Instructor’s Manual
for
THE THERAPEUTIC RELATIONSHIP, INDIVIDUALIZED TREATMENT AND OTHER KEYS TO SUCCESSFUL PSYCHOTHERAPY

with
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psychotherapy.net
The Instructor’s Manual accompanies the DVD The Therapeutic Relationship, Individualized Treatment and Other Keys to Successful Psychotherapy with John C. Norcross, PhD (Institutional/Instructor’s Version). Video available at www.psychotherapy.net.

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Tips for Making the Best Use of the DVD

1. USE THE TRANSCRIPTS
Make notes in the video Transcript for future reference; the next time you show the video you will have them available. Highlight or notate key moments in the video to better facilitate discussion during and after the video.

2. FACILITATE DISCUSSION
Pause the video at different points to elicit viewers’ observations and reactions to the concepts presented. The Discussion Questions section provides ideas about key points that can stimulate rich discussions and learning.

3. CONDUCT A ROLE-PLAY
The Role-Plays section guides you through exercises you can assign to your students in the classroom or training session.

4. ENCOURAGE SHARING OF OPINIONS
Encourage viewers to voice their opinions. What are viewers’ impressions of what was presented in the interview?

5. SUGGEST READINGS TO ENRICH VIDEO MATERIAL
Assign readings from Related Websites, Videos and Further Reading prior to or after viewing.

6. ASSIGN A REACTION PAPER
See suggestions in the Reaction Paper section.
Reaction Paper for Classes and Training

Video: The Therapeutic Relationship, Individualized Treatment and Other Keys to Successful Psychotherapy with John C. Norcross, PhD

• Assignment: Complete this reaction paper and return it by the date noted by the facilitator.

• Suggestions for Viewers: Take notes on these questions while viewing the video and complete the reaction paper afterwards. Respond to each question below.

• Length and Style: 2-4 pages double-spaced. Be brief and concise. Do NOT provide a full synopsis of the video. This is meant to be a brief reaction paper that you write soon after watching the video—we want your ideas and reactions.

What to Write: Respond to the following questions in your reaction paper:

1. Key points: What important points did you learn about the therapeutic relationship, individualized treatment and other keys to successful psychotherapy? What stands out to you about how Norcross works?

2. What I found most helpful: As a therapist, what was most beneficial to you about the information presented? What perspectives did you find helpful that you might use in your own work? What challenged you to think about something in a new way?

3. What does not make sense: What principles/techniques/interventions did not make sense to you? Did anything discussed push your buttons or bring about a sense of resistance in you, or just not fit with your own style of working?

4. How I would do it differently: How might you conduct therapy differently from Norcross? Be specific about what different approaches, interventions and techniques you might use.

5. Other questions/reactions: What questions or reactions did you have as you viewed the interview with Norcross? Other comments, thoughts or feelings?
Related Websites, Videos and Further Reading

WEB RESOURCES
Faculty webpage at University of Scranton for Dr. Norcross
http://academic.scranton.edu/faculty/norcross/

Journal of Clinical Psychology: In Session (edited by Dr. Norcross)
http://onlinelibrary.wiley.com/journal/10.1002/%28ISSN%29291097-4679

Society for Psychotherapy Research
http://www.psychotherapyresearch.org/

Society for the Exploration of Psychotherapy Integration
http://sepiweb.com/

RELATED VIDEOS AVAILABLE AT
WWW.PSYCHOTHERAPY.NET
Stages of Change for Addictions with John C. Norcross
Becoming a Therapist: Inside the Learning Curve by Erik Sween
The Gift of Therapy: a Conversation with Irvin Yalom

RECOMMENDED READINGS


Discussion Questions

Professors, training directors and facilitators may use some or all of these discussion questions, depending on what aspects of the video are most relevant to the audience.

THE PERSON OF THE THERAPIST

1. **Middle path:** What do you think of Norcross’s “middle path” perspective that it is the person of the therapist plus the treatment method that makes a difference? Do you agree or do you think it’s more about the relationship or more about the treatment method?

2. **Manualized treatments?** Have you ever read or utilized a manualized treatment protocol? If so, what was your experience with it? In your opinion, what are the pros and cons of using a manualized approach?

3. **Getting feedback:** What do you think of Norcross’s recommendation that therapists ask their patients for feedback by asking: *How are we doing? How is the psychotherapy doing?* and *How are you doing?* Do you have a practice of asking these or similar questions to your patients? If not, can you imagine integrating these questions into your treatment? Why or why not?

4. **Relationship:** What do you think of the idea of psychotherapy being thought of not as a healthcare treatment but as an interpersonal relationship with curative goals? Does this perspective match how you see psychotherapy? If not, how do you see it differently? How much attention do you tend to put into attending to the relationship with your patients?

PSYCHOTHERAPY IS A RELATIONSHIP

5. **Message:** Norcross stated that the message therapists should give to patients is “I’m here, I’m listening, I care, and together we will travel the path.” Do you think this is the message you’re giving to your patients? If not, what message do you think you might be giving them? What do you say or do that conveys this message?
REPAIRING RUPTURES

6. **Alliance ruptures:** Can you think of any examples of alliance ruptures in your clinical work? How have you handled these ruptures? Have they come up in your own personal therapy? How has your therapist handled them? How might you handle them differently after watching this video?

7. **Neophytes:** What did you think of Norcross’s comment that neophyte therapists get uncomfortable when patients give them feedback about what they didn’t like? If you are a new therapist, is this true for you? Can you think of examples of times you have received negative feedback from your patients? How have you responded to this (both externally and internally)?

THE MAKING OF GREAT THERAPISTS

8. **Cultivation:** What do you think of the ideas Norcross gave for how therapists can improve, grow, and cultivate the person of the therapist? Do you agree that we need to be more selective about who we let into graduate training programs in psychotherapy? Do you agree that personal therapy should be strongly recommended but not required? Why or why not? How about the ideas of lifelong learning and therapist self-care? What self-care practices/activities do you engage in?

9. **Videorecording:** Do you videorecord your sessions? If so, what has this experience been like for you? What have you learned from viewing yourself conducting therapy?

10. **Supervision:** How did you react when Norcross stated that most people will say at least half of their clinical supervision was pretty poor? Is this true for you? What has contributed to helpful supervision for you? Has anything in your supervision experience been hurtful? Has your supervisor attended to these ruptures? If so, how?

11. **Continuing Education:** What are your thoughts on Norcross’s statement about the importance of getting continuing education that challenges us to think about things differently as opposed to just taking CE classes to learn more about what we already
know? Do you, like Norcross, have an interest in taking CE classes on treatment methods you disagree with? Why or why not?

ARE THERAPISTS NUTS?

12. **Motivation:** What motivated you to become a therapist? Do you identify with the term *wounded healer*? Revealing as much as feels comfortable, please share your story of how you came to choose counseling or psychotherapy as a profession.

DIFFERENT STROKES FOR DIFFERENT FOLKS

13. **Self-disclosure:** What are your thoughts on therapist self-disclosure? Do you tend to share stories of your own experiences when you think they’ll be helpful to your patients? Why or why not? What factors do you consider when deciding what and how much to self-disclose?

START WHERE THE PATIENT IS

14. **Therapist-patient match:** How did you react when Norcross shared how he has difficulties with very dependent patients who expect him to be directive and that these are patients he might refer to a colleague? Are there certain people that you are more and less comfortable or effective working with? If so, how would you describe these personalities? Have you referred-out (or declined a referral) that you felt was not a good match for you? If so, describe.

15. **Integration:** Norcross stated that “each clinical encounter needs something a little different,” and that “pure theoretical orientations really are not particularly helpful.” Do you agree with him about this? Would you describe your style as broad and integrative or do you tend to stick to one pure theoretical orientation? Can you name some pros and cons to both sticking to one theoretical approach and taking a more integrative approach?

16. **Therapist individuality:** What did you think of Norcross’s perspective that the individuality of the therapist should be nurtured? Do you believe that your training program and your supervision did/does nurture your individuality as a therapist? What aspects of your individuality would you like to nurture more?
CULTIVATING EMPATHY

17. **Patient individuality:** Norcross stated that “everybody’s way of being understood and connecting with each other is very individualized, idiosyncratic.” How would you describe your favored way of being understood and feeling connected to others? Thinking of your current caseload, describe some differences in your patients’ ways of feeling understood. Do you tend to individualize your treatment to your particular patients or is your style more consistent from patient to patient?

KEYS TO A SUCCESSFUL PSYCHOTHERAPY

18. **Confrontation:** What did you think of Norcross’s statements about confronting patients and how research shows that therapists should use confrontations very sparingly, and only after there is a lot of safety and trust in the therapeutic relationship? Have you had any experiences confronting patients when there wasn’t enough trust and safety yet? How have your patients responded to these confrontations? What positive experiences have you had utilizing confrontation with patients?

19. **Distance/Closeness:** Norcross stated that “very distant therapists are probably not going to have much success, but nor are the very up close people that don’t let patients talk and do their work.” Where do you see yourself on this spectrum: Do you tend to be more distant or more “up close” and involved? How comfortable are you with adjusting your style to match your patients’ needs?
Role-Plays

CONDUCT A ROLE-PLAY

After watching the interview with John Norcross, assign groups to role-play a therapy session. Organize participants into dyads, consisting of one psychotherapist and one client. Then have them switch roles so each person has a chance to play both roles.

This role-play is an opportunity for participants to focus on the relational aspects of psychotherapy and to practice the art of cultivating a trusting, supportive therapeutic alliance. In addition, it is an opportunity for therapists to get more comfortable receiving honest feedback from clients and repairing alliance ruptures.

Instructions for clients: Role-play a client who has been in therapy with this therapist for at least one month. Your therapist did something recently that left you feeling misunderstood, upset or bothered in some way, and you have been hesitant about letting them know. You can indirectly bring it up (e.g. talking about how a friend of yours did something rude the other day, which is similar to what bothered you about your therapist’s behavior) or show other signs of being irritated or hurt (e.g. being withdrawn, or short with responses), but do not talk about it directly until the therapist invites you to talk about it.

Instructions for therapists: Take a nonjudgmental and caring stance, paying particular attention to the interpersonal nuances in the therapeutic relationship. At some point in the session, your task is to actively ask your client about the alliance and if anything particularly upsetting has happened. To initiate this conversation, ask your client the following three questions:

1) How do you think the psychotherapy is going? (i.e. Are you getting what you want? Are we moving toward attaining your goals?)
2) How are we doing? (i.e. How are you feeling in relation to me? Do you feel I am understanding your perspective?)

3) How are you doing in terms of your symptoms and goals? (i.e. What about the treatment would you change?)

When the client responds with some “negative” feedback, it is an opportunity for you to repair the alliance rupture and nurture the relationship. To do this, keep in mind that your most important objective is to completely understand this person and how they are experiencing their life, including how they are experiencing their relationship with you and the treatment. Focus on being present and connecting empathically with your client, sending the message that you care about them. Adopt a nonjudgmental and welcoming stance. Model a way of fixing the problem that doesn’t blame the client but is seen as a problem within the relationship. Facilitate an open discussion of what you both can do to make the therapy work better for your client. Your goal is for the client to leave the session feeling like you really understood them.

Alternatively, client and therapist can decide in advance of the role-play what has transpired between the two of them in a prior session which led to a therapeutic rupture, and either the therapist or client can bring this up.

**Debrief:** After each role-play, debrief the groups. First, have the clients share their experiences. How did they feel about the session? Did they feel like the therapist understood them? Did they feel connected to the therapist? Did they feel like the therapist cared about them? How was it to talk about the therapeutic relationship? Are they feeling any resentment towards the therapist or considering dropping out of therapy? Then, have the therapists talk about what the session was like for them. What did therapists find challenging or exciting about this way of working? How did they feel about asking the three questions? Did they feel uncomfortable when the client expressed their grievances? Why or why not? Finally, have the large group reconvene to share their reactions, and open up a general discussion.
on what participants learned about cultivating the therapeutic alliance and repairing alliance ruptures.

An alternative is to do this role-play in front of the whole group with one therapist and one client; the entire group can observe, acting as the advising team to the therapist. Prior to the end of the session, have the therapist take a break, get feedback from the observation team, and bring it back into the session. Other observers might jump in if the therapist gets stuck. Follow up with a discussion of what does and does not seem effective about Norcross’s approach to cultivating the therapeutic alliance.
THE PERSON OF THE THERAPIST

Randall C. Wyatt: Hi, I’m here today with Dr. John Norcross, psychologist, psychotherapist, researcher, professor. He has been involved in a various number of fields including psychotherapy research, psychotherapeutic alliance, outcome studies, and what we are here to discuss today, the person of the psychotherapist. John, nice to have you here.

John Norcross: Thank you, Randy. Good to be here.

Wyatt: John, why don’t we start out by asking the question, what do you mean by the person of the therapist?

Norcross: The embodied, real person of the therapist who brings a real relationship in the moment with each patient. Literally the person, full of biographical and historical factors, who bring themselves to session after session with particular clients.

Wyatt: How did you first get involved, or what was so important to you about the person of the therapist?

Norcross: Well, it is the encroaching medical model of psychotherapy. I was struck by this duplicity between what the research was saying on the one hand and what most people were trying to tell me on the other. Most of the research, of course, that is published says we should be looking at manualized treatments, which certainly have their place, and I am quite impressed with the advances we have made in manualized treatments.

On the other hand, anyone who has ever seen a client in session knows
it is the immediacy and the relational contact that really makes a difference. So here I am teaching and conducting supervision, and I know it is all about the relationship and about two people or more meeting at a given moment in a healing context. And yet the research keeps saying, “Pay attention to the treatment package, the treatment method.”

And it just felt out of synch, almost hypocritical. And then, of course, when you look at the research a little more closely, you find out that second only to the patient’s contribution to the success of psychotherapy, it is indeed the therapeutic relationship that accounts for most of the success of what we do.

**Wyatt:** Now, as you are talking you it reminds me of a film, which I am sure you are aware of—The Wizard of Oz. In The Wizard of Oz at the end of the film, Dorothy, the Tin Man, the Scarecrow and the Lion go to visit the Wizard, trying to get Dorothy back to Kansas. At one point Toto the dog starts pulling on the curtain. And the Wizard says, “Pay no attention to the man behind the curtain.”

But eventually Toto pulls it back and there is the man behind the curtain. Dorothy, very aghast and upset, says, “My god, the Wizard is just a man.” And she says, “You are a very bad man.” And he says to her—

**Norcross:** “Oh no. I’m a very good man.”

**Wyatt:** “But a very bad Wizard.”

**Norcross:** Yes.

**Wyatt:** So, what you are saying is let’s pull back the curtain on the person of the psychotherapist. Let’s bring him out of the ivory tower, the all-knowing, all-powerful Oz—in this case, the psychotherapist.

**Norcross:** And that is an apt metaphor. And as we pull back that very curtain, we discover that the psychotherapist as a person, not as an archetypal wizard, is the person who is transforming the therapeutic experience. It is the relational context, the healing presence of the therapist that makes the difference.

Over the years, we have asked now 2,000 or 3,000 psychotherapists
to describe to us the singular lasting lesson of their own personal therapy. In 90% of those cases, experienced psychotherapists, the most critical consumers of psychotherapy around, say it is all about the relationship. We should listen to that rather than looking at disembodied treatment manuals and pretend that the therapist is interchangeable.

The therapist isn’t interchangeable, isn’t disembodied. It is the therapist that makes a difference, of course in addition to the patient contribution and treatment method. But the medical model says for the most part it is the pill, it is the technique that makes the difference. That simply does not apply and map well onto psychotherapy.

**Wyatt:** And even in medicine, isn’t it true that hope, the effect of the placebo, and the doctor patient relationship still matters, even for physicians?

**Norcross:** It does matter, but notice that is not what we pay attention to. Anyone who is a patient knows it is the relationship with the physician that makes a huge difference in terms of credibility and compliance and making medical care work.

But what do we largely hear about? Big pharma has now dominated the airwaves and it is which pill to take rather than which physician to listen to.

**00:05:01**

**Wyatt:** And everybody says—not everybody says—“I have a good relationship with my physician.” Now, you want them to be skilled, you want them to be talented. You want them to have the best X-rays and MRIs, but you still want to know that you can trust them.

**Norcross:** Exactly. And unfortunately, in psychotherapy, it has become polarized. You have people who largely talk about treatment method and now you have people who largely talk about the person of the psychotherapist. And this is just a mindless, simplistic dichotomy. Clearly we want a relationally present, healthy psychotherapist who has available to him or her the best treatment methods and assessment tools around.
So it is not either/or. We just really need to follow all the evidence that says, “Let’s make sure we talk about the person of the psychotherapist, the relationship, plus treatment methods.”

**Wyatt:** Let me take a contrarian viewpoint that I have heard for years. Your work and others like you are beginning to say something different, but for years we have been hearing, “CBT is the gold standard and certainly has a lot to offer. Manualized treatments are the way to go—this is more scientific.” What is this going back to therapeutic relationship? Is it going backwards? What is going on? Because so much of the work has been saying these other things.

**Norcross:** Yes. And that certainly is the predominant model at this time in psychotherapy. And you correctly anticipate that much of my work has been directed toward trying to bring us back to the middle path—the middle path that says it is the person of the therapist plus the treatment method that makes a difference. And if we follow the evidence, that is where we come back to.

For example, empathy correlates, if it is the client’s view, 0.3 across hundreds of studies with outcome. If you want to predict outcome, first look at the patient’s contribution to success, and then look at the patient’s view of his or her psychotherapist. That becomes the best outcome predictor.

And we also need to be careful about saying manualized treatments aren’t necessary. I think for training and research they have been an absolute boon to the field. But there is no reliable evidence that following a treatment manual improves the success of psychotherapy.

**Wyatt:** A lot of my colleagues say the manualized books and so forth are helpful as a guide, they are good to look at, it is a good to have a plan, but really the key is a flexibility and an ability to move around based on what your client does and changes.

**Norcross:** Exactly. If we want to manualize anything, let’s manualize flexibility. Let’s manualize responsiveness to the patient. But do so not randomly, but from a systematic perspective that flows from the research. There is lots of research conducted over the last 20 years that says different folks—meaning different patients—different folks
need different strokes. Each of us will respond a little differently to psychotherapy and we have lots of research to show how one can be responsive in a systematic manner.

So, as I like to put it, let’s follow the empirical research in general on how to tailor psychotherapy to the particular patient.

**Wyatt:** Earlier you said something that was very interesting—the client’s view of the therapist. Can you say more about that, about what outcome says about that?

**Norcross:** Yes, this is a very interesting and robust finding from the empirical research. It is not the external judge’s rating or the therapist’s rating of how empathic they are being that correlate with successful psychotherapy. We should probably stop asking those questions. Instead it is the client’s perception that correlates and predicts successful psychotherapy.

So in clinical practice it is not enough to simply ask the therapist, “Well, do you think you are being empathic? Do you feel attuned?” That really doesn’t predict whether it is going well. In fact, the therapist’s perception of how empathic he or she may be only correlates 0.3 with client’s perception of that. So what we need to do is systematically assess and privilege the patient’s perspective on the relationship. That predicts success.

**Wyatt:** And how do we get a sense of that, of what in therapy the client—is it important to gauge? Is this useful in the therapy? Sure, there is research out here, but how is this information useful in the therapy?

**Norcross:** In the moment, it is very useful to psychotherapy and to the respective participants. Research has shown that by asking a few simple questions, either directly in the therapy hour or little questionnaires before or after, improves retention and client satisfaction by about 27%. It is really quite a large effect for something so simple.

00:10:11

I ask simply three types of questions.
Wyatt: All right, let’s hear them.

Norcross: So, I would say, “Randy, how do you think the psychotherapy is going?” — meaning that it is goal-oriented. “Are you getting from psychotherapy what you want? Are we moving toward attaining your goals?” So that is first. “How is the psychotherapy going?”

A second question is, “How are we doing?”—meaning the relationship. And by the way, the question doesn’t work unless you go like this. “How are we doing?”

And then you want to know about the treatment itself. “What would you like more or less of?”—that is, tailor it. So in this way we privilege the patient’s perspective by systematically collecting immediate feedback. “Are you getting what you’re doing?” So, once again, it would be: “How are we doing?”—the relationship; “How is the psychotherapy doing?”; and “How are you doing?” So you have a relationship emphasis, a goal emphasis, and then, “What about the treatment would you change?” Asking those simple questions in the moment decreases dropout and profoundly increases outcome.

Wyatt: It reminds me of what couples therapists say about a marital couple going to a party. They say happier, more satisfied couples—Gottman’s research, for example, says they check in with each other at a party. They hang out together, they go off and they check in: “How are you doing? What’s going on?” So it seems this is good common sense, too.

Norcross: It is good common sense. If you think about psychotherapy not as a healthcare treatment but as an interpersonal relationship with curative goals, checking in with each other, nurturing the relationship, repairing alliance ruptures—all of these things make perfect sense.

Wyatt: Now you have got me going on a quote here that I just came across in a magazine. The quote is this: “You are only a person in relationship.” Said by a great psychologist—I don’t know if you know who it is, the Archbishop in South Africa Desmond Tutu. He says, “I can be human only in relationships. Yes, but none of us is self-sufficient. God made us interdependent. A person is a person through
other persons. This is when God rubs his hands in satisfaction and says”—and he would say it better than I, but—“Yah, mon.” What do you make of these words? And I take it you like these words and their meaning for psychotherapy.

**PSYCHOTHERAPY IS A RELATIONSHIP**

Norcross: I do like those words. I think the most productive and, incidentally, evidence-based manner in which to conceptualize psychotherapy is as a relationship. I adore self-help. I have already mentioned I applaud treatment manuals for their research and training use. But at the core, it is the irreducible unit of contact. And that is just not John Norcross’s perspective, that is 30 years of empirical research. Ask patients what they most got out of psychotherapy—almost always they will say the relational element. Ask patients—as dozens of investigators have done over the years—just ask patients, “How do you think you did well in psychotherapy? To what do you attribute it to?” 80% to 90% of the answers are, “You cared. You listened. You weren’t judgmental. You returned a phone call.”

In my office we call this the Diet Pepsi intervention. I have a small post-nasal drip, so I am usually sipping some water or, more likely, a Diet Pepsi throughout the session. Well, I have always been taught from childhood it is rude to sit there and drink something without offering it to your patients. So from the moment I meet someone, I say—on the way in, the first meeting, I say, “Let me show you our small refrigerator here. Please help yourself to water or one of the sodas.”

I can’t tell you the number of people who have said to me from successful therapy is essentially, “Why do you think psychotherapy went well between us?” They will say, “Because you treated me like a fellow human being. You offered me water and a comfortable chair, and not judgment.” If we follow the evidence, that is privileging the client’s perspective, and that is following what works.

Wyatt: You are really presenting, actually, it reminds me of Freud. Somehow it got lost along the way, that Freud was very welcoming to his patients—“Do you want tea, do you want coffee?”—and
sometimes when they had great interpretation they would share a victory cigar, based on a great interpretation. And that there is a welcoming atmosphere—that it is not a medical enterprise, just surgery. It is a human enterprise, human relationship. And when you go into somebody’s home, you want to feel welcome. It’s not somebody’s home, it is their office. But you still want to feel welcome.

00:15:21

Norcross: And anyone who has been to Vienna to tour Freud’s home would get immediately that impression. They enter through a nice airy area. The room is nicely decorated and furnished. It feels like you have entered someone’s inner sanctum, a precious home. And I have read now four or five autobiographies of Freud’s patients, including the Wolf Man and several others, and they said, almost without exception, “Here was a friendly person who had a great alliance, who treated me with respect and humanity despite my difficulties”—who would occasionally lend people money, give practical advice, and practically invite them into his household, because of course he practiced right there, where he lived.

And you are right—people have forgotten that over the years.

Wyatt: Well, it is good to see that humanity part in the Freudian tradition coming back—and based in research, as well.

Norcross: Yes.

Wyatt: The psychoanalytic and existential folks are quite pleased with this research—for a change, something in their favor.

Norcross: The empirical research is certainly favoring that. And my only caution about that is I don’t wish to contribute to the dichotomy—it is either the person of the therapy or treatment method. If we just think we are multi-faceted people, and different people need different things, it is obviously going to be both. And for certain disorders or treatment goals, the treatment method is probably going to be more important.

Wyatt: Can you speak of any of those?

Norcross: Sure: post-traumatic stress disorder, severe obsessive-
compulsive disorder, bipolar disorder, panic disorders.

**Wyatt:** Speak of panic disorders, just for instance.

**Norcross:** Well, panic disorder, for example. I think any dispassionate examination of the research would suggest that for the most part cognitive behavior therapy is the treatment of choice. By contrast, mild and moderate depression—the relationship is far more important than the particular treatment method you may use. So it probably does vary.

But anyone, including me, who works with panic patients, or severe anxiety or trauma disorders, know it’s impossible to execute the treatment method until you have cultivated a trusting, supportive relationship. That is an early trainee mistake: “Let’s start offering the method before we even have a relationship.”

**Wyatt:** And that is an error in all of life.

**Norcross:** In all of life.

**Wyatt:** You get parents coming in reading a parenting book and saying, “I’m going to do these parenting methods,” and missing out on the relationship with their child.

**Norcross:** Yes, and in fact when I give my workshop, I always identify the trainees in the audience and I say, “You have to pledge not to go OCD with me and try to implement these four or five things on Monday. You would be well intentioned to do so; yes, it is evidence-based and you will be more effective. But ironically, in trying to do those four or five things, you are going to lose your presence and connection to the patient. So just take one or two of these things that we know that work on the basis of decades of research, gradually incorporate them into your working model, and prize the relationship.”

**Wyatt:** The relationship really allows a working alliance for the technique to have a possibility of working.

**Norcross:** Yes. My departed friend, Michael Mahoney said, “This is massive confusion of the message and the medium.” The message to a patient is, “You are a good person. We care about you. We know
your behavior has brought you distress and perhaps distress to other people.” But the message should be, “I’m here, I’m listening, I care, and together we will travel the path.” Let’s not confuse that with what we read in books.

**Wyatt:** Let’s go on a little slightly different track. We are all for flexibility and the therapist having good connection, working alliance, therapeutic alliance. Is there a danger that the therapist is just all over the map, wishy-washy, a chameleon, and just responding to everything and not being true to themselves and their own center, so to speak?

**Norcross:** That is exactly the problem. But that wishy-washy is not eclecticism. In fact the word for that is syncretism—an unsystematic mismatch of different things that people are doing. Good integration is focused and goal directed. I’m going to behave this way for a particular reason. For example, in responding to people, individual clients, we can’t possibly anticipate everything that they may want.

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And of course I encourage people to ask—what is it that you might need from me in this moment in this session to get where you might like to be? But in general, the research also tells us there are certain ways to be, and certain ways—equally important—not to be. So we want to be flexible, we want to attune ourselves to the individual moment, but we also want to backup and do the things that the research suggests almost always work.

For example, empathy, cultivating a therapeutic alliance, positive regard, repairing any alliance ruptures, trying to fix any miscommunications or insensitive remarks—which as humans are almost inevitable. So we can walk this delicate balance on the one hand between being fresh in every moment but also following the research.

**REPAIRING RUPTURES**

**Wyatt:** Recently I read a study, and I lost the study, just so you know that, but I remember this—it says it’s not just the initial positive alliance, because something may happen in the first few sessions that doesn’t go quite right. The therapist attends to that rupture or a little
mistake or a little misunderstanding, and that actually makes the relationship better, and clients report that it is better. Can you speak to that issue?

Norcross: Sure. That is one of now at least a dozen or so studies, largely instigated by the work of Jeremy Safran, on the identification and repair of alliance ruptures. A rupture occurs when there is a misunderstanding or a conflict between the therapist and patient. And the research shows that the vast majority of our patients actually experience such a rupture, but they infrequently speak about it. They want to be a good patient, so they harbor it in, and instead they walk with their feet, maybe perhaps not show up at the next couple of sessions.

Clinical experience along with this empirical research shows that we ought to be actively asking patients about the alliance and asking if there is anything particularly upsetting, and then modeling a way of fixing the problem that doesn’t blame the patient but is seen as a problem within the relationship. Hence when we say repairing alliance ruptures.

Wyatt: Let me give an example. I had a very verbal client, had a lot going on in their marriage and their work, and the session time was running out. I had another client next. And so I began to look at the clock and notice it. And the reason I was looking is I wanted to make sure I wouldn’t cut her off or I had enough time, could I go over a little bit, thinking about who my next client was and so forth, trying to manage it and make sure I attended to her. I thought everything went fine. It went a little bit over, so on and so forth.

A few sessions later she comments on her former therapist who watched the clock. And she thought that was insensitive. Eventually it came out that she was tense and she thought she wasn’t interesting—that I was watching the clock because I could not wait for the session to end.

Norcross: So you could get to a more interesting person.

Wyatt: Right, exactly.

Norcross: And that is a great example. And if we can be sensitive to
those interpersonal nuances, actively ask about the client’s experience, we can identify those early and thereby prevent people from dropping out or carrying that resentment with them.

And in that moment where you work that out with the patient, you are modeling exactly the kind of interpersonal openness, self-disclosure and conflict resolution that psychotherapy should be doing. So the process of psychotherapy parallels perfectly the goal of psychotherapy: “How can we work this out?” And frequently, as every therapist will quickly discover, as Freud anticipated a hundred years ago, the relationship that woman had with you in the moment is frequently the same problematic relationship she enacts outside of here, finding herself boring or uninteresting.

Wyatt: Exactly, and that’s what has been the work.

Norcross: Yes, so what a marvelous, magical moment of psychotherapy when that occurs.

Wyatt: Yet for a student or an intern, this is the worst moment in their life.

Norcross: “Oh, my patient complained to me!” So my supervisees come back and say, “So, do you want to humiliate me some more with your clinical advice?” They come back and I say, “Well, it depends what you are attending to. Was psychotherapy facilitated by this?” And they say, “Yes, but it was living hell when they turned to me and said, ‘Well, if you really want to know, I don’t like what you said before, a comment you made, how you dressed, how you offered me something, how you presented me the bill.’” So, at the moment, neophyte therapists find this very uncomfortable.

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With experience, they soon discover that they can not only handle this sort of feedback and managed the countertransference, but they find, of course, over time, that this facilitates the therapy. And then they love it. But the first couple of times, watch out, particularly if you are a supervisor.
THE MAKING OF GREAT THERAPISTS

**Wyatt:** So, for students and for practicing therapists, what can they do or what has the research shown that they can do to improve? In some ways maybe therapists are born and they have certain gifts in their family, but we all want to improve or overcome certain problems. What does the research show facilitates that growth and cultivates the person of the therapist?

**Norcross:** I’m glad how you asked the question, Randy, because we all know that to some extent psychotherapists may be born that way, but that takes us into a dead end, a nihilistic view that either you have it or you don’t.

The research shows we can do lots of things that improve our success with patients and simultaneously cultivate the persons we are, and are becoming. First, we need to be a little better about who we let into graduate training in psychotherapy. I always tell my colleagues when I am interviewing people, I literally say to myself, “With maturation and additional clinical training, would I feel comfortable having this person treat a member of my family or at least a friend?”

If you say no and you are largely letting the person in to fill a seat and make some tuition dollars, there are some ethical concerns with that. So, first, let’s be a little better with our selection criteria.

**Wyatt:** On a quick note, we asked the question where I taught, “Give an example of when you were treated unfairly in a school or a job. How did you react? What happened?” When people are treated unfairly, oftentimes their interpersonal reactions come out. It was highly correlated—

**Norcross:** Old grudges, entitlement, all kinds of stuff I’m sure I imagine pour out.

So at first I think, as a profession, we have a higher collective responsibility to do a little better than to fill a mandated number of seats in an incoming class. And it is ironic that we don’t look at that sometimes, even though these people subsequently will become licensed as counselors, MFTs, psychologists and so forth. Once they are in, I believe everyone should be watching videotapes of their
Now, at first this is very humbling, probably painful even for experienced people, but one discovers how they are coming off. And it is in the moment. Then, of course, we need to privilege the patient’s experience of therapy. So, asking the patient how it is going, giving them quick little measures of empathy, alliance—“Are your goals being met?” “How are we doing?”

So that gets systematic feedback. Most supervisions should be live or videotaped so that we can actually see what is occurring rather than just hearing about heroic reports from our supervisees. Clinical supervision should be attending not only to technical competence but the person of the therapist. And if we are honest and you look at most of the surveys, most people will say at least half of their clinical supervision was pretty poor.

And that hurts if you think about it. You don’t expect all training experiences to be pristine, but so many report that their clinical supervision was really quite hurtful.

After that, I believe personal therapy should be very strongly required. I just stopped half an inch—I mean should be strongly recommended. I stopped half an inch from saying required just because I believe there may be other formative experiences that could be as effective as personal therapy. It could be meditation, it could be an intense group experience, it could be martial arts—but some formative experience to give each therapist the role of the client, to work their interpersonal patterns out, to model what they have experienced. Literally to occupy the patient’s seat is a very powerful experience.

Then we have a life-long commitment to continued learning. Unfortunately, most people see this as getting the degree and then putting in some mundane continuing education hours. And then I believe in life-long self-care—psychotherapist self-care.

**Wyatt:** This conversation may be continuing education, so this will be a corrective.

**Norcross:** We need something interesting, we need something fascinating and new. Sad to say, most people go to CE to learn
more about what they already know, rather than to freshen their perspective, keep them vibrant, move them in a slightly different path.

Now that is just humanity, right? We stay with what is comfortable, we get complacent. We should occasionally challenge ourselves.

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Several of my colleagues pointed that out over the years. And as an advocate of psychotherapy integration, I should be at the lead of this. So frequently I go to CEs of treatment methods and perspectives that I actually abhor in some ways and wouldn’t think of integrating. That is how you stay fresh and you learn what is out there. And frequently we encounter our own hardening of the categories and our own prejudice, and we discover this other stuff is really much like ours if we can get past out preconceived notions and caricatures we have of other theoretical orientations.

Anyway, that was a long answer to what we can do.

ARE THERAPISTS NUTS?

Wyatt: Now there is a bit of rumor and mythology—I don’t know how true it is—I have seen some of your writings on it, so I know a little bit, but I want to hear what you have to say. Oftentimes people say, “Oh, you are going into psychology or therapy because you come from a crazy family or you are nuts yourself. Most of the therapists I know are nuts,” they say. What does your research say on that? Are therapists more nuts than everybody else?

Norcross: No, it turns out not. But nor are we healthier. Yeah, it is sort of a mixed bag. We are not healthier than others of comparable intelligence and socioeconomic status, but as a group nor are we any crazier.

Wyatt: We are not wizards.

Norcross: We are not wizards. Well, we are minor league wizards. Certainly not the Wizard of Oz. There is a view, started many years ago, that the more effective therapists were those who were wounded healers.

Wyatt: I’m going to get to that.
**Norcross:** All right. And actually the research doesn’t support that as a category. What is far more important is that psychotherapists have lived a full life, know what it is to be in pain, to be dealing with conflict, to have experienced relationships that turned sour and feel like you have been pierced through the heart.

So it is to live a full and vivid life so that you can relate to patients, rather than being extraordinarily wounded ourselves. At the same time, some of Barry Farber’s research shows that when you ask people to list the reasons for becoming psychotherapists, toward the top of it is self-understanding—“to help myself”—and of course to help other people. And as long as helping ourselves is a byproduct to helping others, I think that is a magical profession in which you can perform this enormous service to help others and as a byproduct help yourself grow.

**Wyatt:** So you would speak to that yourself. So, you have had your heart pierced, been through troubles yourself.

**Norcross:** Yes.

**Wyatt:** And did that motivate you to get in the field at all, or what got you in the field, since we are talking why others get into the field?

**Norcross:** A bunch of different reasons. First, the colloquial “to help others.” Both of my parents were dedicated to public service. My father was a labor organizer throughout the country at a time, back in the ’30s and ’40s, where that was a very dangerous occupation. My mother was one of the first full-time park rangers in the history of the National Park Service. So they had emphasized throughout our lives that, “You are here to do a little more than just run toward capitalism. Let’s show a little service.”

In college I actually had temporarily three majors. I wanted to be an English major, and I was a writer, a philosopher and a psychologist. I found out that philosophy didn’t have much in the way of career prospects. And I knew I wanted to write, and I knew I wanted to help people, and I am dedicated to learning more about myself. So, over the years, it was this wonderful confluence of professional and personal reasons.
I wanted to know more about how I tick. I wanted to understand how I function in relationship to other people. And psychology, specifically of all of the mental health professionals, also met my goal of writing and researching along with a service profession.

**DIFFERENT STROKES FOR DIFFERENT FOLKS**

**Wyatt:** Is there any time that you would self-disclose to a client your own experience of pain or suffering or wounds?

**Norcross:** Certainly if it was in their interest, and that is exactly what the research shows.

**Wyatt:** What does that mean?

**Norcross:** That means—

**Wyatt:** That could be a cover-all, “for their interest.” Everybody says it has to be for the patient’s interest, but at any moment we are going to choose what to say.

**Norcross:** Certainly we choose, but we ought to have a filter rather than just bleeding on the patients and saying, “They just talked about something that triggers in me this association.” For example, as a parent, as a husband, as a son, we have all had moments where or client’s experience and feelings are triggering something in us. I would hope people wouldn’t immediately blurt it out and say, “Oh, that happened to me.”

So after that filter, we ought to be saying, “In this moment, is that likely to be helpful for that person?” And it turns out compared to benchmarks on self-disclosure, I am probably a little more self-disclosing, and definitely a little more informal, immediate, than most psychologists.

**Wyatt:** Can you think of a time when you self-disclosed and what it was about at all? Or is that—

**Norcross:** Last week, here is an instance. In comes a fiftyish-old professional talking about his lifelong pain of distress about his child, and that he had this particular image of one of his kids going into a certain profession and following the patient’s footsteps. I remember thinking at the moment, “Wouldn’t that have been nice for my own
children?” And I almost blurted that out, saying, “Isn’t that every parent’s fantasy that your child actually, not so much follows our footstep, but lives up or follows the path that we think would be best for them?” And at that moment I said something like that. It seems to me most parents begin with such an image of where their children will end up. And I just said, “And I have certainly have felt that at times.”

And he just went, “You felt that?” And I said, “And I suspect if you talk to lots of parents, that is a near-universal experience. When they are born we imagine them reaching someplace. And then the pain of maturity as a parent, realizing we are here to foster their growth, not for our children to follow into our preordained paths for them.”

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At that moment he seemed quite surprised that other people would have felt that, including me.

Wyatt: As you are talking about that, I think of my therapist that I am not seeing right now, but I did for quite awhile, and the one thing I always remember was that he self-disclosed about a loss, and the fact that he was out of the country and the grieving people here didn’t tell him that his friend had died. And then when he came back, he found out his friend had died two weeks before and everybody was two weeks ahead in the mourning.

He told me this at a time when something similar to that had happened to me. He didn’t self-disclose much, being fairly psychoanalytic, but still that sticks with me.

Norcross: Enough that it certainly had an impact that, years later, you remember.

Wyatt: Yeah, so I think well timed and well filtered—not necessarily thought out forever, because you have to say it in the moment.

Norcross: Yes, and we don’t know what is emerging in the moment—but something that enhances the client’s work. And the research by Clara Hill and others shows that is exactly what self-disclosure does for most of our clients—it normalizes the experience. It gives a fellow-human-traveler perspective, as I call it. “We are all just traveling through the world, and I have had that feeling, and doesn’t it really
hurt?”

**Wyatt:** Let’s step back a little bit to the wounded healer, based on Nouwen’s work. Some people say a wounded healer is what you referred to—is they’re more wounded. Another way to think of it is that we all have wounds, and the therapist’s task is to attend to those wounds such that it helps them attend to other people’s wounds.

So when I teach and so forth, that is something I always try to remind the students and therapists of, is attending to their own wounds—so that the therapist becomes a warrior, so to speak, in attending to their own wounds.

**Norcross:** Yes. And there are two distinct meanings of this wounded hero. Some people think of it as psychopathology and pain. Others think about it as a special gift, depending upon the perspective. So, the research simply says the people who truly have been through pathological conditions aren’t necessarily any better psychotherapists. But this relentless commitment to attend to ourselves, to be warriors, to model self-care, is precisely what we should all be learning.

And I found over the years, doing workshops, that our fellow mental health professionals very candidly say, “I’m not very good at this. I do not practice what I preach. I frequently feel hypocritical. Here I am at 8 p.m. doing a session with a parent and advising them to go spend more time with their own kids when I as a therapist am not tending toward my kid.” I think many therapists experience deeply that paradox, that we render advice we don’t follow ourselves.

**Wyatt:** That is not uncommon. Like doctors smoking and eating too much and the wrong food.

**Norcross:** And lawyers aren’t any more honest than the rest of us. So it is very reassuring that we are not alone in this, but it is somewhat ironic. I just hope we take a little more of our own medicine.

**Wyatt:** And if the graduate schools supported that, that is a good start.

**Norcross:** It is a fabulous start—if on courses on professional ethics standards, there was a self-care component. If they strongly recommended personal therapy experience. If they provided group experiences for graduate students as they go through. If they warned
trainees about what they are likely to experience, that nearly half of all mental health professionals are going to experience a client’s suicide at some time in their career. We need to be prepared for this in ways we are currently not.

**START WHERE THE PATIENT IS**

**Wyatt:** Exactly.

Let’s go back to the person of the therapist. Now, certainly you said that manualized treatments and the more CBT models certainly have an important role in the field, but back to the person of the therapist, every therapist is a person, has a personality, has a culture, has a gender and so forth. We aren’t cookie cutters.

Some are introverts. Some are extraverts. Just with the idea of extravert/introvert, how does that play—have you thought about that?

**Norcross:** Sure. Not only have I thought about but there has been some research on this. Arnie Lazarus, a colleague and mentor—

**Wyatt:** Extravert.

**Norcross:** Extravert. Has fashioned this notion of an authentic chameleon, saying that we can shift and change our colors—let’s call them our relational stances. We can push ourselves to be a little more extraverted. We can withdraw a little and speak a little less depending upon the particular clinical circumstance and patient.

But like even a chameleon, we can’t turn plaid. So it begins with identifying who we are and our own stimulus value to patients. We don’t have to be able to treat everyone successfully. And if we know who we do not treat successfully, then we can make referrals, or not accept those patients.

Now when I say that, most people immediately think about particular professional activities or diagnostic categories like “I don’t work with children,” or “I don’t do neuropsychological assessment,” or “I don’t do medication management.” I mean this quite differently. I mean it in a relational context.

Very extraverted people will be better with some types of patients than others. More introverted clinicians are likely to be drawn to
theoretical orientations and to relationship stances than others.

Let’s take me for a moment. I’m not nearly as extraverted as people imagine. But when I am teaching, giving workshops, writing, you are the sage on the stage and you should be doing something. Fair enough.

If I have a very dependent patient who wants me to be very directive, I have difficulties with that. Such a patient, I will of course identify that every time I am more directive, what happens to them—and they can usually identify it very quickly—“Well, that makes me feel better in the short run but in the long run, of course, I am now feeling more dependent and more one-down”—only reaffirming their dependent stance in life.

So with such patients I will say, “I am not as directive perhaps in the short run as you would like. If it is in the long-term interest of your therapy, that you are willing to work on that, I would be very happy to work with you. But if you are looking more for six to ten sessions of more focused, very directive work, over there my colleague may be a better fit for you.”

So, it is just not treatment manual matched to a diagnostic category. It is the person of the therapist matched to the person of the client. And we have more flexibility and breadth in how we relate to people. For example, on any given day, to take an example, right now I am the subject of an interview here, but in a few moments I may be asking for directions. I may be a student in a workshop. I may turn around two hours later and be a parent, and then I may be a son.

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So we have very flexible and broad interpersonal repertoire, far more than we think we have. But we do have limits and one has to identify and then refer.

**Wyatt:** We don’t just have the traditional either Freudian or Rogerian one-size-fits-all therapeutic stance.

**Norcross:** Different strokes for different folks. That is the essence of responsiveness. But we can’t be responsive to absolutely everything.

**Wyatt:** Right. Let me give an example where I learned something.
I was speaking to a student who was very quiet and so forth, exceptionally introverted. And I made a comment, “Well, you have to learn to get out there more,” and she probably did. But a colleague of mine said, “Hey, you know some of these introverts are excellent listeners. And they can really listen deeply. Sure, they can learn to come out a little more, and so forth.” And ever since then I have remembered that—to honor the introverts.

**Norcross:** Yes, and to honor what that particular style and goal are. For years we have tried to change introverts to extraverts, with limited success. The new perspective that I think is consistent with that humane set of values you just espoused, as well as the empirical research, is to begin where the patient is and work with that coping style and that personality.

For example, we know in the short run a more directive therapy will help low-resistant, more dependent patients better than lower directive does. But in the old days we would say, “Well, I am going to be less directive to force you to come out.” Now, if you have a hundred sessions, that may be a successful strategy. Now in briefer therapy we say, “We honor the personality”—unless it is of pathological proportions—“and we will be able to work with you.” In the past we have asked, essentially, patients to adjust to us. I think what we have all learned is we need to equally adjust to our patients’ style and preferences.

**Wyatt:** I’m thinking now of a client that doesn’t speak much. The therapist usually likes the client to talk a lot.

**Norcross:** It’s helpful.

**Wyatt:** They can kick back, they can intervene when they need to. But I have thought of myself—when I get supervision or consultation, we talk about, “Now we can learn patience more.” So making it an opportunity to stretch yourself versus trying to say it is resistance, the client’s resistance. We get to cultural issues here.

Certain cultures don’t come in blaming their parents—Asians, for example. It is taboo to really go in and start blaming your mother, your father, your family for all of your problems. The therapist, that
is where they usually go—not to blame, but history and so forth. Can you speak of the cultural issues and say for example the difference between traditional Asian and traditional Western European?

**Norcross:** Yes. Responsiveness should be applied to all of these dimensions and facets of multiculturalism. It isn’t just ethnicity. It is gender and it is age and it is disability status. So, when I say culture, I mean it broadly as individuality. I learned early on when an Asian gentlemen came in, and as I mentioned I tend to be fairly informal. And at the end of the first session I said, “And I am comfortable with you calling me John if you prefer.”

Ninety-eight percent of my patients say, “Well, that’s great, John,” and shake my hand again. This gentleman immediately said, “I think I would be uncomfortable with that.” And instead of thinking it was resistance we should immediately say, “He is using me as an agent of change for the purpose of this psychotherapy. He said he would feel uncomfortable with that.” When I ask patients, “How can we tailor the therapy to meet your needs?” they come up with all kinds of creative, engaging ideas.

“Let’s move our chairs away,” for example. We tend to be fairly close. This may work in the Middle East but in other cultures it won’t. So, I will say, “Are we too close?” Some people would like a coffee table between us. Usually I just work straight on.

So I ask patients, “Please use but don’t abuse me.” And everything they request, of course, I may not be able to accommodate—there are always ethical and legal boundaries involved. But for the most part, if we start where the patient is, and honor and privilege those preferences, therapy is far more likely to achieve its results.

**Wyatt:** The word privilege has lots of meanings. What do you mean by privilege?

**Norcross:** That we respect, we identify it and we try to accommodate those preferences.

**Wyatt:** I hear you on that—sensitivity to the client. But I go back to—we are training many people from different cultures now in graduate
school, people coming from all over the world. Therapy is opening up all over the world. It is no longer a—

Norcross: A middle class, white, European-American pursuit.

Wyatt: Exactly, from Germany and England, coming to America, that is where therapy, the foundations of it are and were. But it is much different now. And it needs to be different.

Norcross: Yes.

Wyatt: But we still have a great expectation of this certain type of person we imagine to be a therapist. And I think that hamstrings people from different—Italians, for example, who are using their hands and “Come on,” and so on and so forth. Or New Yorkers. For a while I was seeing two New Yorkers, one from New Jersey, one Philadelphian. At one point I put them together in a group. And believe me, a reflective, passive style did not work. They were in my face. They didn’t want any California niceness. I learned something there.

Norcross: And we all do. Psychotherapy integration is dedicated to this proposition: that each clinical encounter needs something a little different, and that pure theoretical orientations really are not particularly helpful. It speaks to that immediate, pragmatic injunction of, “Each patient needs something a little different.” And if you have this broad style, you will be able to be responsive to everyone who walks in.

Because culture is like the air we breathe. Until it’s different, we don’t notice it. But not only are the therapists different, we are seeing, the patients are now different.

We always wanted the YAVIS patient, the young, attractive, verbal and intelligent and successful, and largely fairly wealthy white person. That is not who most of us see anymore.

Multiculturalism is upon us and we are likely to be seen as guilty of benign neglect if we don’t start training people for multicultural competence. And as much as I applaud that initiative, I just hope people recast it slightly larger, because this is what we did with feminist therapy: what we prized about the client was simply gender.
Now multiculturalism, if we are not careful, we are only going to be prizing ethnicity and race. I want to prize individuality. So that may be age. That may be ethnicity. That may be disability status, religion, values, introversion, and extraversion.

So when we say culture, as most people now are, I hope we are thinking that more broadly and addressing where the person is rather than just picking isolated gender or ethnicity as a way to respond. So, I think, Randy, we are on the same page. I just see it a little more broadly.

**Wyatt:** That makes a lot of sense.

**Norcross:** Yeah, including international, as you mentioned.

**Wyatt:** Right.

**Norcross:** I have given several workshops in Germany. The audience and the patients they asked me to work with were very different, not only in language but in style, and expectations of therapy and how quickly they wanted advice, versus people working in other countries.

**Wyatt:** John, in training, oftentimes students and early-career therapists are trained for more conformity. Obviously they have to learn their tradecraft and the ways of the world and the ways of therapists. But we don’t want to train out their individuality. How can therapists maximize and leverage their individuality in therapy practice?

**Norcross:** And that, Randy, is really the key: how to produce technically competent therapists while also nourishing the person of the therapist. Because we all know we don’t want these cookie-cutter therapists who all just—in fact, if you want to really enrage me one day, just call me a “provider” and I am likely to come after you with some violent epithet.

And that is it because managed care now expects people to be these interchangeable providers as though the therapist doesn’t matter. So it starts in the training program when we pay attention to the individual therapist. I mean, literally talking like that.

Of course you need to learn the skills associated with, as you say,
the tradecraft. But we are here to leverage that individuality. And that begins by including it in course work, by, every time you do an exercise, prizing individual responses that get to the same place, rather than saying, “Well, that is not toward the model here”—saying, “You got to the same place, you just went a different way and that seem to resonate with you.”

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It is in watching videotapes to look at individuality and say, “That was really great. I haven’t seen that done before.” It is allowing people to bring their individual reactions—filtered, not just countertransferred—disciplined, but truly improvising as an individual. So, it happens in coursework, it happens in supervision, it happens in practicum, that you are able to nurture yourself as an individual therapist in a disciplined way for the benefit of the patient.

And that is just a series of dialectical tensions everywhere. How can I get us over here, as you say, to competency-based, which is sort of the normative or generic? But how at the same time can I make sure you are an individual in which your richness, your nuance, your person shines for the benefit of the patient?

CULTIVATING EMPATHY

Wyatt: Right. That is an excellent point about therapists’ individuality. How can supervisors and professors and teachers of all stripes and types of training help therapists cultivate empathy in the therapeutic connection?

Norcross: You know, it is part by selecting the right person, which we have already discussed, but it is worth reemphasizing that. If you select people who are not committed to service toward others and who have not lived a full and vivid life, it is difficult to pull on previous experiences.

Once again, the field—as all humans tend to do—we tend to think in black and white. Either they are born therapists, or you make them. The research actually shows both are a bit true, but every single therapist can increase his or her ability for empathic attunement. You can begin, again, looking at your videotapes. You can practice
empathic statements. You can keep in your mind for each session, “In this moment my most important objective is to completely understand this person and how they are experiencing their life.”

In some ways Carl Rogers had it absolutely right—although he was a little too absolutist in saying it is only the relationship—in saying, “At the end of the session, do I feel I made the connection? Would the patient walk out and say, ‘That therapist really knew me’?”

They can practice in front of mirrors. They can go in and respond to their own pain. Simply saying something—it almost sounds mindless to say, “You know, as you talk, that really hurts just for me to be in the room with that.” Or to say, “Ouch.” And it is not to follow necessarily these long-winded classical Rogerian reflections. I found years ago working with an adolescent boy, my supervisor was watching and he kept saying, “Give more empathy.”

At one point the boy said, “Why do you keep just repeating everything I have said?” And I realized that empathy comes in what our client-centered researchers call idiosyncratic empathy modes—going back again to this notion of responsiveness. It turns out if he came in and I remembered a good joke from the week, that would be a wonderful way of meeting and being empathic. Giving him a little punch on the arm meant so much more in that moment than my long-winded attempts to reflect his emotions back to him.

So it is also trying to understand the patient’s experience of what is empathic for him or her rather than what may be empathic for us.

Wyatt: One of my adolescent clients said to me, “So do you understand everything? What kind of doctor are you? You understand everything?” As if I was so empathic. And that shut me up. And he said he’d had enough. He took a nap for 15 minutes, and after that we had a better connection.

It is unusual, this idea—you said “idiosyncratic empathic connection”?

00:59:52

Norcross: Yes. Everybody’s way of being understood and connecting with each other is very individualized, idiosyncratic.
Wyatt: Sometimes saying nothing. Sometimes saying a lot. All different things. What you focus on.

Norcross: Sometimes babbling on. Sometimes putting an apple in your mouth is the way to be. Sometimes a light punch on the arm—lest I be misunderstood that Norcross is going around punching his patients. It is all how to meet the person. And you get that, again, partly by responding from your internal response as a therapist.

But in increasingly we have learned it is by asking, systematically, the patient what works for him or her.

Wyatt: It is checking in again.

Norcross: Checking in. “How are we doing? Do you feel I am understanding your perspective?”

Wyatt: Now, just a little reaction to that—we probably don’t want to do that too often either, right?

Norcross: In fact, people who do it too often look like they don’t know what they are doing. And this is a frequent mistake of people who learn this. They ask so frequently that their patients get the impression, “Don’t you know what you are doing?”

Wyatt: “How are we doing now?” over and over.

Norcross: Yes. So I am careful that at the beginning of therapy, this is a wonderful way to introduce that psychotherapy is not like a medical model where I am simply the expert dispensing advice or medication—rather saying, “Here is the collaboration and the goal consensus and with your permission I will occasionally ask those three questions: How are you doing in terms of your symptoms and goal? how is the therapy going? And then, how are we doing?” If you ask that every two or three sessions you find out—and encourage patients for their candor—you find out amazing things that work for them.

From simple things like, “Let’s spend a little more time on processing my feelings toward parental death,” to “Can we move the chairs a little further apart?” to how frequent the sessions should be. Of course, like most people, I used to start out seeing patients once a week. I have now
learned and the research supports that for most people, therapy every two weeks works just as well.

Or I used to have the magical 50-minute hour. I have now learned 30 minutes or more frequently 90 minutes for several of my clients—far more optimal use of their time and money.

**KEYS TO A SUCCESSFUL THERAPY**

**Wyatt:** This is very impressive, all of these details of the therapeutic relationship and alliance. But—I say it somewhat sarcastically although I mean it—for the therapist, what are the core ingredients—and you could come back to just a few things—the core things about the person of the therapist in the relationship?

**Norcross:** I will be research-based in going through the list. The core is empathy. It has, statistically speaking, the highest effect size. Most people these days think it is the alliance, but actually good old-fashioned empathy, which is one part of the therapeutic alliance, is at the top.

There is, of course, the therapeutic alliance. And its parallel in group therapy would be cohesion—group cohesion amongst the members as well as the members’ cohesion with the therapist. It is collaboration. It is goal consensus. It is positive regard. It is the therapist’s genuineness and congruence.

Now, of course, many people would immediately say, “Well, some of those are the Carl Rogers’s facilitative conditions.” And indeed they are. Research has been very supportive. Except today we know there are more than those, and hardly anyone is going to argue that they are necessary and sufficient. They are very facilitative and they may well be necessary, but they are not necessary and sufficient.

**Wyatt:** What about the role of hope, which Carl Rogers talked about?

**Norcross:** And expectancy.

**Wyatt:** Yes, hope and expectancy.

**Norcross:** Hope and expectancy certainly relates systematically to psychotherapy success. But it is interesting how one “installs” hope in someone else. It is by behavior and by specific statements, saying,
“Now that we have met this one or two times and we have come to know each other, I feel confident that you have a very good probability of reaching your goals.”

So it is the therapist’s action rather than hollow words, and of course that is where congruence comes into the picture. One can’t sit there and say, “I’m hopeful and optimistic about your psychotherapy,” unless the therapist has the inner conviction that it is.

That, interestingly, too, relates to findings from the therapist’s personal therapy. They find that one of the lasting lessons is that psychotherapy is powerful because they have experienced it internally.

01:04:56

And this helps many a trainee, and for that matter a seasoned practitioner, during therapies that are going rather slowly and poorly at first. We know that with 85% probability, most psychotherapies are going to be quite successful.

Wyatt: Earlier you said something which I want to go back to. You said there are certain things that therapists can do which don’t work in terms of the alliance and their person of the therapist. Can you speak to that?

Norcross: Sure. Of late we have become very interested in this because the evidence-based movement practice attempts to identify what does work. It strikes us that it is equally important and probably easier to get a consensus on what doesn’t work.

So on the list of the “don’ts,” as it were, is don’t ignore ruptures in the relationship. Your example—the patient who felt it was insensitive of you to be looking at the clock and then impugned your belief in her interest. Many therapists feeling awkward in broaching that with a client would let it go. That is just contraindicated by the research in clinical experience. Let’s shelf for the moment our discomfort and address that.

So don’t ignore ruptures. Another “don’t” is to rely on our belief on how empathic we are being. Remember it is the patient’s experience of our empathy that determines outcome. It is not our belief. So the “don’t” is, don’t just say, “Well, I think I am being empathic. That
was a pretty good reflection a moment ago. That was a poignant interpretation.” It is the client’s experience of it, what is actually received.

Another “don’t” is what we call “ostrich behavior.” A lot of therapists just say, “Hmm, this is a difficult subject”—not just about ruptures but about anything. And they kind of stick their head into the sand. A supervisee came to me just last week and said at her place, Linden Community Mental Health Center, in a partial hospitalization program, a patient was sexually self-pleasuring himself between groups in the bathroom.

And my student was warned as an intern, “You may not want to have much physical contact or shake hands with this gentleman.” I said, “Well, that was a sage warning.” And then I thought for a moment and I said, “What are they doing about addressing the problem of this man self-pleasuring between groups?” And she said, “Well, nothing, we are all just avoiding it.” And immediately I just said, “Come on, this is the thing to be broached in obviously a very sensitive way. But this really should be approached as a treatment goal in a collaborative fashion with this gentleman.”

Therapists are not alone in ignoring pathology. Sometimes we don’t just address the difficult stuff.

**Wyatt:** It can be uncomfortable.

**Norcross:** It will be uncomfortable. I’m glad I am not the person who addresses this. But from afar, I can say that.

**Wyatt:** All right, what else shouldn’t we do? Are there are any postures or styles or ways of relating?

**Norcross:** Yes, anything that is humiliating, pejorative, of course, relates negatively to psychotherapy outcome. It has been demonstrated time and time again. Key on that list would be judgment.

Now, some people mishear this into suggesting somehow then that we don’t leverage our individuality and just sit there and say, “Well, we have no judgments about anything.”

**Wyatt:** Our opinions.
Norcross: Yes. We can do so, though, after establishing a relationship that does not come out as judgmental. Similarly, the research suggests that we ought to be very sparing on confrontations. Now, we have to be careful here. That does not mean we don’t point out inconsistencies or duplicities between what a patient may say and a patient may do, but it is how it is shared.

If it is shared as a confrontation, like Zeus throwing the thunderbolt down on the patient from Mount Olympus, that is what is to be avoided.

Wyatt: I would say, and I have heard from one of my mentors, Jim Bugental, who said, “You’d better have a really good connection,” if, to use your term, you are going to throw a thunderbolt—a lot of safety, a lot of trust, a lot of history. Then you can leverage that if you need to really confront a person.

Norcross: Yes, and Jim’s keyboard of interventions says confrontations should be used sparingly. He anticipates the research and virtually all clinical experience. That doesn’t mean that we don’t bring ourselves or that we ignore stuff, but that all confrontations should be a relational, collaborative act, not a distanced, pejorative statement.

Wyatt: Anything else relational that therapists do?

01:10:00

Actually, one I am thinking of is when people come into therapy and they have been to another therapist or they complain about their therapist in the public square and in the coffee house, “My therapist never says anything. My therapist is so neutral, or so distant. My therapist didn’t even ask me or didn’t wish me good luck on a test. I was taking an exam and he didn’t say that. It’s like, gosh.”

And when they come to me, and they see somebody else, not that I am the perfect therapist either, but they will complain about this kind of distance or apartness.

Norcross: Yes. And I agree both personally and professionally that is to be avoided in most instances, except—always there is an exception, because all of this depends—there are those people who actually do better in therapy with a little more distance, not to the extreme you
are suggesting. For example, patients suffering from suspiciousness, paranoia—we have learned clinically that if we get too close to them we are actually retarding their improvement. So for some people we need to take half of a step back to allow the patient’s comfort to develop, and then we can gradually move ourselves forward.

As you said earlier, so many of us see patients essentially as “little me’s.” That is the therapist mistake of all time. “This is how I would respond, therefore that is how the patient would respond.” That is just classic narcissism, instead of the supposition that maybe this patient responds nothing like me.

So there are those suspicious, paranoid, perhaps patients struggling with hypomania, who need a little more distance or may need a little more structure than we are comfortable with.

**Wyatt:** That is a very good point. And I have heard that, too, to be fair. Some clients will say, “The person was too warm. They were like my friend. I want a doctor. I don’t want touchy-feely.” So again goes back to flexibility.

**Norcross:** Yes. In an article we once wrote, Arnie Lazarus and I related an incident, actually one of his patients. This woman’s name, let’s call her Mrs. Healy, sent in as part of her information packet a request for a forceful therapist. She had already been in therapy with someone she called a “parrot” and wishy-washy. So on the very first session she comes in to Arnie Lazarus’ therapy office, which is attached to his home, and she comes in and says, “Dr. Lazarus, why do you have graves outside of your office?”

Arnie says he replied, “Graves, Mrs. Healy?” She said, “Look outside the window, dummy.” Well, he looks outside and sure enough, on either side of the walk were new bed plants that looked like freshly dug graves because the shoots of the flowers had not come up.

Arnie, being the genius he is, immediately met the woman where she needed to be met and said, “Since you asked, Mrs. Healy, they are for my uncooperative patients. And I have just planted one treatment failure in that one, and if you continue to give me a hard time I reserve that grave for you.”
Now, as a trainee I could not imagine saying that. But as a seasoned therapist, meeting the patient where they are would be perfect. And indeed Arnie says the woman’s eyes sparkled and she said, “I think I found the right therapist.”

Now that is an extreme case. And let’s not go around unconsciously activating our patient’s fears that we are killing them. But the point was some patients are going to require a little more distance. Some patients are going to require a little more structure and closeness. The extremes are probably never to be advocated. It almost always errs to the medium.

So, very distant therapists are probably not going to have much success, but nor are the very up-close people that don’t let patients talk and do their work.

**INFLUENCERS AND INSPIRATIONS**

**Wyatt:** In your background and your training, what therapists, what professors or psychologists have inspired you and made a difference in your work?

**Norcross:** There have been many.

**Wyatt:** Let’s start with a few.

**Norcross:** All right, we will start with a few in the short list. My graduate school mentor would be Jim Prochaska, best known for the Stages of Change, on which he worked for years. And on whom we have coauthored several books on the stages of change and now systems of psychotherapy.

Arnie Lazarus, the father of technical eclecticism, thought I would prefer the term psychotherapy integration.

Larry Beutler, who has done the best research on “different strokes for different folks” in a research tradition that is called aptitude by treatment interaction—patients’ aptitudes interacting with specific types of treatment.

Jim Bugental was a mentor from afar and later in life able to spend some time with him.
**Wyatt:** He wrote *The Art of the Psychotherapist.*

**Norcross:** He did, *The Art of the Psychotherapist,* still a classic, and his early book on existential-humanistic work. There are so many. Albert Ellis, who I was fortunate enough, before his passing, to work with over time.

What is interesting is that—

**Wyatt:** What did you learn from Ellis, since he is a different character in many ways and very outspoken?

**Norcross:** He is a colorful, outspoken therapist.

**01:15:42**

Honesty and empiricism. The man was honest. Thomas Paine once wrote that, “If you don’t displease some people, you are probably not honest.” And Al helped me, in many ways, essentially say, “I disagree with people.” Because by nature I am more collaborative and psychotherapy integration—I try to be pluralistic and see the sides of everything. Al said, “Don’t always straddle the fence. Just say ‘no’ sometimes if some things just sound a little crazy to you,” when we wrote and did some other things.

So I have been very privileged to have accessed some of the cutting-edge people, both in research and in practice, for which I am very grateful.

**Wyatt:** What you say about Albert Ellis, he definitely called it like it was, at least to him.

**Norcross:** Yes.

**Wyatt:** Whereas sometimes psychotherapy can be the art of the ambiguous, the art of ambivalence—seeing all sides of something. And in some ways he goes against that grain, certainly.

**Norcross:** Yes, and his point was, even though I prize the ambiguity and pluralism in life, there are those moments in one’s personal position, that you have to say, “No, I am just not quite for that.”

**Wyatt:** There is something about that, and clients find that refreshing sometimes.
Norcross: Yes.

Wyatt: That a therapist actually can make a direct statement and confirm or give a direct opinion on something.

Norcross: And, again, that is a matter of timing and empathy. Some therapists are there a little too early and they come off as authoritarian. Other therapists, as you well know, can never quite get there at all with a directed, focused statement.

I hope that we can take a middle path that attunes to what the patient needs.

Wyatt: What do you find in your work as a psychotherapist that is most satisfying and most enjoyable?

Norcross: Well, the immediate and obvious answer is patients’ growth. When they come in and have met their treatment goals, restructured a relationship, feel better about themselves, dismissed a symptom, enabled to engage and relate to themselves in a whole new way—that is just a marvelous moment and it makes it all worthwhile.

Other times I really like, it is the flexibility of what I get to do: some individual work, some group work, some couples work. I’m just someone who enjoys the diversity and synergy of professional activities.

And of course, something I really adore about psychotherapy is not having to do it full-time. I learned in my internship and residency that, though I could certainly do it and enjoy it, I didn’t want to see 30 or 40 patients a week.

I am much happier seeing 10 to 15 and spending other times teaching and consulting, supervising and writing.

Wyatt: John, we have been talking a lot about the science of psychotherapy and the research and the studies, and I just mentioned The Art of the Psychotherapist. In what ways are the art and the science of psychotherapy not so different?

Norcross: I don’t think they are that different at all if one looks at all of the science of psychotherapy. Of late I have been very disturbed how the science of psychotherapy has been commandeered by people with
one image of psychotherapy as essentially the medical model: diagnose the patient, assess the symptoms, pick out a manualized treatment, and treat them as if there is no therapist. They are not much of a patient beyond the diagnostic category.

When you really look at the entire science of psychotherapy, then you find the richness of the individual therapist who accounts for between 5% and 9% of psychotherapy success. You get to the psychotherapy relationship that accounts for at least as much as treatment method.

01:19:48
So all that we have called art—cultivating a relationship, selecting and nourishing individual therapists, and of course, technical competency—all of that art converges almost perfectly with science if you look at all of science, and not just distort certain parts of it.

Wyatt: So, the subjectivity, the humanness, the humanity of the therapist and the client and their relationship is part of science, too. And it has been evidence-based.

Norcross: Yes. There is as much scientific evidence for therapeutic relationships than for any treatment manuals. And this is why many people are drawn to the work my colleagues and I have done. On the one hand it is rigorous science and 14 meta-analyses on the one hand. On the other hand, it prizes the relationship, and in harmony it is just magical, like successful psychotherapy. Evidence-based relationships, without getting into mindless dichotomies between “Is it the technique or the relationship?” It is obviously all of them.

And when we can just take that middle path, look at all of science, it converges with the art.

Wyatt: Well, John, it has been a pleasure having you here today, John, and meeting with you and talking about this.

Norcross: Thank you, Randy, and I have enjoyed it.

Wyatt: All right.
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### Experts

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Arnold Lazarus
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**The Therapeutic Relationship, Individualized Treatment and Other Keys to Successful Psychotherapy**

Martin Seligman
Irvin Yalom
...and more

**Therapeutic Issues**

Addiction
Anger Management
Alcoholism
ADD/ADHD
Anxiety
Beginning Therapists
Child Abuse
Culture & Diversity
Death & Dying
Depression
Divorce
Domestic Violence
Grief/Loss

Happiness
Infertility
Intellectualizing
Law & Ethics
Medical Illness
Parenting
PTSD
Relationships
Sexuality
Suicidality
Trauma
Weight Management

**Population**

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Couples
Families
GLBT
Inpatient Clients

Men
Military/Veterans
Parents
Prisoners
Step Families
Therapeutic Communities
Women