at all possible to be found, more supershrink studies are necessary (Hansen, Lambert & Vlass, 2015b). These studies hold great value. As Miller, Hubble and Duncan (2007) have highlighted, should supershrink talents prove transferable, the implications for training, certification and service delivery would be staggering.

A phenomenon associated with Supershrinks, found within the large variety of individual responses to treatment is that of "sudden gains", also referred to as "early gains" or "rapid response" (Hansen, Lambert & Vlass, 2015a).

Sudden Gains

Several methods have been employed to measure this phenomenon, such as the therapist's rating that the client had little to no psychopathology by the end of the second session (Stewart et al., 1998), finding a 50% improvement over two sessions (Beckham, 1989; Renaud, Axelson & Birmaher, 1999) or in terms of the most extreme 10% of client sessions (Finch, Lambert & Schaalje, 2001). Though this phenomenon seems slightly mysterious, it is by no means rare. Studies on this matter report 39% to 50% (Tang and DeRubeis, 1999a; Gaynor et al., 2003; Hardy et al., 2005) of patients meeting the criteria for sudden gains and as much as 50% to 65% of total change happening during sudden gains periods (Gaynor et al., 2003; Hardy et al., 2005). Finally, patients who experience sudden gains tend to maintain their treatment responses when measured during follow up periods (Gaynor et al., 2003; Hardy et al., 2005).

The phenomenon of sudden gains challenges most traditional psychotherapeutic beliefs and evidence-based treatments with fixed session limits, namely in regard to the time necessary for significant change to occur and how patients respond to therapy, that is, in a non-linear, spontaneous way that can vastly differ from patient to patient (Hansen, Lambert & Vlass, 2015a).

Keeping in mind the sobering fact that no therapeutic improvement has been proven in the last 30 years, phenomena such as sudden gains may be precisely the kind of paradigm shift capable of stimulating further scientific development.

Some of the hypothesis regarding the mechanisms of sudden gains include the common factors, due to most of the therapeutic work being employed before any specific technique can be used (Rachman, 1999) as well as the exact opposite, that is, the argument that cognitive techniques are the fuel for these rapid changes (Tang and DeRubeis, 1999). A good fit between client and therapist has also been suggested (Orlinsky, Ronnestad, & Willutzski, 2004), as well as client factors (Finch et al, 2001). The exact reason is still up for debate, though a particular psychotherapist, considered a supershrink, will play an important role in the explanation of how clients can attain these sudden gains.

Erigoni Vlass

Within the field of sudden gains and out of the few existing "supershrink" studies, Hansen, Lambert and Vlass's (2015a) is one of the most recent and complete studies available. In it, Erigoni Vlass (or Eri, as she was referred to) was entitled a supershrink after a full year (2009-2010) of her clients was analysed. This analysis was modelled after Finch's et al (2001) study in which over 11,000 outpatient cases with OQ-45s collected at the beginning of every session were analysed, and then recovery was modelled at every beginning level of disturbance at each session of therapy, identifying the 10% of clients who were responding most positively and the 10% who responded most negatively between sequential sessions.

Out of Vlass's 248 clients, 85 were found to have completed three or more sessions of therapy. Of these 85, 43 (51%) were found to have experienced sudden gains, and 6 (7%) experienced sudden losses. Thus, Eri had over five times the expected rate of sudden gains in her caseload, and about a third less of the expected rate of sudden losses—in sum, her results for sudden gains and sudden losses were statistically exceptional and she could be characterized as a "supershrink." In terms of Eri's overall caseload (N=248), her status of supershrink is again confirmed, with over 4.3 times the number of clients in the top 10% of response, and only 0.70 times the number of clients expected in the bottom 10% of response.

Vlass's method and approach is described in full in the original study (see Hansen, Lambert & Vlass, 2015a). In short, Vlass is an "active problem solver" who is "always open to new

possibilities to improve patient outcome while gathering data on the client's response to treatment" and as having "an eclectic, holistic, and highly individualistic approach to the client and the therapy process that begins in the first session. Moreover, she holds at the forefront of her mind the principle that clients are largely in control of their own change processes, and she values this autonomy and independence" (Hansen, Lambert & Vlass, 2015a). Lastly, Vlass combines two complementary theories, that of Cognitive Behavioural Therapy (CBT; Beck, 1993) for identifying and challenging irrational beliefs, and Compassionate Mind Training (CMT; Gilbert & Procter, 2006), an intervention aimed at alleviating high levels of shame and self-criticism (Hansen, Lambert & Vlass, 2015a).

Hansen, Lambert & Vlass's (2015a) study was designed with the purpose of investigating the phenomenon of sudden changes and the role of the therapist variable. For this objective, the measures utilized were the Outcome Questionnaire 45 (OQ-45), as a measure of mental functioning; the Consumer Reports Satisfaction Survey (CRSS-4); the Working Alliance Inventory (WAI) and the Client Change Interview Protocol (CCIP).

With a clinical cut-off point on the OQ-45 of 63/64, the average intake for blue cases was 111.4, which is "extremely high" at the 99.7th percentile, and an average "still quite high" 92 for red cases, in the 98.6th percentile. For post treatment, Blues had a "statistically significant" drop of 73.8 points into the non-clinical domain and the Reds a non-significant 8.4 points to 83.6, which is still in the clinical domain (Hansen, Lambert & Vlass, 2015a). Between their final session and a two year follow up, both blue and red cases remained, on average, at a similar level of distress, suggesting stable long term therapy effects.

As far the results for the WAI, all blue cases rated the quality of the therapeutic alliance higher, with less variability in their scores than the reds. This result is consistent with some of the theoretical approaches presented previously, namely the contextual model. However, the two groups had a similar level of trust, acceptance, and confidence within the therapeutic relationship with Eri. What differed most was that blues had higher scores on the Tasks and Goals subscales, which is indicative of the importance of setting agreed upon goals for therapy (Hansen, Lambert & Vlass, 2015a).

In the CCPI self-description at the two year follow up, blue cases were notably more positive in describing their self-images, wherein reds used more negative adjectives and noted substantial areas for improvement (Hansen, Lambert & Vlass, 2015a). In terms of Unique

Therapist Qualities, both blue and red cases commented on factors related to the therapist's personality and approach that they considered helpful, using adjectives such as "lovely, very welcoming, soothing, compassionate, non-judgemental, open and welcoming" and feeling "ease of connecting", "easy rapport", "comfortable", "understood", "supported" as well as "validation" and "reassurance" (Hansen, Lambert & Vlass, 2015a). Eri's abilities were also mentioned, namely "connecting thoughts and emotions" which brought about relief, a "connection between past experiences and present emotions", "helping with decision making", Vlass's help in stabilizing sleep patterns even her meditation CD, which Vlass offered to her clients. Finally, her spirituality and mindfulness-based interventions were positively mentioned by some patients (Hansen, Lambert & Vlass, 2015a). As far as the negatives, one blue mentioned the hypnosis and the computed scores as disappointing, and another criticised the lack of time. The reds criticised mindfulness-based interventions and showed greater hopelessness. Several other client characteristics are described in the original article (see Hansen, Lambert & Vlass, 2015a).

Four out of five blue cases achieved their sudden gains in session 2, with the last patient having such gains in session 4. To explain such results, the authors present the following explanation: "The client descriptions of their therapeutic relationship with Eri portray a therapist with charisma, with the ability to make a strong, immediate connection, with a clear and persuasive plan for change based on both medical and psychological principles, and with an expectation of quick change. In line with this, her techniques are designed to empower clients to find their own solutions, and her pragmatic approach does not require lengthy treatment. Thus, Eri provides her clients a holistic, top-down view of their psychopathology within the first session, so that they have a working rubric to organize their symptoms and seek to find solutions in a timely period." (Hansen, Lambert & Vlass, 2015a).

Lastly, in one of the hypotheses put forth to explain the difference in treatment results between blue and red cases, the authors note: "it is possible that therapy is merely more effective with people who share similar values and goals with the therapist." (Hansen, Lambert & Vlass, 2015a).

Eri has also detailed some information regarding herself: *"I am very vigilant with self care. I maintain a healthy lifestyle exercising everyday, eating healthy foods and getting adequate sleep. I practice mindfulness meditation. During treatment sessions I am very focused on the person I am working with and no matter how difficult the presenting problem or the underlying problem for*

that matter, I know that I will be able to respond appropriately. I have had extensive clinical experience over the past twenty years working in areas such a post natal depression, sexual health, child and adolescent anxiety, trauma, drug and alcohol, eating disorders, bereavement and loss, sleep disorders, anxiety and depression, family therapy and parenting. As a member of the Australian Psychological Society we are required to complete 30 hours of professional development a year, which means that we attend conferences workshops and engage in peer supervision." (Hansen, Lambert & Vlass, 2015b).

Hansen, Lambert and Vlass (2015a) have presented us with a greatly detailed investigation of a "supershrink", with the admitted limitations of having a small sample size, the possibility of conflating correlation and causation and the retrospective nature of the study. Though a direct causation could not be established with such study design, these authors do offer a uniquely practical perspective on therapist expertise. Indeed, this study dives deep in the uncharted waters of "supershrinkdom". After this publishment, the authors subsequently published a following article titled "Calling for More Case Studies of Exceptional and Efficient Psychotherapists" (Hansen, Lambert & Vlass, 2015b) wherein they answer to some constructive criticism (see Laska & Federman, 2015; Pereira & Barkham, 2015).

In this paper, I intend to answer these authors' call. Having established Erigoni Vlass as a person deserving of the supershrink title and in the spirit of supershrink investigation, the present study will attempt to dive deeper still, by qualitatively analysing transcriptions of three full therapeutic treatments consisting of two consultations of two of Erigoni Vlass's patients (that is, the first session and the second being the final session) and a one and only session of another patient, with the objective of learning and detailing the therapeutic actions and factors that might allow for such rapid, significant and long lasting results.