# The effective group psychotherapist

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This paper will address factors that contribute to improved group psychotherapist effectiveness, linking empirical research with clinical experience. Although there is common acceptance that the psychotherapies as a whole are generally equivalent in their effectiveness, psychotherapists as a whole are not (Norcross & Wampold, 2011). Understanding what contributes to improved group therapist effectiveness serves an important function in improving clinical outcomes and increasing accountability to our patients and to those who pay for the provision of effective clinical care (Weissman, 2013).
The paper will address: group cohesion; empathy and therapeutic opportunities within the patient-therapist relationship, in particular within the here and now of interpersonally oriented group therapy; principles of therapeutic metacommunication and how processing within the therapeutic relationship enhances effectiveness; and, the therapist's use of judicious transparency.

**Clinical illustration**

I begin with a clinical illustration from a recent session of an open-ended therapy group of four men and four women. The group members permit use of clinical examples with my commitment to disguise individual characteristics.
Melanie, a 42-year-old single woman working as an English tutor begins the session. She seeks group therapy to deal with chronic issues of depression, poor self-esteem, poor relational choices, substance abuse and significant feelings of shame. Another key member is Noah, a 45-year-old married businessman. He seeks group therapy to deal with issues of interpersonal isolation and chronic relational and marital dissatisfaction, feeling neglected and unrecognized for his talents and abilities.
Melanie, relatively new to the group, began this session in obvious emotional distress. She was grateful to be in the group but self critical for having made little use of it to date. She entered today's meeting determined to open up to the group about her core concerns. She had seen others in the group do this over time to good effect and she was unhappy going home repeatedly feeling that she had barely scratched the surface.
Despite apprehension, Melanie described

in detail her life long struggle with poor self-esteem and self-worth. Growing up as an only child with a single mom, abandoned by her father, she always wondered about her self-worth, noting that she made choices that seemed to play to her vulnerabilities, engaging men who were exploitative and abusive. To deal with strong negative emotions, she abused marijuana and cocaine resulting in significant financial debt, which in turn meant that she had to work incredibly long hours as a tutor to pay off her debts. This was a powerful revelation, even more notable as it was her first major disclosure and she held the group's focus for a significant segment of the meeting.

We processed with her the experience of the disclosure and provided feedback. Group members were spontaneous and forthcoming, supporting her self-disclosure and making similar self-disclosures about substance abuse, debts, and their history of poor choices. One group member commented how she could feel palpably the kind of shame that Melanie carried around these behaviours and past choices, and wanted to reassure her that everyone could relate and that the best way to deal with negative behaviours was to illuminate and tackle them with the support of the group. The impact this had on Melanie was quite profound. She continued to cry but now in relief and acknowledged how grateful she was for the group's support and care. Another member of the group noted how much respect she had for Melanie, directly challenging Melanie's shame and anticipation of a judgmental or rejecting response when in fact was she not only identified with, she was actually the object of admiration regarding her courage and openness. They added how much they appreciated having Melanie in the group and they looked forward to continuing to work with her.

Throughout, Noah sat seemingly disengaged. Others recognized the importance of Melanie's work, but Noah did not say one word, evoking in me substantial countertransference. Although we had worked on Noah's narcissistic self-absorption and his tendency to seek from the group without giving to it, clearly, it had not impacted as intended, evident in Noah's seeming disinterest in Melanie at this pivotal moment.

With the momentary kind of pause that groups often use to shift foci, Noah jumped in, exclaiming he also had important things to address describing another round of difficulties with his wife's lack of responsiveness toward him. In contrast to the earlier segment in which people were literally leaning forward in their chairs, drawing as close as they could to Melanie, people listened politely without much evident engagement. I made a process inquiry asking the group to compare how they felt in the first part of the meeting with how they were feeling now. There was little response to that question, so I decided that I would move into a zone of therapist transparency and speak about my reaction to Noah.

It went something like this: 'Noah – I am going to take a bit of a risk here and share with you something that I hope I convey in

a way that you are able to hear. I hope you do not experience this as harsh but I found myself finding it hard to generate interest in what you were saying to the group, not because what you feel is not important to me – it is very much so – but I was feeling disappointed that you had been silent throughout the meeting. I want to ask you how you felt about Melanie'.

Noah acknowledged it was important and he was supportive of her but he chose not to speak, waiting to talk about his own concerns. I noted that his lack of response to Melanie made it harder for me to respond to him. Perhaps the group's subdued response to him reflected the same dynamic – a few heads nodded in agreement. I went on to describe to Noah how his waiting for an opening to turn the group's attention onto him rather than responding to Melanie was concerning. I asked him to consider again the importance of reciprocity and that attention is not a zero sum game but rather a renewable resource: the more he gives to others, the more he will be reciprocated, unlike his very competitive and narcissistic family of origin in which care and support were in fact a zero sum. As he had shared with us, growing up the loudest and most demanding person received whatever little bit there was available.

Noah acknowledged my feedback hurt and wondered how long I had harbored that feeling. I answered I had been thinking about it throughout the meeting and spoke about it as soon as I was clear how I could address it. He added that he valued our relationship and would think about this feedback, asking others what they thought. Jack, an older man in the group commented that it was incredibly useful feedback – he hoped Noah would be able to hear it. He wanted to give Noah similar feedback but found no way to do so without being hurtful and he credited the therapist for finding a way to do so, encouraging Noah to use this opportunity.

Noah seemed to take this in and Susan, a depressed and isolated middle-aged woman who grew up in an environment with great emotional deprivation and neglect asked how I determined to say what I did. Was that technique or did it come from a genuine place in me?

I responded that I felt everything I said, and would only say what I felt genuinely. Choosing to share it and trying to find the best way to do so, involved technique but I felt connected emotionally to what I was saying. I inquired what that feedback meant to her, adding that the capacity of caregivers to be authentic and reliable was enormously important in allowing her to feel safer. She needed to know that she could trust that the group and I were operating in a genuine way rather than in a perfunctory fashion.

This vignette illustrates some of the key elements that make group therapy and the group therapist effective:

1. The importance of cohesion regarding the group members' evident emotional bond and task effectiveness.
2. The illumination and disconfirmation of toxic pathogenic beliefs, in Melanie's case detoxifying the critical shame that had kept her disengaged in the past.

3. The group social microcosm as members bring themselves genuinely into the here and now. Noah's behaviour is in fact exactly what he needs to be demonstrating, as it creates an opportunity for illumination and for the disruption of negative relational complementarity and maladaptive transaction cycles (MTC).
4. Recognizing relational complementarity to Noah marked by non-responsiveness to him due to countertransference that could serve to amplify neglect and stoke his self-absorbed interpersonal style.
5. Therapeutic metacommunication and feedback, tailored to align intent and impact to be maximally useful in interrupting the complementarity of perfunctory attention or neglect.
6. Judicious therapist self-disclosure in commenting about something that was alive and palpable in the group that others at that moment felt unable to address constructively. The group leader has an essential role in setting group norms and modeling authentic, compassionate feedback.
7. It is critically important to metabolize countertransference before speaking to it. I needed to recognize that I was hooked interpersonally and needed to unhook or I would stay disinterested or angry with Noah, which would have perpetuated another MTC. Instead, I tried to use my disinterest to understand empathically his experience of neglect, weaving that into feedback that would access more of the recognition and connection that he desperately sought (Yalom & Leszcz, 2005).
8. In responding to Susan, I am also guided by my appreciation of her pathogenic beliefs re how much am I present in a genuine way and how much am I guided only by a technical model?
9. Process, process, process, at every step along the way is essential to illuminate pathogenic beliefs and interpersonal choices that reinforce or disconfirm these beliefs. This opens up many doors within the here and now.

Re Melanie: what was it like coming home after each group for the last several sessions knowing that you hoped to talk but hadn't; what will it be like tonight going home knowing that you had opened up; what would it be like coming back to the next meeting; what surprised or disappointed you?

Re Noah: how did you hear the feedback and what are you going to do with it? I made it expressly clear that I liked him and wanted him to be able to hear this feedback in the spirit in which I intended, hoping he would make the best use of it possible.

Finally, I shared with him, that if I found it hard to be responsive to him, might the same dynamic apply at home with his wife. If so, could he move beyond a zero sum game regarding attention and interest there?

**The evidence-based group therapist**

Our contemporary environment demands that we be evidence-based, linking the science and art of our work together. Theory serves an important role in teaching

us where we should head in treatment. Technique is equally important because it teaches us what to do when we arrive clinically where theory directs us.

What are the key elements associated with improved group therapist effectiveness? The literature is very clear, well summarized by the recent American Psychological Association (APA) Evidence Based Therapeutic Relationship Task Force publication of a series of meta-analyses highlighting the empirically significant impact that group cohesion and empathy make to outcome (Norcross & Wampold, 2011). Group therapists are more effective, and psychotherapists in general are more effective when they are able to maximize the power of the therapeutic alliance in individual therapy and its group psychotherapy equivalent, group cohesion. The second important variable is empathy. Although empathy is multi-dimensional, I will emphasize a number of key factors. Empathy includes receptive or understanding, and expressive or communicative capacities. It is much more than kindness and it demands specific, tailored in-depth understanding and articulation of that understanding, always privileging the patient's position.

The APA Task Force noted that there is encouraging evidence to support the value of goal consensus and collaboration, therapist positive regard and the value of managing countertransference, but these elements have not, to this point demonstrated the statistical significance of cohesion, empathy and client-centered tracking. Client centered tracking will not be addressed in detail in this paper.

Recent studies demonstrate that there is a broad range in the effectiveness of therapists. One study demonstrated in a sample of 71 therapists treating over 6000 clients in college counseling centers, that although gender, age, experience or model did not distinguish effectiveness, there was a significant difference between the top 10% and the bottom 10% of therapists. Although the study focuses on individual therapy, there is no reason to believe the same is not true about group therapy. Clients lucky enough to see the top 10% of therapists had a 44% recovery rate and a 5% deterioration rate whereas those seeing the bottom 10% had only a 28% recovery rate and an 11% deterioration rate. Put in other terms, the top 10% of therapists were nine times more likely to produce positive effects than negative effects whereas the bottom 10% were barely twice as likely to achieve the same effect (Okiishi e.a., 2006). Another study looking at nearly 700 therapists treating 7000 patients in varying models of 16 session psychotherapy noted that effective therapists had average positive effect sizes of 1.0 to 1.52 and ineffective therapists had negative effect sizes of 0.91 to 1.49. These are very large statistical and clinical distinctions.

What makes these findings more compelling is that individual therapists tend to underestimate deterioration effects even when they are asked to anticipate them and look for them in their practice (Hannan e.a., 2005; Chapman e.a., 2012). Part of the value of

client-centered tracking is that it promotes earlier detection of failing therapies.
In the absence of this practice-based evidence, it becomes more incumbent for group therapists to self examine, pursue supervision and consultation as needed, and commit to maximizing their reflective capacity with regard to their work.

**Group cohesion**

Cohesion is one of the core mechanisms of action of group psychotherapy. It is powerful in its own right with regard to its impact on providing support, containment, value and disconfirmation of pathogenic beliefs regarding one's worth and value. It is also facilitative of all other group therapeutic mechanisms and group factors (Bernard e.a., 2008; Yalom & Leszcz, 2005). It appears to explain more patient improvement than specific mechanisms of action, models or protocols.
Group cohesion is defined in terms of relational bond elements and task effectiveness. Cohesive groups pull members to the centre of the room and create strong emotional bonds. In addition, they use this as a platform to do the meaningful work of psychotherapy. Group cohesion is often likened to the therapeutic alliance in individual work but it is much more complex involving member-to-member, member-to-group and member-to-leader relationships and is even more complicated in settings where co-therapy may be applied. Burlingame and colleagues have developed an innovative, succinct measure, the Group Questionnaire, to evaluate the degree of group cohesiveness (Krogel e.a., 2013). The group questionnaire evaluates the degree of positive bond, positive work and the presence of negative relationship factors related to mistrust, shame, avoidance and distancing. A consistent and strong relationship exists that is both positive and linear with regard to cohesion and although the correlation is small to moderate in its scope at 0.25, it is significant and important (Burlingame e.a., 2011; Burlingame e.a., 2013). Group cohesion links to higher self-disclosure; acceptance of feedback and may buffer and retain members when conflict appears in the working phase of the group. Moderators of cohesion include younger age, group duration greater than 12 sessions, a group size of 5-9 members and groups that have an interpersonal focus. Specific therapist actions foster and improve cohesion as described in The American Group Psychotherapy Association (AGPA) group psychotherapy clinical practice guidelines (Bernard e.a., 2008). Group CBT is beginning to recognize the importance of using the unique elements of group psychotherapy to enhance the effectiveness of interventions, beyond using the group only as a setting to deliver CBT (Bjornsson e.a., 2011).
Seven therapeutic principles enhance group cohesion (Bernard e.a., 2008; Burlingame e.a., 2013). These fall into three domains: (1) group structure, (2) verbal interaction and (3) emotional climate. Group structure is enhanced by the use of pre-group preparation, and the articulation to new members

about the role and expectations of group psychotherapy participation. Allied with this, the group leader defines and articulates group processes early in sessions to demystify the group. Early structure predicts higher levels of self-disclosure and reduces unnecessary anxiety. The third principle involves composition – selecting patients balancing individual member needs and group members' needs as whole, reducing the likelihood of a discordant fit.

With regard to verbal interaction, principle four requires the group leader to model real time observations, guiding effective interpersonal feedback, operating with moderate control and high levels of affiliation. The group leader needs to be mindful of his impact on the group and ensure, according to principle five, that the timing and delivery of feedback is matched to the group's developmental state and to members' capacity to make use of feedback. More challenging feedback is better offered after the group has developed some cohesiveness.

Principle six underscores the leader's important role in establishing and maintaining a proper emotional climate, managing her own emotional presence and dealing with interpersonal conflict constructively. Principle seven notes the therapist aims to reinforce and value emotional engagement and disclosures.

**Empathy**

Although empathy has been viewed as a non-specific factor, the evidence-based group therapist applies a greater level of specificity to the meaning, experience and operationalization of empathy. This aligns with Wampold's concept of creating a healing context (Wampold, 2001) and the evolution of psychotherapy emphasizing the importance of relationships, intersubjectivity, therapist engagement, presence and the concept that the therapeutic relationship is co-constructed. Allied with this is a commitment to create a therapeutic environment that is adaptive, flexible and responsive so that a developmentally necessary, new and contrasting relational experience is created in therapy in contra-distinction to the patient's negative expectations. In a moment-to-moment fashion the effective group therapist emphasizes this need even as there may be strong interpersonal and transferential pulls that recruit a relationship that is constrictive, damaging and confirming of pathogenic beliefs (Weiss, 1993).

Our work demands that the therapist places himself in the centre of an intersubjective, relational process moving back and forth from conjunction to disjunction dealing with the inevitable 'tear and repair' process (Hill & Knox, 2009). Depth understanding of the patient couples with depth understanding of one's countertransference and should be aligned with the capacity to communicate through feedback and meta-communication. The group leader engages each patient in a non-blaming, non-shaming fashion, valuing patients bringing themselves as they genuinely are to the social microcosm of the group. The here and now difficulties link to the member's problems outside of the group as he authors, for

better or for worse, his relational environment (Leszcz & Malat, 2012; Yalom & Leszcz, 2005).

This requires therapist capacity to recognize when he is hooked into an interpersonal loop with a patient and how to unhook through reflection and meta-communication, reducing inadvertent expressions of hostility, power or rejection.

The receptive aspect of empathy is enhanced by the therapist's capacity to formulate and understand each member of the group regarding pathogenic beliefs that each member carries, that in turn shape the interpersonal behaviour that becomes manifest in the group. Many contemporary models of psychotherapy emphasize this belief-behaviour sequence, alternately describing it as a cognitive interpersonal schema (Safran & Segal, 1990), a misconstrual misconstruction sequence (Strupp & Binder, 1984) or cyclical psychodynamics (Wachtel, 2011). A useful overarching model is the plan formulation model created by Weiss (1993) and the Mount Zion Psychoanalytic Group. This model conceptualizes each patient entering treatment with a plan to work in psychotherapy to disconfirm pathogenic beliefs and overcome obstructions that block development and growth. It is a model that emphasizes adaptation rather than pathology and posits that despite manifest behaviour that recruits maladaptive responses, patients hope for a therapeutic response that will promote growth through the disconfirmation of pathogenic beliefs. Research demonstrates that the more aligned the therapist is with the patient's plan and able to disconfirm pathogenic beliefs, the following ensues: greater patient self-awareness; greater access to affect and healthy self-reference; spontaneous genetic recovery of early life experiences that contribute to the pathogenic beliefs; progressive emboldenment on the patient's part (Weiss, 1993).

The Plan Formulation consists of four elements:

1. the patient's goals: developmental tasks, relationships, or personal growth.
2. obstructions: in the shape of pathogenic beliefs emerging from early life experiences that generally fall into one of six categories that are not entirely distinct. These include self-doubt, doubt of others' capacity to care, fear of anger or assertiveness, fear of closeness, guilt regarding personal success and guilt and apprehension about autonomy (Sammet e.a., 2007). Pathogenic beliefs gain impact through
3. the interpersonal articulation of the pathogenic beliefs in the form of transference tests. A transference test is the way in which an interpersonal process recruits responses that, if unacknowledged and untended to, run the risk of re-confirming pathogenic beliefs, but if empathically recognized, the therapist can step back from the interpersonal pull and respond in ways that illuminate and disconfirm pathogenic beliefs.

   Transference tests are often expressed in readily recognizable fashion, by direct displacement, bringing the past into the present as Melanie demonstrates.

Alternately, the transference test may be expressed through mastery by inversion, turning passive into active. This is harder to recognize and there is a greater hazard of failing the transference test as, for example, could occur if the therapist's response to Noah was rejecting and hostile in response to Noah's dismissive and self-absorbed interpersonal stance.

4. Both insight and relational experience matter, placing demands upon the therapist with regard to the expressive elements of empathy.

The capacity to identify the transference test and the way a maladaptive transaction loop is enacted enhances our effectiveness. Kiesler's concept of the impact message (Kiesler, 1996) highlights the self-reflection necessary to getting unhooked. Getting hooked is not the problem. The therapist who fails to be hooked is not sufficiently alive to the therapeutic process in the group. The key is to get unhooked through reflection and then address the hooking metacommunicatively. The impact message encourages the therapist to reflect deeply on the therapeutic encounter by examining his experience with each patient: what direct feelings is she having to a patient; what behavioural pulls are evident; what fantasies or reverie emerge; all linked to the perceived evoking message – how does the patient generate his interpersonal impact.

Recognizing interpersonal pulls is essential in this regard. Kiesler's concept of interpersonal complementarity is very instructive (Kiesler, 1996). Each interpersonal behaviour is an amalgam of two vectors. One axis is the interpersonal dimension of agency or power and runs from a position of dominance to a position of submission. The other axis is affiliation and runs from hostility on one extreme to friendliness on the other. Behaviour may reflect dominance or submissiveness, hostility or friendliness, or combinations thereof including a friendly dominant position, a friendly submissive position, a hostile dominant position, and a hostile submissive position. Interpersonal complementarity is the natural, initial pull to the evoking interpersonal behavior. The axis of agency recruits an initial response of inversion. Hence, a dominant response initially recruits a submissive response and vice versa. Along the axis of affiliation, a concordant response is elicited. Hostility recruits hostility and friendliness generally recruits friendliness. A hostile dominant patient will recruit a hostile submissive initial response concordant on the dimension of hostility and reciprocal on the dimension of agency. This awareness can improve therapist reflective capacity to metabolize countertransference and respond in ways that do not reinforce negative loops. This interrupts circular causality and the inevitable interpersonal recapitulation that perpetuates patient difficulties. The patient gains awareness of his contributions to his difficulties, which promotes broadening of his interpersonal repertoire and effective authorship of his relationships, linked to the treatment goals. This means that we are always on the cusp

of either a self-fulfilling or a self-defeating sequence: of rupture or repair.
Reflecting upon countertransference and being able to metabolize it to use it as data is key. It requires acknowledgement of the co-construction of the patient's difficulties responding ideally without blame, anger, dismissiveness, defensiveness or insincerity (Harmon e.a., 2007).

**Therapist transparency**

This shifts us to the expressive aspects of empathy, predicated upon the therapist's ability to employ therapeutic metacommunication, defined by Kiesler (1996) as 'any instance in which a therapist provides to the client verbal feedback that targets the central, recurrent and thematic relationship issues occurring between them in the therapy sessions'. Critically important is the therapist's capacity to align his intention with his impact and it is useful to check on that by processing the patient reaction's experience within the here and now (Wachtel, 2011; Yalom & Leszcz, 2005). Metacommunication requires capacity to find palatable ways of saying unpalatable things and elevates the therapist's use of language as a key component of therapeutic effectiveness. Metacommunication is ideally provided in a way that is both assertive and tentative, builds on the therapeutic alliance, and begins at lower levels of inference, gradually becoming more explicit as the patient's engagement with the process becomes more evident. It interrupts negative complementarity and can have a profound unlocking capacity. It demands the therapist demonstrate positive regard and blend tact with authenticity. Growth and new behaviour emerging on the part of the patient should similarly be acknowledged. Balancing positive feedback with more critical feedback can lower the stakes, making it easier for the patient to absorb challenging feedback.
The therapist's use of self as a therapeutic tool requires judicious self-disclosure through feedback and metacommunication (Wachtel, 2011; Yalom & Leszcz, 2005). It is an essential, often powerful component of helping our patients restore a sense of cause and effect in the authorship of their interpersonal world. Factors for the therapist to consider include: good language skills; boundary preservation; distinguishing what is induced by the patient regarding objective countertransference, as distinct from subjective countertransference emerging from the therapist's own life, past or current; what is the purpose of the disclosure, recognizing that transparency is a tool and not an end in itself. Benefits are enhanced and risks are reduced if the therapist is able to provide an ahistorical perspective tied to the here and now. It is clearly not a vehicle for the expression of therapist hostility or self-aggrandizement.
Its power accounts for why most therapists become less transparent as they gain experience, always of course guided by the axiom that what therapist does and says must always be in the interest of the patient (Leszcz & Malat, 2012).

## References


Bernard, H., Burlingame, G., Flores, P., Greene, L., Joyce, A., Kobos, J.C., Leszcz, M., Feirman, D., Science to Service Task Force, American Group Psychotherapy Association (2008). Clinical practice guidelines for group psychotherapy. *International Journal of Group Psychotherapy,* 58 (4), 455-542.

Bjornsson, A.S., Bidwell, L.C., Brosse, A.L., Carey, G., Hauser, M., Mackiewicz Seghete, K.L., Craighead, W.E. (2011). Cognitive-behavioral group therapy versus group psychotherapy for social anxiety disorder among college students: a randomized controlled trial. *Depression and Anxiety,* 28 (11), 1034-1042.

Burlingame, G.M., McClendon, D.T. & Alonso, J. (2011). Cohesion in group therapy. *Psychotherapy (Chic),* 48 (1), 34-42.

Burlingame, G., Strauss, B. & Joyce, A. (2013). Change mechanisms and effectiveness of smallgroup treatments. In M. J. Lambert (Ed.), *Begin and Garfield's Handbook of Psychotherapy and Behaviour Change.* (640-689). New York: Wiley and Sons.

Chapman, C.L., Burlingame, G.M., Gleave, R., Rees, F., Beecher, M. & Porter, G.S. (2012). Clinical prediction in group psychotherapy. *Psychotherapy Research,* 22 (6), 673-681.

Hannan, C., Lambert, M.J., Harmon, C., Nielsen, S.L., Smart., D.W., Shimokawa, K. (2005). A lab test and algorithm for identifying clients at risk for treatment failure. *Journal of Clinical Psychology: In Session,* 61, 155-163.

Harmon, S.C., Lambert, M.J., Smart, D.W., Hawkins, E.J., Nielsen, S.L., Slade, K. & Lutz, W. (2007). Enhancing outcome for potential treatment failures: therapist/client feedback and clinical support tools. *Psychotherapy Research,* 17, 379-392.

Hill, C.E. & Knox, S. (2009). Processing the therapeutic relationship. *Psychotherapy Research,* 19 (1), 13-29.

Kiesler, D.J. (1996). *Contemporary Interpersonal Theory and Research*. New York: J. Wiley & Sons Ltd.

Krogel, J., Burlingame, G., Chapman, C., Renshaw, T., Gleave, R., Beecher, M. & Macnair-Semands, R. (2013). The group questionnaire: a clinical and empirically derived measure of group relationship. *Psychotherapy Research,* 23 (3), 344-354.

Leszcz, M. & Malat, J. (2012). The interpersonal model of group psychotherapy. In J. L. Kleinberg (Ed.), *The Wiley-Blackwell Handbook of Group Psychotherapy.* (First ed., 33-58). West Sussex, UK: John Wiley and Sons, Ltd.

Norcross, J.C. & Wampold, B.E. (2011). Evidence-based therapy relationships: research conclusions and clinical practices. *Psychotherapy,* 48 (1), 98-102.

Okiishi, J.C., Lambert, M.C., Eggett, D., Nielsen, S.L., Dayton, D.D. & Vermeersch, D.A., (2006). Analysis of therapist treatment effects: toward providing feedback to individual therapists on their patients' psychotherapy outcomes. *Journal of Clinical Psychology,* 62, 1157-72.

Safran, J.O. & Segal, Z.V. (1990). *Interpersonal Process in Cognitive Therapy.* New York: Basic Books.

Sammet, I., Leichsenring, F., Schauenburg, H. & Andreas, S. (2007). Self-ratings of pathogenic beliefs: a study based on the psychodynamic control-mastery theory. *Psychotherapy Research,* 17 (4), 494-503.

Strupp, H.H. & Binder, J.L., (1984). *Psychotherapy in a New Key*. New York: Basic Books.

Wachtel, P. (2011). *Therapeutic Communication*. New York: Guildford Press.

Wampold, B.E. (2001). *The Great Psychotherapy Debate: Models, Methods and Findings.* Hillsdale, New Jersey: L. Erlbaum Press.

Weiss, J. (1993). *How Psychotherapy Works: Process and Technique.* New York: Guildford Press.

Weissman, M.M. (2013). Psychotherapy: a paradox. *American Journal of Psychiatry,* 170 (7), 712-715.

Yalom, I.D. & Leszcz, M. (2005). *The Theory and Practice of Group Psychotherapy* (5th ed.). New York: Basic Books.