On Becoming a Psychotherapist

The Personal and Professional Journey

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Introduction

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How does someone become a psychotherapist? What sort of education and training, life experiences, and professional experiences are necessary to become a competent psychotherapist? Do certain childhood experiences, or some combination of genetic endowment and personality traits, equip one to become a more effective and successful psychotherapist? Is there a common path that psychotherapists follow in their development? These are issues of significant interest to both the mental health professional community and to the public that relies on the quality of its services. Because of the rapidly changing health care environment, these issues have become increasingly salient and require thoughtful consideration. Our goal in this volume is to comprehensively explore the many experiences that therapists have over the course of their lifetimes, both personal and professional, that contribute to their professional identities as practicing psychotherapists, a process that we construe as an ongoing lifetime endeavor that ends only when the practitioner ceases to practice.

To achieve our aim of exploring the process of how therapists develop into the clinicians they become, we have made an effort to deconstruct the process—that is, to identify what we understand to be the key developmental experiences that most therapists go through in their professional evolution. We are well aware that this process is highly individualized, and that there is enormous variation between and among therapists as to what influences are most important in their development. However, we also believe there are certain influences that virtually all clinicians experience that inevitably have an impact on how they develop as therapists.

The issues we have chosen to explore will be addressed in a series of chapters written by acknowledged experts in our field. Our authors all draw upon their experience and expertise, as well as their personal reflections. Wherever possible, they incorporate findings from relevant empirical research into their chapters, and highlight ethical, cultural, and diversity issues. Let us briefly describe the influences we have decided to highlight in this volume.

First, we will take up the influence of early life experiences. Freud's early writings alerted us to the lifelong impact that early life experiences have on

how our lives unfold, and there has never been any serious refutation of this notion; in fact, it is at this point a universally accepted truism. We will then look at therapists' experiences with mentors and other role models. Most of us meet people along the way who make deep impressions on us, and whose influence we look back upon as having been formative in our becoming who we become. We often meet such people well before we embark upon a particular professional course.

Once we have embarked on the road to becoming a therapist, and sometimes even before (that is, in undergraduate courses), we begin our didactic preparation for becoming a practicing clinician by taking courses and reading about such things as normal development, psychopathology, and even approaches to treatment. This continues in graduate training, where there is typically some time spent in the classroom before actually beginning to see patients. Of course this varies from profession to profession: often psychiatric residents begin seeing patients before spending much time on didactic preparation. But the typical sequence is to do some didactic preparation before entering the clinical fray.

What comes next is our beginning encounters with actual patients. Such encounters almost always have great influence on how we develop as clinicians: the experience is usually very challenging, and can easily be traumatizing. We move on from a consideration of these early clinical encounters to a discussion of the developing clinician's experiences in supervision. Here we will focus not only on early supervisory experiences, but also on supervision throughout one's professional career. Most clinicians have experiences with multiple supervisors over the course of their careers, at least some of whom are usually pointed to as formative as clinicians reflect on how they have developed into the therapists they have become.

We then take up the question of the influence of personal treatment on the development of the therapist. While some specialty approaches to psychotherapy (e.g., psychoanalysis) require their candidates to undergo personal treatment, training programs in psychiatry, psychology, social work, and the related disciplines typically do not. Nevertheless, a high percentage of mental health professionals in training, and subsequent to training, voluntarily avail themselves of the opportunity to experience personal treatment, often more than once, over the course of their careers (see Chapter 7). For those who do, the experience is almost always an important influence on how they develop as therapists. We then move on to a consideration of the therapist as "wounded healer." There is a widespread notion that therapists enter the field in order to resolve their own personal issues. We do not necessarily subscribe to this notion, but we do believe that *everyone* sustains wounds over the course of a lifetime, and that therapists need to deal with their wounds if they are going to be successful in their professional roles.

Next we take up a recent development in our field that has begun to influence all practitioners, and that is likely to have increasing influence in the years ahead: the increased emphasis on evidence-based treatment.

For many of us, we have been practicing without clear and objective evidence that what we are doing is effective. We adapt to this reality in different ways, of course, but now that there is increasing pressure to provide such evidence, we are all confronted with the need to come to grips with this in some way, if only internally. We then turn to a consideration of cognitive-behavioral therapy (CBT), the approach to treatment that has been most responsive to the increased emphasis on evidence-based treatment. This chapter will highlight the ways in which CBT is different from psychodynamically oriented treatment approaches, but also how they overlap. It will permit us to examine in greater detail differences between the developmental pathways available for both CBT and psychodynamically oriented clinicians. Finally, we provide an overview of the status of empirical research in our field that bears upon changes in current and future clinical practice patterns. This will lead us into our concluding chapter, in which we will summarize the insights and contributions of our authors, put forth a general model of psychotherapist development, and make suggestions about therapist growth and well-being garnered from what we have learned by shepherding this book to its conclusion.

Our efforts to identify and explore the essential components of how psychotherapists become the practitioners they are will not be limited only to an examination of their formal education and training, but will also include consideration of their lives, careers, practices of psychotherapy, and patterns of self-care and personal growth. We will attempt to shed light on how these components are effectively organized and integrated, and address the current controversies that surround what constitutes the optimal set of experiences for the developing psychotherapist. The challenges facing practitioners in the contemporary health care environment will be examined in terms of their implications for psychotherapist selection, education, supervision, practice, and continued professional growth, and with an eye toward delineating what mitigates for and against good treatment outcomes.

Literature Review

When compared to the research on psychotherapies, research about psychotherapists is relatively limited. (In 1997, for example, *Clinical Psychology: Science and Practice* presented a special series entitled: "The therapist as a neglected variable in psychotherapy research.") The literature in the area of psychotherapist development is even more sparse. Some authors have provided biographical or autobiographical accounts of well-known analysts (Gay, 1988; Jung, 1989; Strozier, 2001). A few contributions have appeared on the evolving professional self (Cross & Papadopolous, 2001; Kottler, 2003; Mahoney, 2001; Skovholt & Ronnestad, 1995). Others have focused on how one becomes a "master" therapist (Jennings & Skovholt, 1999; Skovholt & Jennings, 2004); the frequency and value of personal treatment for the

psychotherapist (Bike et al., 2009; Brenner, 2006; Freudenberger, 1986; Geller et al., 2005; Norcross, 2005; Penzer, 1984); and the process of adopting a theory that works for the particular therapist (Truscott, 2010). Conscious and unconscious motives for practicing psychotherapy have been described (Ellis, 2005; Farber et al., 2005; Mahrer, 2005; Norcross & Farber, 2005; Orlinsky, 2005; Reppen, 1998; Sussman, 1992), as has the importance of psychotherapist resilience (Skovholt, 2001). Bergin and Garfield's *Handbook of Psychotherapy and Behavior Change* has contained in each edition (1971, 1994) an extensive compilation of research on therapist variables and their relationship to outcome in psychotherapy. Specific therapist characteristics thought to promote effective treatment outcomes have been the subject of extensive investigation (Bergin & Garfield, 1971, 1994; Crits-Christoph et al., 1991; Garfield & Bergin, 19781978, 1986, 1990; Lambert, 2004; Norcross, 2002a, 2002b). Therapist use of self (Basescu, 1990), the personal life of the therapist (Guy, 1987), therapist self-care (Baker, 2003; Norcross, 2000), and attempts to identify what creates and sustains commitment to the practice of psychotherapy (Dlugos & Friedlander, 2001; Miller, 2007) have all received considerable attention. Efforts have also been made to examine the therapist as wounded healer (Millon et al., 1986; Rippere & Williams, 1985; Sherman & Thelan, 1998; Stadler, 1999) and to explore therapist burnout (Deutsch, 1984, 1985; Edelwich & Brodsky; 1980; Maslach, 1982, 1986; Maslach & Leiter, 1997). In recent years, ethical and professional issues facing therapists have been receiving increased attention (Brabender, 2006; Cottone & Tarvydas, 2003; Pope & Vasquez, 1991; Truscott & Crook, 2004; Welfel, 2002). So, too, is the importance of recognizing and effectively dealing with multicultural issues, including race, ethnicity, and gender (APA, 2002; Baruth & Manning, 2003; Brinson & Cervantes, 2003; Comas-Díaz, 2005; Debiak, 2007; Fish, 1996; Markus, 2008; Pope-Davis & Coleman, 2001; Robinson & Howard-Hamilton, 2000; Sue & Sue, 1999). Several recent series of journal articles describe the journeys that practitioners have taken over the course of their professional lives (Bernard, 2008; Rhead, 2006).

Only a few contributions, however, have specifically dealt with the evolving professional self (e.g., Belson, 1992; Dryden & Spurling, 1989; Farber, 1990; Goldfried, 2001; Kottler, 1986, 2003; Orlinsky & Ronnestad, 2005; Orlinsky et al., 2005; Skovholt & Ronnestad, 1995). Of these, Orlinsky & Ronnestad (2005) have produced by far the richest and most comprehensive work in the field. Through their use of a detailed questionnaire, they collected self-reports from nearly 5,000 psychotherapists from countries worldwide at different points in their careers. Initiated in 1989, they then studied therapeutic work and professional growth for 15 years as a cooperative enterprise under the auspices of the Society for Psychotherapy Research. Their research clearly underscores the important contribution made by psychotherapists to clinical outcomes. It also attempts to determine whether patterns of professional work and development can be identified, and whether these are similar across professions.

With regard to professional development *per se*, innumerable didactic curricula have been developed by all of the disciplines involved in the teaching and training of mental health professionals that specify the body of knowledge that needs to be mastered to become an effective psychotherapist. But few if any authors have attempted to provide a volume that effectively integrates both professional and personal development. Moreover, no one has yet examined the matter of psychotherapist development in the current socioeconomic and cultural context, which is characterized by both an emphasis on brief, cost-efficient, evidence-based treatment and a growing body of theory and research that suggests that more attention needs to be devoted to the person of the psychotherapist in order to better understand treatment process and outcome.

This volume seeks to address the need for an integration of what is involved in the development of the psychotherapist at both the personal and professional levels. Among the matters that will be considered is how the training of mental health professionals should be affected by the increased recognition of the importance of the therapist's person to treatment outcome; how to integrate our understanding of the personal and professional experiences that developing psychotherapists have with the formal training they receive; and how the shifting cultural context affects the demands and challenges facing psychotherapists today. Ultimately our field would do well to have a comprehensive and generalizable model for therapist growth and development. Our intention is to address these various needs.

Why Now?

We believe this volume is timely for a number of reasons. First, as you see from the literature review we have provided, there has not been a great deal of work published about the topic of therapist development. While we all go through a developmental process, we are often not aware of how the various influences we discuss in this volume are affecting us cumulatively. Also, we believe that those who are charged with shepherding therapists in training through the developmental process will find this book valuable in thinking about how they structure their training programs to facilitate optimal therapist development.

A second, equally important rationale for organizing this book now is that there has been a fundamental evolution in our field in the direction of greater appreciation for the contribution of the therapist's person to the treatment process. The notion of the therapist as a "blank screen" onto whom the patient projects his or her transferences, to be interpreted by a neutral, objective and non-contributing therapist, is all but passé. The emerging consensus over the past few years is that therapists are active co-participants in the interpersonal field that develops between them and their patients (Aron, 1996; Mitchell, 1988). This "intersubjective" approach has been gaining increasing

attention and support (Fosshage, 2003; Ogden, 1994; Stolorow & Atwood, 1992). It follows that the more we know about therapists as persons, and the process of development that has led them to bring what they bring to the therapeutic encounter, the more we will know about what ultimately transpires in the consultation room. It is noteworthy that this consensus extends even to many therapists who practice CBT and other approaches that follow manualized protocols (see Chapter 10). The particulars of the nature and extent of the therapist's influence on the unfolding treatment process are just beginning to be fleshed out in research, but the general sense that the therapist's contribution is profound is increasingly held to be beyond dispute—thus the importance of understanding as much as we can about who therapists are and how they become the practitioners they become.

Finally, therapists are facing many new pressures as psychotherapeutic practice continues to evolve. Later in the chapter we will briefly describe some of the sociopolitical, scientific, and theoretical developments that are having an impact on contemporary practice. The pressures exerted by managed care companies and the increased emphasis on evidence-based treatment are prodding therapists to justify what they are doing. The economic pressures that impinge on both therapists and patients profoundly affect the treatment experience as well. We need to know as much as we can about how these matters influence what therapists bring to their therapeutic encounters. In sum, the more we know about the person of the therapist, the more we will know about the process of therapy and what individual practitioners and training programs can do to facilitate optimal therapist development.

Factors Impinging on Contemporary Therapeutic Practice

There can be little doubt that we live in an age of rapid, kaleidescopic change, with shifting realities and priorities. We believe it is especially timely to assemble this volume since the entire health care field has been undergoing enormous change. As this chapter is being written, the U.S. Congress is struggling to come to terms with proposed legislation that would fundamentally change the way health care is practiced and paid for in this country, a topic deemed to be of the highest priority by the Obama administration. Among the critical questions that are being addressed in the current debate are: Can we make health care available to all, or at least to a greater number of people than we do currently? If so, how will it be paid for? Can we create a "public option"? How will quality of care be affected by the changes that are being contemplated? Will we establish a two-tier health care system in which only the wealthy or privileged will be able to gain optimal care? Stakeholders in this important discussion include, among others, health care consumers, health care providers, insurance companies, administrators, actuarial cost-benefit analysts, and of course politicians, who seek both to represent their

constituencies and to be re-elected. Many powerful and well-organized voices are being heard during the debate. We hope that those of the poor, minorities, immigrants, the elderly, and the historically underrepresented will also be heard. Precisely whose interests will be best served remains to be seen. But no matter how these issues are addressed and resolved, the answers will have a profound impact on the nature, availability, quality, cost, and delivery of mental health services.

In the following sections we want to briefly identify and highlight those specific factors that have affected mental health and have had the most significant impact on the practices of those who become psychotherapists. Specifically, we will address the issues of managed care, the increased prevalence of short-term psychotherapy and manualized treatment, advances in neuroscience, changes in psychopharmacology, the changing patient population, differences in services and providers, accountability and evidence-based treatment, and changes in psychodynamic theory that underlie much of the psychotherapy that practitioners currently offer their patients.

Managed Care

Any clinical professional who currently practices psychotherapy or who is preparing to enter the field as a provider must take into consideration the complex and influential reality of managed care. In most managed care operations, case managers now determine what practitioners are permitted to do, with whom, and for how long. Clinician treatment plans must be approved, mandated treatment reviews are required, treatment results must be documented in clearly measurable terms, and any form of treatment that extends beyond a short time period must be preauthorized. The days when long-term, uncovering, insight-oriented treatment would be covered by health insurance are over. Five years of psychoanalysis has largely been replaced by five sessions of approved care. Treatment geared to promoting self-awareness and establishing more authentic, gratifying human relationships is a hard sell today. Managed care companies apply continual pressure to keep all forms of treatment brief and cost-effective. At the same time as this pressure is being exerted by the managed care industry, our culture has put more and more emphasis on achieving immediate results, so there is pressure for quick results from consumers as well. Instant food, instant housing, instant information, instant gratification, and instant treatment are often what seem to be desired.

Short-Term Psychotherapy and Manualized Treatment

Developments in the theory and practice of short-term psychotherapy seem to reflect this uniquely American perspective. Various models of short-term individual (e.g., Davanloo, 2001; Mann, 1973; Sifneos, 1987) and group psychotherapy (e.g., Budman et al., 1996; Klein, 1985; MacKenzie, 1997)

have appeared in the literature over the past half-century. For the most part, these short-term approaches advocate addressing more limited treatment goals with a more narrowly defined patient population. Of particular interest here is the fact that these approaches lend themselves more easily to research than do longer-term treatments. More recently, short-term approaches have been bolstered by the development of what have been called "manualized" treatment approaches, which attempt to provide a clear set of instructions for the therapist to apply in conducting more time-limited forms of intervention. In large part, the impetus here is to make the process of psychotherapy more objective and standardized, and to make it easier to train successful, competent therapists. Implicit in this effort is the notion that all therapists are equal and interchangeable, and that the method of treatment, not the person of the therapist or his or her relationship with the patient, is critical for producing change.

Advances in Neurosciences

At the scientific level, the practice of psychotherapy has also been influenced significantly over the past two decades by advances in the areas of neuroscience and biochemistry. As a result, we have begun to fashion a more complex view of human development, and, therefore, the treatment of illness or disorders. To view psychiatric disorders as purely biologically determined, and not significantly influenced by experience, is now considered an overly simplistic, reductionistic view. Recent findings in neuroscience indicate that interactions with the environment, especially interactions with other people, have a direct impact on the structure and function of the brain (Siegel, 1999; Siegel & Hartzell, 2003). One need not choose between biology versus experience, or mind versus brain. Understanding brain/mind functioning and the flow of energy and information in the brain requires an understanding of how human relationships can affect neuronal activity, organization, and function. Mental health treatment, therefore, must consider biological and experiential factors as well as their reciprocal influence upon one another.

Changes in Psychopharmacology

In conjunction with these developments, as the biochemical/biological components of various symptoms and diseases are being more clearly identified, we have witnessed a veritable explosion in psychopharmacological treatments. While it is not our purpose here to review these advances, it is important to note that new and reportedly more effective medications with fewer side effects are available for treating a host of different disorders. Furthermore, advances in psychopharmacology have paved the way for significant reduction of the disabling symptoms that, in past years, often prevented or significantly interfered with patients' capacities to make successful use of psychotherapy (e.g., patients suffering from psychosis, obsessive-compulsive

disorder, bipolar disorder, or severe depression). Such patients, when properly medicated, are now more frequently amenable to psychotherapy.

This proliferation of medications, however, has also ushered in new problems. Thus, for example, these medications are now being prescribed not only by psychiatrists, but also by primary care and other non-psychiatric physicians, advanced practice nurses, and so forth, many of whom have only limited experience in using these medications to deal with difficult-to-treat clinical situations. As a result, complications not infrequently arise in treatment when a prescribed medication does not work as hoped for. Patients are often referred for treatment to a mental health professional only after unsuccessful treatment attempts have been made by the patient's primary care physician.

In addition, successful use of medications may have paved the way for unrealistic wishes, on the part of patients, clinicians, and insurance companies, that medication alone will be sufficient, and that a short-term, cost-effective solution can be easily found. Such beliefs are maintained even though studies involving random controlled trials repeatedly confirm that the combination of medication and psychotherapy is more effective than either alone in treating a variety of psychiatric disorders (e.g., Eddy et al., 2004). Providing only psychotherapy without at least raising for consideration with the patient the potential use of medications may soon be construed as malpractice. The opposite, of course, may also hold true: simply providing medications without considering psychotherapy may be viewed as untenable.

Even so, one cannot turn on the television without being bombarded by a spate of commercials advertising one or another new medication that is good for whatever ails us. Many of these medications are for treating psychiatric problems. Possible medication side effects and complications are carefully listed and consumers are, of course, reminded to talk to their doctors about whether such medications are right for them. Nevertheless, the overall impression conveyed is that most psychiatric problems, especially depression and anxiety, can be successfully treated by some form of medication.

It is important to note in this regard that the impressive advances made in the field of psychopharmacology do not reduce the importance of psychotherapy. Even when treating those disturbances now thought to have a biological basis, "talking therapy" remains a cornerstone of what mental health professionals have to offer (Engel, 2008). Each of these sets of symptoms or disorders has significant personal and interpersonal antecedents and clearly has profound consequences for one's present life. Anyone who has suffered from, treated, or lived with a patient suffering from an affective or anxiety disorder, for example, will attest to the fact that these disorders disrupt and negatively affect all those involved with the individual struggling with the problem. In fact, most people come into treatment seeking help with how they are feeling about themselves and their interpersonal relationships, not simply relief from their symptoms. After all, it is a human being who is experiencing these problems. The best health professionals treat the person, not

the symptom or the disease. Furthermore, medications themselves are prescribed within an interpersonal, relational context. In fact, one might argue that the therapeutic relationship is crucial in determining the success of a treatment intervention, even when that intervention is primarily or exclusively psychopharmacological.

Practicing psychotherapists, therefore, need to remain aware of the increasing array of available medication options, and must possess some understanding of their indications and contraindications for use, as well as their benefits and limitations. Psychotherapists must also be prepared to work collaboratively with other health care providers.

The Changing Patient Population

Another factor that continues to affect the journey of becoming a therapist is the changing nature of who comes for treatment. Psychotherapists are no longer simply treating the "worried well." YAVIS syndrome (young, attractive, verbal, intelligent, and successful) patients seems to be in far less abundance. Instead, mental health professionals are being asked to treat more and more people with complex, hard-to-treat disorders, including substance abuse, dual diagnoses, eating disorders, and severe personality disorders. These individuals come not just from the white, upper-middle class, but from all walks of life, with different cultural backgrounds, and varying levels of education, verbal ability, and psychological mindedness. They, therefore, pose new challenges for clinicians. Older, more traditional models for conducting psychotherapy are often not relevant in working with these patients. In addition, clinicians themselves are much more diverse, and they, like the patients they treat, bring with them into the consulting room their own beliefs, values, and cultural traditions. Furthermore, many clinicians are moving beyond the consulting room into the community. Planning, implementing, and evaluating post-disaster mental health interventions is becoming an area of heightened concern for many professionals. Worldwide dissemination of intervention protocols requires a much more sophisticated recognition and appreciation of cultural differences. Furthermore, helping patients dealing with sudden and overwhelming loss, complicated grief and depression, and post-traumatic stress disorders is stressful for therapists and requires additional training, a new set of skills, and different levels of supervision and support for treaters (Klein & Phillips, 2008; Klein & Schermer, 2000; Saakvitne & Pearlman, 1995).

Different Types of Services and Providers

With the increasing demand for mental health services has come increased competition in the marketplace. More and more people are presenting themselves as "therapists," regardless of their training. Even though licensure and certification requirements are becoming more stringent for some professions

in some states, this trend is more than offset by the proliferation of people who hold themselves out to be helpers in one way or another. New fields are evolving as offshoots of more traditional psychotherapy, such as "life coaching." Anyone seeking psychotherapy quickly realizes that various types of "therapy" are practiced by mental health professionals as well as others who do not necessarily have a background in the social and natural sciences. Many of these "therapists" are not subject to state licensure requirements, nor are they necessarily part of any national professional regulatory organization. Modes of delivery for psychotherapy are also undergoing significant change. One can currently be treated, for example, by telephone (Simon et al., 2004, 2009) or via the Internet (Christensen et al., 2004; Griffiths & Christensen, 2007; Horgan et al., 2007; Kessler et al., 2009), not just in a professional office. Computer-aided psychotherapies are being used with increasing frequency (Marks et al., 2007; Marks & Cavanaugh, 2009). However, in our view and for the purposes of this volume, the term "psychotherapy" refers to face-to-face treatment provided by helping professionals trained in the traditional mental health disciplines of psychiatry, psychology, social work, and nursing. This includes directive and non-directive mental health counselors in a variety of specialties; psychoanalysts and analytic therapists; cognitive and behavioral therapists; group therapists; family therapists; gestalt therapists and transactional analysts; and those with psycho-spiritual or faith-based emphases. The preparation and training of all such psychotherapists includes exposure to empirical research as well as theory, and careful consideration of ethical, cultural, and diversity issues associated with the practice of psychotherapy.

Accountability: Evidence-Based Practice

Concurrent with these developments, there has been a much broader, rapidly growing national trend, fueled by multiple sources (e.g., the federal government, consumers, providers, and insurance companies), that reflects an increasing emphasis on accountability. The crucial question/challenge being raised is: Does psychotherapy work, and *can it be "proven"*? Practitioners are being asked to demonstrate the efficacy of what they are doing—that is, to prove that psychotherapy works (Burlingame & Beecher, in press; Klein, 2009). This escalating pressure has given rise to increasing demands for "evidence-based" practice. Treatments that are evidence-based have been demonstrated to be effective utilizing scientific criteria (Burlingame et al., 2004a, 2004b). Both the Rosalynn Carter Symposium on Mental Health Policy (2003) and the President's New Freedom Commission on Mental Health Final Report (2004) formally endorsed evidence-based practice. Each maintained that effective services and supports validated by research found their way too slowly into practice. They suggested that a premium be placed on rapidly incorporating evidence-based practices as the bedrock for clinical mental health services. Treatment approaches that fail to do this and/or

cannot demonstrate through systematic research that they are efficacious may well fail to qualify for reimbursement, and may in the future even be regarded as unethical.

Despite these admonitions, considerable ambiguity, confusion, and controversy have continued to surround the notion of evidence-based practice (Bohart et al., 1998; Chambless & Ollendeick, 2001; Norcross et al., 2005). Although the term "evidence-based" is frequently used to confer the mantle of scientific legitimacy and respectability on particular interventions, it is often unclear what this term actually means. On the most fundamental level, what constitutes acceptable "evidence," and at what levels of specificity should it be required (Burlingame & Beecher, in press)? Are we talking about empirically supported treatments, or what were previously called empirically validated treatments? The American Psychological Association has used the notion of "evidence-supported treatments" based on randomized clinical trials, widely regarded as the "gold standard." In contrast, should evidence-based treatment conform to generally accepted "practice guidelines" (e.g., Bernard et al., 2009), a more descriptive than prescriptive approach suggested by the American Psychiatric Association? Demonstrating "efficacy" requires randomized controlled trials, the hallmark of drug studies, while "effectiveness" rests on studies conducted under naturalistic conditions. With regard to psychotherapy practices, nearly 80% of the studies demonstrating efficacy are based upon cognitive and/or behavioral approaches (Burlingame et al., 2004b). Psychodynamic and humanistic approaches remain underrepresented (Wampold, 2001). Does that mean that it is much more difficult to demonstrate the efficacy of such treatment approaches, or that they are of more limited value (Leichsenring, 2005; Wampold, 2007)? In addition, since most research is about pure outcome without consideration given to relevant process variables, it is virtually impossible to determine what specifically accounts for change. Might most of the variability in reported success rates be attributable not to the particular technical model under investigation, but to common factors across different approaches, or to differences in the quality of the patient–therapist alliance (Ahn & Wampold, 2001; Frank & Frank, 1991; Hubble et al., 1999; Kazdin, 2005)? Impassioned debates continue to be waged about precisely how to define and measure "success" in treatment: From whose perspective? At what points in time? Measuring symptom change is certainly considerably easier than attempting to define and measure changes in the quality and depth of self-understanding or interpersonal relationships. Precisely how these issues will influence the ways in which psychotherapy will be practiced going forward and, therefore, how practitioners need to be trained, remains to be seen.

Changes in Theory

An additional compelling reason for doing a book on psychotherapist development at this point in the evolution of our field has to do with recent

theoretical advances in the area of psychodynamic treatment that have emphasized that the psychotherapist is not simply a blank screen upon whom the patient projects his or her problems. Rather, these theories maintain that the person of the psychotherapist is a crucial contributor to the treatment of patients. Of particular importance in this regard is the growing interest in intersubjective and relational models of treatment, which have as their premise the notion that psychotherapy is a co-creative process between therapist and patient. As such, the person of the therapist is a crucial contributor to, and determinant of, the success of a treatment experience. These theoretical advances have been supported by a growing body of evidence in the form of both research and clinical experience that has shown that the therapist-as-person has a profound impact on treatment outcomes above and beyond his or her training and theoretical orientation (e.g., Garfield & Bergin, 1990; Lambert, 2004; Luborsky, 1992; Norcross, 2002a, 2002b). From the current intersubjective and relational perspectives, the therapist's own experience, attitudes, and unconscious processes interact reciprocally and mutually with those of his or her patients, so that the effectiveness of treatment depends crucially on the nature and quality of the therapeutic relationship and the "match" between therapist and patient. Thus far, therapy has by and large put its "microscope" on the patient and his or her psychopathology, but it is clear that more needs to be known about what the therapist and the therapeutic interaction bring into the equation. If this volume adds to our knowledge of what is involved in the development of the therapist's persona, and how we can promote increased awareness on the part of the therapist regarding the nature of his or her contribution to the treatment process, we will have accomplished our purpose.

Implications for Therapist Training and Development

What, then, are the implications of these factors that currently affect the process of becoming a psychotherapist? How might they affect or fundamentally change the education and training, as well as the long-term professional and personal growth, of practitioners? What can we expect the next generation of clinical practitioners to be facing, and how can we best prepare them to function effectively?

Several preliminary suggestions can be made, each of which will be explored, developed, and augmented in the chapters that follow. To begin with, it seems clear to us that psychotherapists need to develop and maintain flexibility and range in their modes of intervention, a firm grasp of their limitations and biases, and an awareness and appreciation of what other mental health professionals have to offer. It is clear that psychotherapists as a group will continue to be called upon to provide treatment to an increasingly broad range of patients, many of whom are difficult to treat. They will be asked to

do so using a variety of strategies and techniques, applied under a variety of circumstances, in a variety of settings. For example, treatment is needed not only for the "worried well," but also for patients with complex dual diagnoses. In such clinical situations, being able to work (conjointly and) collaboratively with professionals from other disciplines is essential to ensuring quality of care. *It will be incumbent upon clinicians to remain sensitive to sociocultural differences.* Furthermore, whether one is treating a patient and/or a family on an inpatient or outpatient basis, or providing help following a disaster to organizations and communities, one must remain aware of what is possible to accomplish and what is not.

It is safe to assume that the influence of managed care, with its preoccupation with cost-effectiveness, and the demand for accountability, in the form of the increased demand that treatments be evidence-based, are not likely to diminish in the near future. Hence, psychotherapists will need to have available within their treatment arsenals short- as well as long-term treatment strategies and methods. Furthermore, such practices will need to be based on empirical research, or they may not be covered by insurance, and might even be considered unethical.

While no single psychotherapist can necessarily master all of these elements so that he or she can provide effective care to the full range of patients no matter what the circumstances, each will need to be well schooled in multiple approaches to treatment, without being casually eclectic. A core set of fundamental beliefs, values, and ethical standards will be needed to anchor this level of flexibility. Furthermore, whatever form of treatment he or she provides, it will be essential to understand the significant contribution of the therapist's self as person to the interpersonal process of psychotherapy. Increased self-awareness will also be needed to determine what patients, methods, and theories of psychotherapy one can work with effectively. Making this determination will require the integration of personal and professional development. The task of integrating the personal and the professional, in our view, can best be accomplished by therapists engaging in personal psychotherapy.

From this perspective, it is also clear that the knowledge base for the next generation of psychotherapists will need to expand. Psychotherapists, for example, will need to know more about developments in neuroscience and psychopharmacology. They also will need to become sophisticated consumers of research on psychotherapeutic process and outcome. They will need to learn how to make use of new approaches that appear to be promising. Positioning oneself to be equipped to incorporate into one's arsenal those approaches supported by research will become increasingly important.

At a broader level, psychotherapists in the next generation will need to be trained to manage the stress of the occupation, adapt to changing circumstances, and maintain their core identities and values—all while learning to make a living! Three central lifelong challenges must be repeatedly faced by all psychotherapists: (1) how to remain sufficiently open to permit new

learning/growth as a person and as a professional; (2) how to most effectively use oneself in the treatment process; and (3) how to maintain resilience, arrive at a viable balance between professional and personal concerns, and continue to function in a committed, vibrant, and authentic fashion.

Stages of Therapist Development

One area of interest that we plan to investigate is whether we can identify stages of therapist development. Apart from the contributions of Ronnestad and Skovholt (2003) and Orlinsky & Ronnestad (2005), relatively little systematic research has been conducted in this area. Nevertheless, we believe that it is worth having a closer look to try to determine how professional psychotherapists develop over their careers, and how that developmental process affects both their personal and professional lives. Is there a discernible pattern to such development? Can common features be identified? How important are certain aspects of development? Is there an optimal sequence that should be followed to become an effective and successful psychotherapist? If, for example, we can outline a series of developmental stages, each of which contains a specific task or set of tasks to be negotiated and mastered, it may be possible to draw some important implications for therapist selection, education, and training and for therapists' future growth, development, and sustainability.

In this connection, it is important to acknowledge that we will be working with a limited database from which to draw generalizations. Our efforts to postulate a theory of therapist development will not be based upon a large stratified sample drawn from multiple countries (Orlinsky & Ronnestad., 2005). Rather, our data will largely be gleaned from those who have contributed to the available literature (e.g., Sussman, 1992, 1995, 2007), plus self-reports, reflections, and observations gathered by our own chosen group of authors, each of whom has taught, supervised, and/or treated many psychotherapists over the years. Our hope is that these sources of information, coupled with our own experiences, will enable us to formulate some useful hypotheses about the complex nature and interrelatedness of professional and personal development for psychotherapists.

Integrating Personal and Professional Experiences

One of the issues we are addressing in this volume is how personal and professional experiences become integrated in the developing therapist. As indicated, we will be exploring the influence of therapists' early life experiences on their professional development, as well as their relationships with mentors and other role models, the wounds they experience as they go through life, and the personal treatment they engage in. At the same time, we will be

looking at the professional experiences developing therapists have, including the didactic preparation they engage in, their early clinical experiences, and their supervisory experiences both during training and thereafter. It is of course impossible to specify precisely how all of these various experiences influence how therapists develop, at least in part because it is undoubtedly different for different people, but our contention is that these experiences have great mutual influence on the developing therapist, and are usually important contributors to how therapists ultimately come to work.

This brings up the whole issue of "clinical intuition." What exactly is it? Some people see it as "flying by the seat of one's pants," the notion being that there are some people who have excellent inherent intuition about things, while others presumably do not. While there may well be innate differences along this dimension between people entering the mental health field, our conviction is that intuition is not random; rather, it is developed and cultivated (Lomas, 1993). We believe that one's intuition is in fact informed by our cumulative developmental experiences at both the personal and professional levels. Our life experiences, our clinical experiences, what we learn in supervision, what we learn about ourselves in our personal treatment, and our didactic preparation all come to inform what is called our "intuition." Thus, an important premise of this volume is that understanding as much as we can about the formative influences on developing therapists will help us demystify the concept of "intuition" and help us understand what influences contribute to becoming an effective clinician.

Life is an ongoing learning experience. Everything that we experience potentially contributes to what we learn about ourselves and the lives of those with whom we come in contact, both in the professional context and in every other aspect of our lives. At the most obvious level, developing therapists have personal relationships of all kinds, from which they have the opportunity to learn about what happens when people attempt to relate to each other. All therapists experience the wide array of affects that inevitably arise as we go through life: anxiety, fear, sadness, and even despair. It is our contention that those who learn and grow from these experiences are likely to be more effective therapists than those who do not. As therapists have come to appreciate the reality that they contribute a great deal to the dynamic that unfolds between them and their patients, it has become clear how important it is for us to understand as much as we can about how a developing therapist's personal experiences contribute to the kind of professional he or she becomes.

The Concept of the "Good Therapist"

Implicit in our exploration of the developmental trajectory for therapists are notions about what makes for a good therapist. This of course is a complicated and layered question. For a comprehensive discussion of research findings linking specific therapist characteristics with successful therapeutic

outcome, the reader is referred to Garfield and Bergin's *Handbook of Psychotherapy and Behavior Change* (1990). Is it even reasonable to posit that there is such a thing as a "good therapist"? Given the variety of approaches to treatment that exist, as well as the enormous variability among patients who present for treatment, perhaps it is more accurate to say that there are many kinds of good therapists, and that a good therapist for some kinds of patients may be quite different from a good therapist for other kinds of patients.

And yet perhaps it is possible to identify certain characteristics that most people would agree are part and parcel of what is necessary to be a good therapist, regardless of the theoretical approach employed. For instance, we would suggest that certain interpersonal skills are necessities for all good therapists. An example would be the ability to understand the experience of others. This is certainly difficult to measure, but that does not mean that it is a meaningless statement. The phenomenological experience of those who present themselves for treatment needs to be accurately understood if therapy is to have any chance to succeed.

A closely related interpersonal skill that characterizes all good therapists is the ability to communicate empathy in a way that is credible and can be taken in. Patients who experience their therapists as being able to feel, and vicariously experience, what they are going through in their lives have a much better chance of finding treatment beneficial than those who do not.

To be able to understand and empathize with their patients, therapists need to get outside themselves. Countertransferential feelings get induced in therapists all the time; the difference between good therapists and those who are less so is the ability of the former to recognize and keep in check what is evoked in them, to not enact their emotional experiences but use them in the service of understanding their relationships with those they treat, and to keep their focus on what they are learning about their patients' experience of their lives.

Once a patient's life experience is well understood, and credible empathy is communicated in an ongoing fashion, the question is how this material is massaged so that treatment becomes a transforming experience. A premise of this book is that good therapists need to find ways to utilize their personas toward this therapeutic end. It is not simply a matter of applying therapeutic technique for the betterment of our patients. Rather, it is a matter of entering a two-person field (or multi-person field, if one is working with a group, couple, or family) and utilizing oneself in the therapeutic relationship in such a way as to create a space from which the patient can emerge transformed. Thus, good therapists are ones who incorporate what they have learned from others into an approach in which they utilize their selves and their sensibilities in their efforts to effectively relate to their patients. This premise is not one shared just by psychodynamically oriented therapists; as you will see in Chapter 10, it is one to which an increasing number of cognitive-behavioral therapists subscribe as well.

Much more can be said about what constitutes a good therapist. For instance, good therapists are willing to acknowledge error and learn from their experience. They recognize that one never "arrives" at a final point in the developmental process; rather, one must continue to learn, evolve, and grow as long as one continues to do the work. They remain humble in the face of the enormous challenge of playing a role in effectuating change in those who come to them for treatment. We hope to shed further light on the question of what constitutes a good therapist as we explore the developmental journey that therapists take as they evolve into the clinicians they become.

Organization of this Volume

In organizing the chapters you will be reading as you proceed through this volume, we have tried to take a more-or-less sequential approach, taking up issues as they typically emerge in the developing clinician's unfolding life. Having said this, we are well aware that different individuals have experiences that occur at different points in their lives. For instance, some clinicians might have an experience with a mentor or other kind of role model that shapes them early in their life experience, while others might have such an experience much later in their development. Nevertheless, there is a logic to how we have arranged this volume. Let us describe the chapters you will be reading in the order in which we have sequenced them.

We begin with the chapter on early life experiences. The author of chapter 2, John O'Leary, PhD, is a supervisor and faculty member at the William Alanson White Institute, a well-regarded psychoanalytic institute in New York City. He brings an analyst's sensibility to his depiction of the contribution of early life experiences to therapist development, acknowledging the contributions of genetics and environmental influences on the developing clinician as well. His focus on psychological-mindedness and resilience is a useful antidote to those who focus on the wish to master unresolved conflicts as the main reason most therapists enter the field.

We then move on to a chapter on the influence of mentors and other role models. As acknowledged above, this kind of experience can occur at almost any point in a clinician's development, but many do point to early life experiences with such people as formative in their development. Robin Gayle, PhD, MFT, is a psychology professor in California and has done a great deal of writing in this area. Dr. Gayle's focus is not so much on the characteristics of mentors and other role models, which obviously are vastly different for different people, but rather on the way in which the relationship between the mentor and mentee unfolds. She underscores that these relationships afford the mentee the opportunity for a relational and intersubjective experience that can serve as a model for the quality of relationship therapists seek to establish with their patients.

Chapter 4 focuses on the didactic preparation that beginning clinicians typically go through before they begin to work with patients. We are well aware that this too differs from setting to setting, and from discipline to discipline. But for the most part didactic preparation precedes initial clinical encounters. Victor L. Schermer, MA, LPC, CAC, a private practitioner in Philadelphia and one of the editors of this overall volume, has undertaken to write this chapter. He presents us with a comprehensive discussion of the variety of forms that didactic preparation takes, as well as the role it plays in overall clinician development.

Jerome S. Gans, MD, then takes up the area of the early clinical experiences that all developing clinicians have, and the disproportionate influence they invariably have on therapist development. In Chapter 5 Dr. Gans, an Associate Clinical Professor of Psychiatry at Harvard, does a masterful job of describing some of the conundrums that beginning clinicians often encounter when they start treating patients. He articulates a set of critical tasks to be faced, and then identifies a series of desirable traits that clinicians will ideally emerge with that set them on the road to becoming effective therapists.

Beginning clinical experiences are almost always accompanied by clinical supervision, so Chapter 6 takes up the complexities of the supervisor–supervisee relationship, and the outcomes that ideally emerge from these experiences for the developing clinician. Molyn Leszcz, MD, FRCPC, a Professor of Psychiatry at the University of Toronto, describes a model of supervision that aims to facilitate trainees' synthesizing an identity that balances their professional and personal selves. While he draws a clear distinction between supervision and psychotherapy, he puts forth a model that is highly personal, and emphasizes the transmission of the core values of the field of psychotherapy, the crucial importance of the clinician being able to self-reflect, and the central importance of establishing relationships with patients that are respectful and have boundaries.

Chapter 7 focuses on the personal treatment that a high percentage of therapists choose to engage in, often for a combination of personal and professional reasons. Personal treatment is typically not required in generic therapist training programs, though it certainly is in specialty training programs such as psychoanalysis. Nevertheless, there is evidence that a high percentage of developing clinicians voluntarily enter into treatment. Suzanne B. Phillips, PsyD, ABPP, CGP, FAGPA, an Adjunct Professor of Psychology at Long Island University, describes the enormous number of benefits that can derive from a successful personal treatment experience, particularly in terms of the recognition of the importance of the person of the therapist in the therapeutic encounter. She describes what developing clinicians can learn from their own treatment experience: an awareness of how much a therapist's reliability and commitment facilitates the treatment process; the central importance of a therapist's warmth and empathy; the crucial importance of a therapist's patience and tolerance; the opportunity to see that therapy can work;

and increased self-awareness, self-esteem, and openness to genuine human relating.

In Chapter 8 we then turn to the idea of the therapist as "wounded healer." Cecil A. Rice, PhD, co-founder and president of the Boston Institute for Psychotherapy, elaborates this idea, starting from the premise that woundedness is universal, and that what distinguishes good therapists is their willingness, and even desire, to acknowledge their scars, to understand them as well as they can, and to live with them in a self-aware fashion. He argues that unrecognized woundedness is an impediment to the healing process.

We then take a turn in the direction of discussing one of the most momentous developments in the field of psychotherapy in some time: namely, the increasing emphasis on evidence-based practice. Along with the increasingly pervasive presence of managed care, with its profound impact on how clinicians practice, the focus on evidence-based practice confronts therapists with a new set of challenges, and coming to terms with it is appropriately construed as a developmental challenge. Debra Theobald McClendon, PhD, and Gary M. Burlingame, PhD, both from Brigham Young University, address this phenomenon and describe their approach to evidence-based practice (which they call "practice-based evidence"), placing it within the larger context of evidence-based practice and elaborating its many potential benefits.

When we organized this volume, we were keenly aware that the authors we were inviting to write chapters were all from the world of psychodynamic treatment, broadly defined. We came to see this as a limitation, and decided that we would do well to include a chapter on another widely-used approach to treatment: cognitive-behavioral therapy (CBT). Edmund C. Neuhaus, PhD, ABPP, an Assistant Clinical Professor of Psychology at Harvard, agreed to write the chapter, and more specifically to address the question of whether and how the utilization of the therapist's person is important in the practice of CBT. As we learned from working with Dr. Neuhaus, this is a controversial matter in the CBT world. You will see from reading his contribution that there is an increasing view among CBT practitioners that the person of the CBT therapist is indeed an important contributor to the treatment experience, even when the treatment that is being delivered is manualized.

Finally, we have a chapter on the status of psychotherapy process and outcome research, and its implications for therapist development. Shannon Wiltsey Stirman, PhD, currently a Clinical Research Psychologist in the Women's Health Sciences Division of the National Center for PTSD in Boston, and Paul Crits-Christoph, PhD, a Professor of Psychology at the University of Pennsylvania, have written just such a review, and offer a variety of ideas about therapist development that emanate from the current state of knowledge in our field.

The book concludes with a chapter by the co-editors of the volume in which we summarize and integrate the salient points made in each chapter of the volume, propose a model for therapist development, and offer a set of recommendations for therapist selection, training, lifelong learning, and self-care.

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