# Speaking about therapists...
# Old questions and some answers derived from empirical evidence

Santo Di Nuovo[1]

## Abstract

The paper presents a review of the therapist's role and characteristics with reference to issues regarding general and specific training, theoretical and personal background, the capacity to initiate and maintain therapeutic alliance, the setting, differences between 'novices' and 'experts', the need for the clinical psychologist to be an active researcher within his/her practice. The concept of 'responsibility' as effective integration of technical competencies and ethical values is outlined. Each of these issues is accompanied by a brief synthesis of the research evidence.

[1] University of Catania, Italy.

E-mail: s.dinuovo@unict.it

(Received 27 June 2011; Revised 13 July 2011; Accepted 21 September 2011)

## Introduction

In clinical research, after an initial period where great attention was paid to the specific psychotherapist's role, the successive debate and related empirical studies focused on other factors, e.g. analysis of the therapeutic process and its relation to outcomes, according to the different theoretical and methodological models; the most suitable instruments and techniques for attaining the proposed goals. For a long time the figure of the psychotherapist was considered a "neglected variable" (Orlinsky & Rønnestad, 2005) in psychotherapy research.

However, in the light of the problems posed by the need for a more effectively organized training of therapists so that their engagement in health policies is designed not only to address clinical pathologies, it seems appropriate to renew debate regarding the figure of the therapist on the basis of recent evidence derived from empirical research.

This article will propose a synthesis through an overview of the literature, establishing a premise for a meta-analytic study on the main aspects of this complex topic and will discuss some major themes, offering for each one a brief synthesis of relevant evidence.

## General vs specific training

How can a clinical psychologist become a therapist? How can psychotherapy be learned? The answers to these questions are discussed in some textbooks (Beitman & Dongmei, 2004; Bender & Messner, 2003; Cozolino, 2004); the Journal *Psychotherapy Research* dedicated a special issue, edited by Rønnestad & Ladany (2006), to specific psychotherapeutic training and its impact on therapeutic efficacy/efficiency.

The training of a mind which takes care of another mind must take into consideration the "reflexive function" and "awareness" implemented during professional training. But when and how can the management of the mind be trained in order to contrast or prevent pathology?

This issue is currently a subject of debate, especially in Italy, where research with contradictory results has been published (e.g., Bani,

Strepparava & Rezzonico, 2010). It seems there is general agreement that the training of a therapist should be based on a general clinical training, focusing on knowledge of all the clinical models and approaches; among these, one in particular will be further particularly trained and utilized in practice. What we mean by "clinical" intervention should be well-defined and obviously formulated on specific scientific criteria rather than on "mystical" or even "magical" alternative approaches, which was the situation for a long time, and which still has its advocates in certain areas of the profession and psychotherapeutic training.

Psychotherapy as a science is grounded on a series of interconnected hypotheses:

- the psychotherapy process is a mindful action, aimed at changing and preventing the pathological and maladaptive components of personality, with specific aims stemming both from the patient's own personal problems, and from the therapist's theoretical and methodological model;
- the aims defined are pursued in each model using specific techniques, the most suitable and economical in terms of the client's specific situation and context;
- change has to be produced inherent to a relation between 'subjects' (therapist, client), whose specific dimensions can be evaluated and should be comprehensible in both theoretical and factual terms.

However, in this field the scientific approach finds persistent resistance, deriving from the assumption that therapy is a complex multi-determined system which leaves no possibility for mechanic causal deductions or predictions. As a result, quantitative analysis of linear relationships among observed data would be misleading and reductive. Surely, many years of empirical research in clinical psychology have demonstrated that the space allocated for this kind of research is not defined either by deterministic forecasting nor by a purely quantitative logic (for a synthesis on these issues: Wampold, 2001). Even if therapeutic work by its very nature is a very

complex discipline, its regularities can be inferred through the systematic study of the indicators representing its core aspects, permitting a formulation of the sense of unease that therapy aims to "deconstruct" and of the well-being it wants to "reconstruct."

The specific training of the therapist, in postgraduate courses of specialization, necessarily follows a basic training to acquire –during the degree course– the necessary competencies in wide-range clinical work and in related clinical scientific research.

**The theoretical background: single or 'blended'?**

A direct consequence of the previous discussion on proper training becomes a dilemma if the theoretical model each therapist follows must remain fixed, i.e. the same in every occasion, or if it should vary according to the requirements of the client or the context. For example, will the therapist use the same model both in his/her own private and public practice, e.g., when it has to be applied in juridical or penitentiary contexts? Or will he/she be able to integrate the basic model with approaches and techniques derived from other models more suitable for these contexts?

In other words, the problem to solve is whether the model which influenced the therapist in training and of which he is an expert can always be strictly applied or rather if the model can be modified when needed, by implementing the so-called "integrated therapy." In this perspective, it is needed to avoid the risk that this integration will become an ineffectual mixture of methods and techniques assembled without scientific rigor, but only based on (possibly faulty) personal intuition that may cause great confusion and useless procedures.

According to Castonguay, Boswell, Constantino, Goldfried, & Hill (2010), very few formal training programs or guidelines exist with the premise of systematically guiding clinicians to develop a competent integrative practice. Despite this, a recent web-based survey involving about 2000 therapists (Cook, Biyanova, Elhai, Schnurr, & Coyne, 2010) showed that the majority of them use a "mix" of at least two different models and practice a therapy

defined as *eclectic*. The methodological integration mainly concerns techniques oriented to the relation whereas are the integrations of biofeedback, neurofeedback, body therapies, hypnotherapies with more traditional treatments are less frequent. Similar results were obtained in a survey conducted in the United States, demonstrating that almost all the interviewees endorsed techniques quite different from those typical of their respective orientations (Thoma & Cecero, 2009).

Flexibility, including a change of model, and theoretical and methodological perspectives, is an essential function of an efficient therapist. At the same time, however, these changes or integrations have to follow strictly scientifically based criteria and not casual or subjective fluctuations (Goldfried, 2001; Orlinsky & Rønnestad, 2005). Very significant in this sense is the role of training and supervision (Boswell, Nelson, Nordberg, McAleavey, & Castonguay, 2010; Farber & Kaslow, 2010). These are issues that will be examined in the following sections.

In a recent article, Buckman & Barker (2010) discussed whether the preference shown toward a certain therapeutic approach compared with an alternative showed factors mainly related to personality or training previously received. They showed that psychodynamic therapists are more influenced by specific training while cognitive-behavioral therapists are influenced by personality traits, and systemic therapists by both factors. Other authors (Topolinski & Hertel, 2007) found differences linked to the temporal distribution of the training process: at the beginning the training variables are more important for the therapeutic approach in practice, whereas personality factors have more influence on the subsequent phases, e.g. the orientation toward insight is influenced by intuition, openness to experience and need for cognitive "closure." The congruence between personality and therapeutic approach also influences the degree of therapist work satisfaction.

The personal cognitive and emotional style of the therapist has a positive impact on the outcome of the therapy based not only on theoretical and technical expertise, but also on flexibility in taking into account the patient's

specific needs, disturbances, and the particular contextual variables (Castañeiras, García, Lo Bianco, & Fernández-Alvarez, 2006).

**The therapist's personal background**

Personality factors, aptitudes, cognitive and emotional style, personal constructs, interpersonal sensitivity, relational competencies, ability to work in a team or network, ability to manage impasses and errors, and to learn from experience, are the main variables involved in giving greater support to the expertise of a therapist. The nature of the therapist's professional development, adopting different approaches including the correlates and the personal and contextual determinants perceived as relevant, have been extensively studied in different countries and cultures in a multicentric study conducted by Orlinsky & *SPR Collaborative Research Network* (1999).

Wampold (2001) outlined that the individual differences among therapists, and their particular ways of establishing their personal identity, are the main factors in explaining the variability of therapeutic results. The therapist's personal factors affecting his/her daily work have been studied by various authors (e.g., Anastasopoulos & Papanicolaou, 2004; Beutler, Crago, Arizmendi, 1986; Hill, 2006; Okiishi, Lambert, Eggett, Nielsen, Dayton, & Vermeersch, 2006). Caspar (1997) underlined the need to make a deeper study of the thinking processes that motivate the therapist to formulate hypotheses about the patient and the therapeutic program. A recent issue of the Journal *Psychotherapy: Theory, Research & Practice* was devoted to the different social status of the therapist, e.g. racial and ethnic factors, that can influence the work especially with patients belonging to different ethnic groups, as ever more frequently occurs in practice (Gelso, 2010).

Other studies focused on how the therapist must take great care of himself to maintain the personal well-being necessary to flourish in a difficult and emotionally draining "helping" profession (Baker, 2003).

An old but still topical question is whether, in order to control all these factors, the psychotherapist's training has to include personal therapy,

differing from the usual supervision process.

Geller, Norcross & Orlinsky (2005) confirmed that personal therapy (that 70% of therapists admit having undertaken) is extremely useful for maintaining the therapist's personal sense of well-being while also promoting the enhancement of the client-therapist relationship. According to Daw & Joseph's (2007) data, two thirds of the therapists did personal therapy, the motivation being to encourage personal growth and the need to control stress. In 1987, a national survey in the United States examined how therapists chose their own therapist; the study, repeated after a 20-year interval, confirmed that the theoretical orientations most frequently chosen are integrative, eclectic, cognitive, and psychodynamic, more rarely behavioral or systemic; the choice is based mainly on traits of competence, warmth, experience, openness and good reputation (Norcross, Bike, & Evans, 2009).

But, even if not all approaches consider it always necessary to carry out psychological "work" on oneself, no one can doubt the essential centrality of the supervision process, i.e. the monitoring, with external support, not only of the techniques adopted but also of emotional reactions and relations (Ogden, 2005; Strozier, Kivlighan, & Thoreson, 1993). While Falender and Shafranske (2004) underline the importance of an approach to supervision based on competencies, other authors point out the need to work through the perceptions of the experiences, including those linked to an emotional transferernce (Fink, 2007), and others emphasize the managing of the critical events occurring in the supervision itself (Ladany, Friedlander, & Nelson, 2005).

Different studies have examined the factors that determine how well the supervision intervention works (Ladany, 2004; Wheeler & Richards, 2007). Results demonstrate that meaningful self-disclosure, and attention to the supervisory working alliance, promote efficacy, while lack of adequate feedback and excessive directivity diminish its utility. The importance of supervision is stressed by therapists dealing with extended numbers of patients, by those in training, and by women (Grant & Schofield, 2007).

Group supervision and peer confrontation, including Balint groups, have been adopted successfully over a long period of time (Benshoff, 1992; Rabin, Maoz, & Elata-Alster, 1999; Robiner & Schofield, 1990).

Whether the therapist opts for his/her own psychotherapy, or for the constant support of a supervisor, in the training of a helping professional personal enrichment is necessary for the best use of one's technical abilities. The deontological norms suggest retaining permanent and updated professional training, referring to the enrichment not only in scientific knowledge, but also in the growth of the professional as an individual (Giusti & Pastore, 1998). This personal growth is the core of the therapist's professional development (Orlinsky & Rønnestad, 2005) and may be the antidote against possible psychological breakdowns due to the persistent stress inherent to working with pathologies. This stress is due to emotional involvement in the client's problems, typical of the helping professions but particularly relevant in psychotherapy, in conditions leading sometimes to potential burnout (Baker, 2003; Mahoney, 1997; Raquepaw & Miller, 1989).

We have to remember that among the helping functions of the therapist, one is to "hold back" the client's problems, supporting and reassuring him/her at the appropriate emotional level. Another concurrent function is to "perturb" a psychological system which is often rigidly balanced, consequently managing the reactions. Responding to these reactions and to their internal resonances, the therapist who aims to represent a secure base for the patient risks losing his/her own basis of safety.

Metacognitive and interpersonal competencies –acquired also during the training process and supervision– help the therapist to express and accept feelings and emotions, to solve the problems posed within the therapeutic relation, while increasing its therapeutic value (Hill & Knox, 2009): this is a core theme in the therapeutic process, brought into focus in the next paragraph.

**Several labels for the "Holy Alliance"**

What happens within the psychotherapeutic process, i.e. between the therapist and the client (single, couple, family, group), has come to be conceptualized in different ways over time and subject to differing therapeutic approaches (Horvath, 2005).

The concept of *self-disclosure* of the therapist has been considered important for establishing an effective relationship, since it produces a corresponding disclosure on the part of the client (Barry, 2006; Roncari, 2001). According to Bottrill, Pistrang, Barker, and Worrell (2010), the therapist's tendency to disclosure is linked with his/her training and with the "philosophy of therapy," and it has become a means to define the professional's personal identity.

Psychoanalysis has proposed the constructs of *transference* and *counter-transference* to define the affective and emotional dynamics involved in the relationship as grounding factors and sources of change, and many studies have addressed these constructs (Eagle, 2000; Hayes, 2004; Levine, 1997; Murdin, 2009; Wiener, 2009; Zetzel, 1956).

Pessier and Stuart (2000) suggested a new method to investigate therapist and patient transference: A characteristic pattern of lags may be hypothesized between the transference interpretations and their therapeutic effects. The authors, in three consecutive sessions taken from each of three different psychodynamic therapies, studied the effects of the patient's answers to the transferral interpretations considered as relational episodes. They found that often the transference work appeared to have an initial inhibitory effect, but facilitated progress over the course of the entire session.

With regard to counter-transference, Normandin and Bouchard (1999) proposed an integrated approach comparing three models of counter-transferral activities: objective-rational, reactive, and reflexive (i.e., a conscious attitude with an interpretive function). The psychologists following a humanistic and psychodynamic approach prove to be more reflexive, while behavioral therapists adopted more frequently an objective-rational attitude.

Other authors introduced the concept of *empathy* as an a-specific factor in terms of the techniques, determining positive progress in the therapy (Bolognini, 2002; Morandi, 2002; Patterson, 1983). Empathy is defined as a sudden and spontaneous exchange of meanings (Gandino, 2003) and, in neuroscientific terms, as a capacity to understand the affective and emotional states of another person through the activation of a neuronal architecture producing these states, even if other factors intervene, like the capacity to monitor cognitive and emotional processes useful to prevent confusion between self and others (Decety & Jackson, 2006). Empathy was associated with *emotional reciprocity*, but a clear distinction between the two constructs is needed in the complex cognitive systems approach (Reda, 1986).

The aspect of communication and interaction crucial for the psychotherapeutic process and for determining beneficial outcomes is called *cooperative bond*. But how does this cooperation occur?

An essential contribution to the definition of the relational bond produced by the therapy, based on models of pre-existing bonds renewed or reconstructed within the sessions, was offered by the *attachment* theory (e.g., Bowlby, 1988; Cassidy & Shaver, 2008; Wallin, 2007; moreover, Oppenheim & Goldsmith, 2007, Obegi & Berant, 2009, respectively for child and adult therapies). Dozier and Bates (2004) defined attachment as a "state of mind" influencing the therapeutic relation. Saypol and Farber (2010) connected the styles of attachment with the client's capacity of disclosure, and found a negative relationship between the unpleasant feelings associated with the disclosure and the "secure" style of attachment, whereas the opposite occurred in the "anxious" attachment style.

The Journal *Psychotherapy Research* devoted a monographic issue to the therapeutic relationship, edited by Hill and Hentschel (2005). Hill and Knox (2009) reviewed the relevant literature, concluding –based on empirical evidence– that if therapists and clients are able to directly analyze their relationship and the problems occurring inside its confines (including "here and now" feelings about each other), the expression and acceptation of

feelings is easier, the bond is reinforced, and the patient will transfer the learned abilities to other relations outside of therapy.

To study how the therapeutic relationship is improved by communication, Lepper and Mergenthaler (2007) analyzed the transcripts from all eight sessions of a successful brief psychodynamic psychotherapy by means of conversation analysis, observing the turn-by-turn analysis of the talk in combination with a computerized text analysis following the therapeutic cycles model locating clinically significant events. The data showed that the coherence of sequences in the communication enhances the bond and is significantly related to the productive process of the therapy.

The possibility of critically analyzing what occurs within the therapeutic process is in turn connected to *relational meta-cognition*, i.e. the capacity (both of therapist and patient) to be thoughtful regarding the relationship itself; the *personal construct system* in Kelly's terms has been considered as the basis for the reciprocal understanding between therapist and client through the cognitivist and structuralist approaches (Bara, 2005; Chiari e Nuzzo, 1998). These processes have been explained more recently according to the *theory of mind* (e.g. Mundo, 2009).

The term most frequently used to define the "healing relational bond" is *therapeutic alliance*. It involves an agreement between therapist and client about the aims and the functions of the treatment, and implies a positive relation both in affective and interpersonal aspects (among the many studies on this issue: Gaston, 1990; Horvath, 2005; Horvath & Greenberg, 1994; Lingiardi, 2002; Meissner, 1996; Safran & Muran, 2000; Verga, Azzone, Vigano', & Freni, 1999).

Hatcher (1999) studied the alliance as perceived by the therapist, underlining that a collaboration termed "confident" (i.e., trust-based) shows high correlations with therapist's and patient's estimates of improvement, and therefore has to be considered a key element of the alliance construct.

Rubino, Barker, Roth, and Fearon (2000) demonstrated that the therapist's typical styles of attachment influence the manner in which he/she manages the breakdown phases, i.e. the negative changes in the

quality of alliance, analogous to what Kohut called “failure of empathy.” The more anxious therapist responds less empathically to the problems occurring in the critical moments; moreover, the patient’s style of attachment stimulates different answers from the therapist, according to his/her own attachment style.

In general, empirical evidence confirms a consistent correlation between alliance and a positive psychotherapeutic outcome (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000; Norcross, 2002): A positive alliance enhances the compliance to the treatment (Blackwell, 1997), and prevents early drop-out from therapy (Tryon & Kane, 1995). But this correlation, although consistent in several studies, is of moderate size, since it shows very high variability, depending on the different kind of therapy, patients and settings. Moreover, a relevant difference was often found between the individual perceptions of alliance from both therapist and patient (Horvath & Bedi, 2002). Even though several explanations have been hypothesized for this difference (e.g., Horvath & Luborsky, 1991), few of them are based on controlled studies. Surely this discrepancy in the perception of alliance could influence the negative outcome of therapy, and therefore should be taken into account in the monitoring of the therapeutic process.

Obviously, the alliance is even more complex when it is evaluated in group, couple, or family therapy, and/or when it involves a co-therapy (Hoffman, Gafni, & Laub, 1995; Roller & Nelson, 1991).

Considering the diversity in conceptualization and evaluation of the alliance, and consequently the great variety of assessment instruments (individual or joint self-report, participant observation, external evaluation), we can explain the variability and the discrepancies found in the cumulative analyses on the alliance (Lambert, 2003). After the alliance is carefully defined, a multi-modal and possibly multi-level evaluation –by the therapist and at the same time by the client and external observers– is needed to reliably study concordances and divergences among different models and contexts.

**Setting: preferred vs forced?**

The setting of psychotherapy, e.g. where the work takes place with a single client, group or family, in a private or public consulting room, is generally chosen by the therapist himself. But often the therapist is compelled to work in a setting not chosen but imposed, e.g. when clients are involuntary institutionalized, as in penitentiary contexts. The therapy with an abused child, or a detainee who attempted suicide in prison, have very different features compared with those the therapist is used (or trained) to treating.

Moreover, the therapist may be required to work with clients belonging to other cultures. This problem, which has long been present in other contexts, has also become important in Italy.

The setting may be connected with the client's motivation. It is well known that patients whose therapy has been solicited by third parties (families, criminal court, etc.) often do not share the motivations which prompted the referrals to the therapist in question and who then has to re-orient (i.e., manipulate) the client's needs or to modify the aims proposed by the sending party. At any rate, as suggested by Tjeltvet (1999), when third parties directly pay or indirectly fund the therapy, they tend to influence time contexts and aims of the treatment; the therapists treating unwilling clients, such as antisocial adolescents or convicted individuals or "designated patients" in a family system, know this problem well.

In these cases, the patient and the commissioning party may have a sharply contrasting view of the aims of the treatment, challenging the therapist's responsibility and professional ethics (see the concluding section). It is not sufficient to follow slogans like "client's motivation has to be enhanced" –i.e., to share the aims of the unwanted intervention– or "client's rights over all," contrasting the requests made by the party that sent the client. To manage these situations, specific therapist's attitudes and skills are required that should be trained in advance, along with the technical competencies.

**Novices vs experts**

Okiishi, Lambert, Eggett, Nielsen, Dayton, and Vermeersch (2006) have studied in a wide sample of therapists the incidence of expertise in determining the outcome of treatments, obtaining non significant results. The therapist's experience instead appears to influence the modalities of formulating the diagnosis, planning the subsequent therapeutic program (Eells & Lobart, 2003) and the capacity for "metabolizing" the case, using "theoretical and clinical knowledge in an intuitive, flexible manner that responds and adapts to the unique and complex context of the treatment" (Betan & Binder, 2010, p. 141).

Certainly, the experience helps the therapist to focus on the main patterns of dysfunctional relationships, i.e. the core elements that lead to a positive outcome of the treatment (Scognamiglio, Capelli, Fava, Taglietti, Conserva, & Schadee, 2006).

Moreover, Hickman, Arnkoff, Glass, and Schottenbauer (2009) have verified, in a sample of 24 therapists with an average of 32 years of experience, that expert therapists find it easier to integrate different techniques, incorporating new treatment methods into the main approach they already use.

Expertise plays an important role in the capacity of overcoming situations of impasse, and helps to cope with unwilling patients, less motivated to the treatment. But experience can play a negative role when it leads to pre-judicial evaluations based on schemas that were previously functional, but are not correct in the present case. By paradox, the novice who has less stabilized schemas derived from experience shows a more open attitude in discovering what the case at hand allows to emerge, without overlapping his/her own conceptualizations.

Both novices and experts should maintain the *research attitude* which means, in the terms of "phenomenological mind" according to Gallagher and Zahavi (2008):

- not permitting pre-conceptual schemas, although useful in other cases or contexts, to influence the present evaluation;

- in contrast, finding what is original and particular in the case in question, planning the treatment on this basis;
- establishing the correct goals to verify the efficacy and efficiency of the treatment itself.

In a word, the therapist should be –in all senses– also a 'researcher'. This is the essential theme for the final point in this discussion.

**Clinicians vs researchers**

In an essay published many years ago, the Author, reviewing the possibilities of implementing in clinical practice psycho-social models based on empirical research, concluded that clinicians must not try to cross over into research which is not their area of expertise. According to this view, basic researchers and professionals should be in a productive, symbiotic relationship: researchers indicate the general models; clinicians apply them in the real world (Brehm, l976).

But the old separation between those who produce research and those who apply it, is widely contradicted by recent findings in the social sciences. Moreover, from a normative point of view, the law which in Italy regulates the psychology profession declares in its first article that experimentation and research are among the typical duties for professionals in psychology. The figure of the clinician who is also researcher is greatly needed; one who is able to integrate therapeutic work in an action-research perspective where the professional is directly engaged in monitoring and verifying the efficacy and efficiency of his/her own work. In this approach therapeutic work is grounded on both research and application; the figure of the professional-scientist is also necessary for progress of the therapy (Lane & Corrie, 2006).

At present the test of efficacy is considered a core issue for encouraging scientific debate in clinical psychology, since it both allows the monitoring of what occurs within the confines of therapy and favors exchange among psychotherapists from differing theoretical approaches, which also fosters their external visibility in the scientific community and in a wider social context.

Castonguay, Nelson, Boutselis, Chiswick, Damer, et al. (2010), analyzing a sample of psychotherapists who collaborated with researchers in designing and conducting a psychotherapy study within their own clinical practices, have reported benefits both at the scientific level and in efficacy of the therapy itself, identifying a number of strategies used by psychotherapist-researchers to address obstacles that they encountered. The time and effort required to integrate research protocol into routine clinical practice were rewarded by the useful information derived from research, which improved working relationships with clients, and gave rise to the idea that it would be useful for other psychotherapists to know about their scientific efforts. The experience is defined as a promising pathway for building a stronger link between practice and research.

In another interesting book on the "bridge" among research and real life, the work of 28 distinguished psychotherapy researchers was studied, showing how their research programs changed the way psychotherapy came to be practiced (Castonguay, Muran, Angus, Hayes, Ladany, & Anderson, 2010).

We should avoid limiting research on psychotherapy exclusively to academic researchers, who are used to laboratory procedures and inclined to consider the clinic as a kind of laboratory. Research opportunities should be extended to include a network of professional therapists who day by day attempt to "think through" and apply their research skills utilizing fundamental scientific aims and methods.

**Technical vs ethical issues (as a conclusion)**

In conclusion, we hypothesize that the common element in the various aspects of psychotherapeutic treatment, focusing attention on the therapist, could be the concept of *responsibility*, defined as:

- taking care of, and managing, the specific problems of the client and the relationship with the therapist (i.e., "alliance"), avoiding defensive closure, prejudicial evaluations or use of inappropriate techniques and manipulative "shortcuts" with

unwilling clients;

- applying in the most effective way the techniques learned in training, but with a willingness to integrate them –in a thoughtful and scientific way– with other strategies and techniques more suitable for the client's needs and/or given context, and ready to give up the assignment if the client and the context are not manageable with his/her integrated competencies;
- openness to communication and exchange with colleagues, including forms of regular supervision or peer confrontation;
- complete willingness to respond, for one's actions and their eventual consequences, to the scientific community (assessment and evaluation of efficacy and efficiency of the therapies) and to the professional deontological and juridical norms.

Assuming these responsibilities is essential for correct ethical behaviour by all professionals; in particular they must be the core values of those who use interpersonal relationships as therapeutic tools in clinical work. These aspects should be given a more significant part in the professional training programs than they are at the present time.

## References

Anastasopoulos, D., & Papanicolaou, E. (2004). *The Therapist at Work. Personal Factors Affecting the Analytic Process.* London: Karnac Books.

Baker, E. K. (2003). *Caring for Ourselves: A Therapist's Guide to Personal and Professional Well-Being.* Washington: American Psychological Association.

Bani, M., Strepparava, M. G., & Rezzonico, G. (2010). La formazione in psicoterapia: Un dipinto in chiaroscuro [Training in psychotherapy: A dark and light picture]. *Ricerca in Psicoterapia/Research in Psychotherapy,* 13(1), 6–22.

Bara, B. (2005). *Nuovo manuale di psicoterapia cognitiva. Vol. 2: Clinica* [New handbook of cognitive psychotherapy. Vol. 2: Clinics]. Torino: Bollati Boringhieri.

Barry, F. A. (2006). *Self Disclosure in Psychotherapy.* New York: Guilford Press.

Beitman, B. T., & Dongmei, Y. (2004). *Learning psychotherapy* (2nd ed.). New York: Norton.

Bender, S., & Messner E. (2003). *Becoming a Therapist. What Do I Say and Why?* New York: Guilford Press.

Benshoff, J. M. (1992). *Peer Consultation for Professional Counselors.* Ann Arbor: ERIC/CASS.

Betan, E. J., & Binder, J. L. (2010). Clinical expertise in psychotherapy: how expert therapists use theory in generating case conceptualizations and interventions. *Journal of Contemporary Psychotherapy, 40*(3), 141–152.

Beutler, L. E., Crago, M., & Arizmendi, T. G. (1986). Research on therapist variables in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of Psychotherapy and Behavior Change* (pp. 257–310). New York: Wiley.

Blackwell, B. (1997). *Treatment Compliance and the Therapeutic Alliance.* Amsterdam: Harwood Academic Publishers.

Bolognini, S. (2002). *L'empatia psicoanalitica* [Psychoanalytic Empathy]. Torino: Bollati Boringhieri.

Boswell, J. F., Nelson, D. L., Nordberg, S. S., McAleavey, A. A., & Castonguay, L. G. (2010). Competency in integrative psychotherapy: perspectives on training and supervision. *Psychotherapy: Theory, Research, Practice, Training, 47*(1), 3–11.

Bottrill, S., Pistrang, N., Barker, C., & Worrell, M. (2010) The use of therapist self–disclosure: Clinical psychology trainees' experiences. *Psychotherapy Research, 20*(2), 165–180.

Bowlby, J. (1988). *A Secure Base: Clinical Applications of Attachment Theory.* London: Routledge.

Buckman, J. R., & Barker, C. (2010). Therapeutic orientation preferences in trainee clinical psychologists: Personality or training? *Psychotherapy Research, 20*(3), 247–258.

Caspar, F. (1997). What goes on in a psychotherapist's mind? *Psychotherapy Research, 7*(2), 105–125.

Cassidy, J., & Shaver, P. R. (2008). *Handbook of Attachment.* New York: Guilford Press.

Castañeiras, C., García, F., Lo Bianco, J., & Fernández–Alvarez, H. (2006). Modulating effect of experience and theoretical–technical orientation on the personal style of the therapist. *Psychotherapy Research, 16*(5), 587–593.

Castonguay, L. G., Muran, J. C., Angus, L., Hayes, J. A., Ladany, N., & Anderson, T. (2010). *Bringing Psychotherapy Research to Life: Understanding Change through the Work of Leading Clinical Researchers.* Washington: APA.

Castonguay, L. G., Nelson, D. L., Boutselis, M. A., Chiswick, N. R., Damer, D. D., . . . Borkovec, T. D. (2010). Psychotherapists, researchers, or both? A qualitative analysis of psychotherapists' experiences in a practice research network. *Psychotherapy: Theory, Research & Practice, 47*(3), 345–354.

Castonguay, L. G., Boswell, J. F., Constantino, M. J., Goldfried, M. R., & Hill, C. E. (2010). Training implications of harmful effects of psychological treatments. *American Psychologist, 65,* 34–49.

Chiari, G., & Nuzzo, M. L. (Eds.). (1998). *Con gli occhi dell'altro. Il ruolo della comprensione empatica in psicologia e in psicoterapia costruttivista* [Through the eyes of the other: The role of empathic understanding in constructivistpsychology and psychotherapy]. Padova: Unipress.

Cook, J. M., Biyanova, T., Elhai, J., Schnurr, P. P., & Coyne, J. C. (2010). What do psychotherapists really do in practice? An Internet study of over 2,000 practitioners. *Psychotherapy: Theory, Research & Practice,* 47(2), 260–267.

Cozolino, L. (2004). *The Making of a Therapist.* New York: Norton.

Daw, B., & Joseph, S. (2007). Qualified therapists' experience of personal therapy. *Counselling and Psychotherapy Research, 7*(4), 227–232.

Decety, J., & Jackson, P. L. (2006). A social neuroscience perspective on empathy. *Current Directions in Psychological Science, 15*(2), 54–58.

Dozier, M., & Bates, B. (2004). Attachment state of mind and the treatment relationship. In L. Atkinson & S. Goldberg (Eds.), *Attachment Issues in Psychopathology and Intervention* (pp. 167–180) Mahwah: Erlbaum.

Eagle, M. N. (2000). A critical evaluation of current concepts of transference and countertransference. *Psychoanalytic Psychology, 17*(1), 24–37.

Eells, T. D., & Lombart, K. G. (2003). Case formulation and treatment concepts among novice, experienced, and expert cognitive–behavioral and psychodynamic therapists. *Psychotherapy Research, 13*(2), 187–204.

Falender, C., & Shafranske, E. P. (2004). *Clinical Supervision. A Competency–Based Approach.* Washington: APA.

Farber, E. W., & Kaslow, N. J. (2010). Introduction to the special section: The role of supervision in ensuring the development of psychotherapy competencies across diverse theoretical perspectives. *Psychotherapy: Theory, Research, Practice, Training, 47*(1), 1–2.

Fink, K. (2007). Supervision, transference and countertransference. *International Journal of Psychoanalysis, 88*(5), 1263–1273.

Gallagher, S., & Zahavi, D. (2008). *Phenomenological Mind.* London: Routledge.

Gandino, G. (2003). La conversazione terapeutica: un'analisi semantica [Therapeutic conversation: A semantic analysis]. *Terapia familiare, 71*, 80–88.

Gaston, L. (1990). The concept of the alliance and its role in psychotherapy: Theoretical and empirical considerations. *Psychotherapy, 27*, 143–153.

Geller, J. D., Norcross, J. C., & Orlinsky, D. E. (2005). *The Psychotherapist's Own Psychotherapy*. New York: Oxford Press.

Gelso, C. J. (Ed.). (2010). The diversity status of the psychotherapist: Editorial introduction. *Psychotherapy: Theory, Research & Practice, 47*(2), 143.

Giusti, E., & Pastore, F. (1998). *Dialoghi sulla deontologia in psicoterapia* [Dialogues on ethical code in psychotherapy]. Roma: Armando.

Goldfried, M. R. (2001). *How Therapists Change.* Washington: American Psychological Association.

Grant, J., & Schofield, M. (2007). Career–long supervision: Patterns and perspectives. *Counselling and Psychotherapy Research, 7*(1), 3–11.

Hatcher, R. (1999). Therapists' views of treatment alliance and collaboration in therapy. *Psychotherapy Research, 9*(4), 405–423.

Hayes, J. A. (2004). The inner world of the psychotherapist: A program of research on countertransference. *Psychotherapy Research, 14*(1), 21–36.

Hickman, E. E., Arnkoff, D. B., Glass, C. R., & Schottenbauer, M. A. (2009). Psychotherapy integration as practiced by experts. *Psychotherapy: Theory, Research, Practice, Training, 46*(4), 486–491.

Hill, C. (2006). Introduction to special section on therapist effects. *Psychotherapy Research, 16*(2), 143.

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

Hill, C., & Hentschel, U. (2005). On new developments. Introduction to special issue: the therapeutic relationship. *Psychotherapy Research, 15*(1–2), 1–2.

Hoffman, S., Gafni, S., & Laub, B. (Eds.). (1995). *Cotherapy with Individuals, Families, and Groups.* Northvale: Jason Aronson.

Horvath A. O. (2005). The therapeutic relationship: Research and theory. *Psychotherapy Research, 15*(1–2), 3–7.

Horvath, A. O. & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy Relationships that Work: Therapist Contributions and Responsiveness to Patients*. New York: Oxford University Press.

Horvath, A. O., & Greenberg, L. S. (1994). *The Working Alliance. Theory, Research and Practice*. New York: John Wiley & Sons.

Horvath, A. O., & Luborsky, L. (1991). The role of therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology, 61*, 561–573.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and out–come in psychotherapy: A meta–analysis. *Journal of Counseling Psychology, 38*, 139–149.

Ladany, N. (2004). Psychotherapy supervision: What lies beneath. *Psychotherapy Research, 14*(1), 1–19.

Ladany, N., Friedlander, M. L., & Nelson, M. L. (2005). *Critical Events in Psychotherapy Supervision.* Washington: American Psychological Association.

Lambert, M. J. (2003). *Handbook of Psychotherapy and Behavior Change* (5th ed.). New York: John Wiley & Sons.

Lane, D. A., & Corrie, S. (2006). *The Modern Scientist–Practictioner. A guide to Practice in Psychology*. London: Routledge.

Lepper, L., & Mergenthaler E. (2007). Therapeutic collaboration: How does it work? *Psychotherapy Research, 17*(5), 576–587.

Levine, W. B. (1997). The capacity for Countertransference. *Psychoanalytic Inquiry, 77*(1), 44–68.

Lingiardi, V. (2002). *L'alleanza terapeutica*. Milano: Cortina.

Mahoney, M. J. (1997). Psychotherapists' personal problems and self–care patterns. *Professional Psychology: Research and Practice, 28*(1), 14–16.

Martin, D., Garske, J., & Davis, K. (2000). Relation of therapeutic alliance with outcome and others variables: A meta–analytic review. *Journal of Consulting Clinical Psychology, 68*, 438–450.

Meissner, S. J. (1996). *The Therapeutic Alliance*. New Haven: Yale University Press.

Morandi, C. (2002). Uno studio sul processo attraverso l'empatia [A process study through empathy]. *Ricerca in Psicoterapia, 5*(1–2), 44–56.

Mundo, E. (2009). *Neuroscienze per la psicologia clinica* [Neuroscience in clinical psychology]. Milano: Cortina.

Murdin, L. (2009). *Understanding Transference: The Power of Patterns in the Therapeutic Relationship.* Basingstoke: Palgrave Macmillan.

Norcross, J. C. (Ed.). (2002). *Psychotherapy Relationships that Work: Therapist Contributions and Responsiveness to Patients.* New York: Oxford University Press.

Norcross, J. C., Bike, D. H., & Evans, K. L. (2009). The therapist's therapist: A replication and extension 20 years later. *Psychotherapy: Theory, Research, Practice, Training, 46*(1), 32–41.

Normandin, L., & Bouchard, M. A. (1999). L'influenza dell'orientamento teorico e dell'esperienza sul controtransfert razionale, reattivo e riflessivo [Theoretical orientation and experience's influence on rational, reactive and reflective countertransference]. *Ricerca in Psicoterapia, 2*(1–3), 7–33.

Obegi, J. H., & Berant, E. (2009). *Attachment Theory and Research in Clinical Work with Adults.* New York: Guilford Press.

Ogden, T. H. (2005). On psychoanalytic supervision. *International Journal of Psychoanalysis, 86*(5), 1265–1280.

Okiishi, J., Lambert, M. J., Eggett, D., Nielsen, L., Dayton, D. D., & Vermeersch, D. A. (2006). An analysis of therapist treatment effects: toward providing feedback to individual therapists on their clients' psychotherapy outcome. *Journal of Clinical Psychology, 62*(9), 1157–1172.

Oppenheim, D., & Goldsmith, D. F. (2007). *Attachment Theory in Clinical Work with Children: Bridging the Gap between Research and Practice.* New York: Guilford Press.

Orlinsky, D., & SPR Collaborative Research Network (1999). Development of psychotherapists: Concepts, questions, and methods of a collaborative international study. *Psychotherapy Research, 9*(2), 127–153.

Orlinsky, D. E., & Rønnestad, M. H. (2005). *How Psychotherapists Develop. A Study of Therapeutic Work and Professional Growth.* Washington: American Psychological Association.

Patterson, C. H. (1983). Empathy, warmth, and genuineness in psychotherapy. *Psychotherapy, 21*, 431–438.

Pessier, J., & Stuart, J. (2000). A new approach to the study of therapeutic work in the transference. *Psychotherapy Research, 10*(2), 169–180.

Rabin, S., Maoz, B., & Elata–Alster, G. (1999). Doctors' narratives in Balint groups. *British Journal of Medical Psychology, 72*(1), 121–125.

Raquepaw, J. W., & Miller, R. S. (1989). Psycho–therapist burnout: A componential analysis. *Professional Psychology: Research and Practice, 20*(1), 32–36.

Reda, M. A. (1986). *Sistemi cognitivi complessi e psicoterapia* [Complex cognitive systems and psychotherapy]. Roma: Nuova Italia Scientifica.

Robiner, W. N., & Schofield, W. (1990). References on supervision in clinical and counseling psychology. *Professional Psychology: Research and Practice, 21*(4), 297–312.

Roller, B., & Nelson, V. (1991). *The Art of Co–Therapy. How Therapists Work Together.* New York: Guilford Press.

Roncari, L. (2001). La relazione terapeutica dalla parte del terapeuta: una ricerca su neutralità e self–disclosure [Therapeutic relationship on the role of therapist: A study on neutrality and self–disclosure]. *Ricerca in Psicoterapia, 4*(2–3).

Rønnestad, M. H., & Ladany, N. (2006). The impact of psychotherapy training: Introduction to the special section. *Psychotherapy Research, 16*(3), 261–267.

Rubino, G., Barker, C., Roth, T., & Fearon P. (2000). Therapist empathy and depth of interpretation in response to potential alliance ruptures: the role of therapist and patient attachment styles. *Psychotherapy Research, 10*(4), 408–420.

Safran, J. D., & Muran, J. C. (2000). *Negotiating the Therapeutic Alliance: A Relational Treatment Guide.* New York: Guilford Press.

Saypol, E., & Farber, B. A. (2010). Attachment style and patient disclosure in psychotherapy. *Psychotherapy Research, 20*(4), 462–471.

Scognamiglio, R. M., Capelli, E., Fava, S., Taglietti, S., Conserva, R., & Schadee, H. (2006). *The influence of therapist's relational competence on the outcome of treatment*. Paper presented at the 37th Annual Meeting International Society for Psychotherapy Research (SPR), University of Edinburgh. Ulm: Ulmer Textbank.

Strozier, A., Kivlighan, D. M. Jr., & Thoreson, R. T. (1993). The process of supervision. *Psychology*: *Research and Practice, 24*(1), 13–19.

Thoma, N. C., & Cecero, J. J. (2009). Is integrative use of techniques in psychotherapy the exception or the rule? Results of a national survey of doctoral–level practitioners. *Psychotherapy: Theory, Research, Practice, Training, 46*(4), 405–417.

Tjeltvet, A. C. (1999). *Ethics and values in psychotherapy.* London: Routledge.

Topolinski S., & Hertel, G. (2007). The role of personality in psychotherapists' careers: Relationships between personality traits, therapeutic schools, and job satisfaction. *Psychotherapy Research, 17*(3), 365–375.

Tryon, G. S., & Kane, A. S. (1995). Client involvement, working alliance, and type of therapy termination. *Psychotherapy Research, 5*, 189–198.

Verga, M. C, Azzone, P., Vigano', D., & Freni, S. (1999). Approccio empirico al concetto di alleanza in psicoterapia: alleanza di aiuto, di lavoro, terapeutica [Empirical approach on the alliance's concept in psychotherapy: helping, working, therapeutic alliance]. *Ricerca in Psicoterapia, 2*(1–3), 34–62.

Wallin, D. J. (2007). *Attachment in Psychotherapy.* New York: Guilford Press. Tr. it. *Psicoterapia e teoria dell'attaccamento*. Bologna: Mulino, 2007.

Wampold, B. E. (2001). *The Great Psychotherapy Debate: Models, Methods, and Findings.* Mahwah: Lawrence Erlbaum.

Wheeler, S., & Richards, K. (2007). The impact of clinical supervision on counsellors and therapists, their practice and their clients. A systematic review of the literature. *Counselling and Psychotherapy Research, 7*(1), 54–65.

Wiener, J. (2009). *The Therapeutic Relationship: Transference, Countertransference, and the Making of Meaning.* College Station: Texas A&M University Press.

Zetzel, E. (1956). Current concept of transference. *International Journal of* Psychoanalysis*, 37*, 369–375.