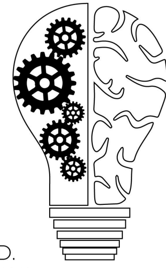
Episode 110: The Hero’s Journey for the Mental Health Professional

David Puder, M.D.



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There are no conflicts of interest for this episode.

In the last episode we talked about the first two stages of the hero’s journey.

First, the departure, which includes the call to adventure and then oftentimes the refusal of the call. This is usually followed by a guide coming along and giving supernatural aid to the hero. We discussed the importance of the guide, or multiple guides, in our journey. The importance of being receptive to feedback from the guide is a central theme.

Within the departure is also the “belly of the whale” moment, when the hero comes up against their unconscious and often the darker sides of their personality (shadow) such as aggression, jealousy, resentment, and other aspects of themselves that they would rather not face and believe.

Next comes the initiation of the hero’s journey. This includes trials and temptations that lead to the hero getting off track. We talked about trials mostly in negative terms, as the things that can distract them.

In this episode I will focus on the path of the hero as it specifically applies to mental health professionals.

I teach that there are three areas that require continual growth for mental health professionals. In this episode I will discuss exactly what those are and how these are areas in our core being that simply cannot be faked. Meaning, unlike head knowledge that we can learn and therefore know, the areas we will be discussing require the hero (us) to develop and mature at the core of our being, to embody these things, and to be fundamentally transformed.

I had someone email me recently as to why there were looking at my resource library:

“I want to lie better,” they said.

I was completely shocked and then just very sad. Can we just learn how to lie better? Is that what makes a good therapist? This is a perfect example of knowledge without inner

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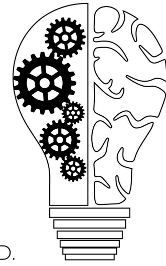

transformation. The thing about lies is that at some mirror neuron level they are not registered as truth.

Recently in a forum I am a part of a psychiatrist posted this:

"Today a patient told me, 'The way you're showing empathy is making me irritable.'"

Now, this could say more about the patient than the provider, but imagine that the provider's empathy came with a lie; they really did not feel into the person's experience. While listening, they had other internal dialogues going on: the kids, spouse, how their debt felt against their shoulders, the patient who had threatened a lawsuit, their teenage daughter who was out late the night before. If many other thoughts were going through their head, the patient may have felt their empathy was a lie.

I responded to the post by saying that I imagined the patient was feeling distrustful and unheard. They are letting you know that something about the empathy does not allow them to feel felt, that something about the empathy seems robotic or distant; they don't feel you are present.

Secondly, I suggested saying, "Thank you for letting me know." I truly believe this statement. If the patient corrects me and I accept the correction, it allows me to reset and pay attention to what is going on between us. It lets me know something needs to be adjusted. Instead of putting these comments back on the patient, I first look inside myself. It takes two to have any relationship.

As a side note, one of my biggest new pet peeves is when a therapist blames someone that is not in the room, the other person, and gives the patient a psychological out. For example, I believe that at the core, conflicts in marriage are always about two people and not just one spouse. Our responsibility is to work with the person in the room because that is the only person we can change.

So I look at myself first. I ask myself if I was distant, not listening, or missing something. By choosing gratitude for this chance to recalibrate, I am choosing the chance to connect. In a culture where ghosting someone is more and more the norm, it is precious to have a chance to actually hear a piece of interpersonal feedback that could lead to increased knowing. We can be grateful that there is a real connection on an honest level.

This may also mean your patient has moved into a more critical thinking space where they can hold together their representation of you as a mix of the good and the bad at the same time. That is a huge psychological improvement!

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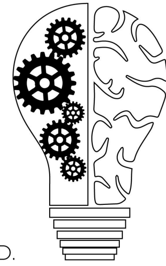

The next thing I say is, "Help me understand what bothers you, in particular." This statement is an inquiry out of a true desire to know more about what is going on. I don't want to project my own estimation of what happened. I want to know.

At times, patients will feel like you are not a real person and that you are playing a part. We cannot simply play a part; we must get away from that. We have a role to be there for them, but we are real people who need to be present with the intent to listen and help; just our presence can be of help. It may mean they won't feel as alone in distressing memories if they can feel connected and understood. Perhaps they will have a new way of looking at past traumatic events.

What I am communicating today is that it is necessary to have a level of inner transformation that matches our knowledge in order to gain the three gifts we need to be able give to our patients: learning to become empathic (empathy), connected (therapeutic alliance), and having the ability to navigate our own conflicting internal feelings (countertransference).

Let's look at them further:

1. Empathy:
    a. Being empathic through a mindful practice of deeply listening, attuning our affective empathy, and reading others body language.
    b. Three different levels of empathy: an emotion flashing on the face; the context of the emotion; the "chapter" vs. the "book" itself (a series of events vs. the context of the whole of their life).
2. Therapeutic Alliance:
    a. Enjoying and desiring deep, meaningful connections with others; this is embodied in our thoughts on therapeutic alliance.
    b. There is a pleasure that comes with connecting with people, even people you may not connect with at first.
    c. It can be a sacrifice to grow in this area.
    d. Growing in the ability to connect with people is interrelated to empathy and countertransference.
3. Countertransference:
    a. Deeply understanding the difficulties others have and working through our own traumas and difficulties so that our "countertransference" is minimal or none.
    b. It's unlikely we will ever get to "none." But if we have a large reaction, this may point to work that needs to be done in our own lives. This entails identifying their narratives that are entangled in our past narratives, untangling them and instead

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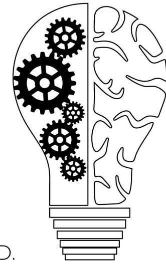

learning compassion for those with attachment and personality issues instead of reacting to our own.

c. Be curious about what is really going on and listen to the associations that come up.
d. Tolerance vs boundaries: Our own lack of boundaries may indicate that we have a high level of tolerance for a certain type of person and may need to look at our boundaries to ensure they are healthy. This will help us in our relationships with our clients.

To get to a place where these things are who we are is the therapist’s hero’s journey. It is tragic that psychotherapy is largely taught through giving knowledge, manualized approaches (which have very little to do with what I am talking about), and little true mentorship or relationship. It is easier to teach content to a group than have a one-on-one relationship. Further, it is not just a crisis in the psychotherapy world. I see this in other areas outside of the psychotherapy world; many spiritual leaders go to seminary and it is a lot of head knowledge too. Additionally, many seek spiritual growth from psychedelics rather than the heavy labor of doing “the work.”

We often have a desire to grow in this way, but feel the cost is too much. Many feel that doing their own work is too time intensive or expensive. But at the same time, they go out and get a forty-thousand dollar car or pay forty thousand dollars for one year of school (which, by the way, is essentially 2-4 years of the highest end of therapy or supervision).
If you are fresh out of school, pursue your own mentorship and supervision. Be willing to pay them; budget for it. Make the financial sacrifice and it will be one of the best investments you can make for your career. Find someone you respect, that is well-respected, and, practically speaking, someone with a license in your state.

Carl Jung said, “Beware of unearned wisdom.” It is the concept of “knowledge without transformation.” It is wisdom that is not embodied, knowledge without a fundamental or a spiritual transformation. This is why I am talking about this as the therapist’s journey. We have the need to look into the other world, the world deep in ourselves and, hopefully, come out more fundamentally empathic, connectable and tolerant of others.

Imagine, for example, you have every bit of knowledge about forgiveness. You have done the research and understand all aspects of it, even health benefits such as decreasing chronic stress. You teach others about its value, but deep down inside yourself you feel resentment and bitterness towards things in your past. Let’s say sixty percent of your emotional energy each day is consumed by your anger towards that ex, parent, or person who hurt you.

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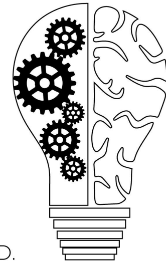

Consequently, your ability to guide someone through the act of forgiveness will be thwarted. It will be limited on several fronts, the first being that you bring the resentment in yourself into your relationship with that person and it can't be completely hidden. Additionally, it means you have not developed the ability to find peace at your core. On some unconscious level, you will be registering your resentment in their experience of you.

There is also the potential that you will have countertransference towards them if they remind you of that person. They will feel your unresolved internal conflicts. We unconsciously leak out our resentments.

I was in this place once- filled with cognitive knowledge of the value of forgiveness, but so full of anger and bitterness. I knew that I could not forgive out of my own strength. I prayed for the ability, the gift, the grace to be able to forgive. It took multiple times, a process of days, but I felt it shift inside me on some fundamental level. I softened. My critical mind and obsessive anger was not just pushed further into my unconscious, but gone; it never bothered me again.

It is through trials, pain and suffering, good guides, and a healthy spirituality that one transcends. It is through learning from our own life; it is from struggling mindfully in our own journey. Knowledge may precede the embodiment, which can potentially take years and lots of reminding to develop. Ultimately, it takes a full reorienting of our mind.

How does one get the skills necessary for the quest that awaits them?

You might be thinking, "Doesn't excellence simply come with practice? Just doing something?" If you were to ask me this a few years ago I might have told you I believed that was 90% of it.

But over the years I have had to reprocess this belief. I began thinking about becoming a master in a particular skill and it brought me back to an early book I read called *Talent is Overrated*. In it, the author deconstructs the myth that world-class performers only reach ultimate success based on talent. Rather, the book argues the importance of disciplined practice.

Ericsson authored many of the seminal papers on disciplined practice, which can inform our understanding of how to become an expert in something or guide someone else into becoming an expert.

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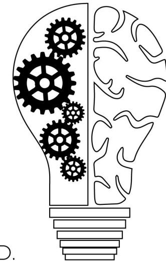

I was once rebuked by my rowing coach, Steve Gladstone, when I said, "Yes, I guess I just need to spend more time rowing." He said, "No, you need to spend more time *mindfully rowing*, focusing and being fully present with every stroke. Time where you are getting feedback." This has always stuck with me. Deliberate practice is not just about quantity of time. After reading research later on in my life it meant even more.

Research shows that deliberate practice contains these components (Miller, 2018):

1) **Individualized learning objectives**
   a) The best performers direct their time, attention, and energy to the steps required for reaching their goal.
   b) Better results are achieved with higher levels of involvement and motivation.
2) **Ongoing feedback regarding performance and learning**
   a) Checking in with your patients each session (post-session evals- verbal or written)
   b) Monitoring expressions of anger when giving empathy.
3) **Involvement of a coach**
   a) Someone who is viewing your sessions or who is guiding you.
   b) This person would ideally embody the traits that you are working to develop (empathy, therapeutic alliance, countertransference, etc.).
4) **Successive refinement**
   a) Slowly, progressively refining your work

Miller, et al, found that just doing the activity had a 0.2 correlation with success. The correlation between success and deliberate practice was found to be 0.4, which, comparatively, is much higher (Miller, 2020). When you multiply the correlation against itself it gives you the between-person performance variance. This means that deliberate practice accounted for 16% whereas just doing the activity accounted for only 4% of between-person performance variance!

Let's take a deeper look at these four components:

#1 Individualized learning objectives: Sometimes called the "zone of proximal development", this is the space between what someone can do without help and what they need assistance to accomplish. Identifying the challenging objectives and breaking them down into small individual steps leads to forward movement and eventual completion. By applying time, attention, and energy towards the small steps, these challenges are not too difficult as to be overwhelming or too easy in which they might lead to boredom. They just go beyond the comfort zone.

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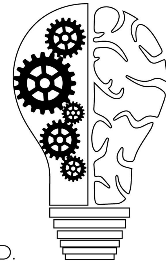

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#2: Ongoing feedback regarding performance and learning: Effective feedback is timely, continuous, immediate and has a plan of action. It enhances specific strengths, reinforces certain behaviors, or remediates certain deficits. Not all feedback is useful. One study found the effect size of feedback to be .41, but >⅓ of feedback was associated with worse performance (Kluger and DeNisi 1996). Feedback is more effective when it is targeting core skills rather than the final game day result.

#3: Involvement of a coach: When a coach is involved, the elements of focusing on technique improvement and execution are incorporated. Coaches also interact as cheerleaders and encouragers.

#4 Successive refinement: This means working on the edge of your abilities rather than staying in your comfort zone. It is achieved by repetition and is often conducted alone.

- I think of Katniss Everdeen in the Hunger Games; her father was an illegal hunter who took her into the woods beyond District 12 to teach her to hunt. She spent countless hours practicing shooting her bow.

- I think about Daniel in the Karate Kid. He was trained by Mr. Miyagi, often cleaning and remodeling Miyagi’s house with the movements necessary to do karate well.

- Sometimes therapists played the role early on as peacemakers in their family. Our training in countertransference may have started at a very early age.

If you are a therapist, the next question to ask yourself is what the things are that you want to practice and perfect. A singular diagram comes to my mind when I think about this question:

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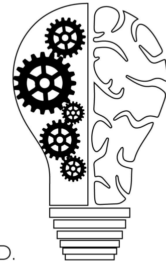

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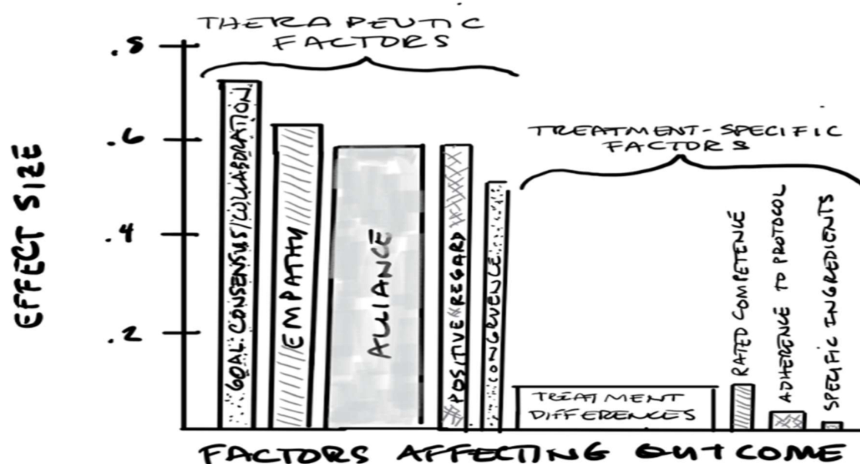

***Figure 6.4.* The Effect Size of Factors Affecting the Outcome of Psychotherapy**

(*Note:* Width of bars reflects the number of studies reflecting effect sizes for each therapeutic factor. Adapted with permission from "The Great Psychotherapy Debate," by B. Wampold and Z. Imel, 2015, p. 258)

(Miller, 2020)

It shows that the factors that affect outcomes include:

- Goal consensus, collaboration
- Empathy
- Alliance
- Positive Regard
- Congruence

Whereas, factors that don't make much of a change include:

- Treatment differences
- Adherence to protocol
- Specific ingredients

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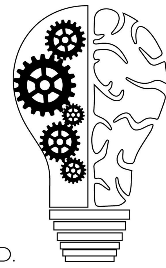

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Yet, most training sessions are held in group settings and mainly emphasize the newest techniques; there are very few relationships forming. However, when we look at therapists within a study setting and some are doing better than others, the therapists that are doing the best are more skilled in empathy, therapeutic alliance, and so on.

To grow in authentic empathy, alliance, and positive regard we have to walk our own journey and practice receiving feedback; we can only learn so much from a textbook.

Choosing the Guides in our Journey

I teach empathy to residents, so I know there is a certain amount that can be taught. We watch videos of each other doing therapy. We look at microexpression, small moments of connection and disconnection. We study to see things we otherwise might not see. We can see when a patient does not feel heard and watch to see if reconnection is established within the session.

I once had a resident who was treating a very difficult patient that I had followed for years. The therapy ended after only a few months. The resident often said the right things, but at the core level of their being they did not have empathy, love, or kindness. The patient likely reminded the resident of someone from their past.

I take responsibility for part of this, not being a guide in a way that would have allowed the resident to transcend what was going on. These moments should wake us up so we can grow into being fully present. The core of our work is relational, so we have to do relational work.

There is a spiritual saying "you will know them by their fruit"– fruit being love, peace, joy, patience, kindness, self-control. Look for these attributes in a supervisor. This fruit has come from real growth, not just knowledge.

In the same way, I have noticed that when a resident does not embody these "fruits" towards a patient, the treatment is stifled. Often, working with a client will bring up things from our past that we need to work through. When we don't, this can keep us from the true embodiment of these characteristics that we need in our core being to relate to our patient.

The implicit reactions we have are not just cognitive. Countertransference is something that starts early in our lives and is deeply ingrained. It's not something that happens quickly; it takes time. Consequently, it can take years and lots of work to untangle these countertransferences.

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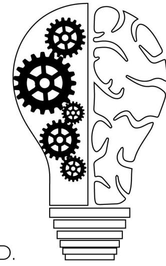

Be patient with yourself in this process. It is ok if you have strong reactions to some clients. Keep working through them.

Connection within a supervising relationship, in my research, has four domains:

1. Empathy
2. Educational Alliance
3. Psychological Safety
4. Feedback

We have talked about all of these except psychological safety, which is the ability to give your supervisor feedback and for them to accept it and make sense of it without lashing back or shaming you. It is so important for us to have this for those we train and for our clients. Look for someone who embodies these four things. We have found that when an attending is highly connected, the burnout of the resident decreases. So there is therapeutic value in this for your job, as well.

Having an empathic supervisor is important because to some degree the teaching is implicit, it is "caught" and not taught. It gets integrated into you.

The next question I have is, "What is the nature of this work?" Some of the nature is looking into the parts of ourselves that we would rather hide. For example, we would rather project an image of success. I don't know how we can be more kind to ourselves, more truthful, until we know that the truth is ok to hear.

St. Augustin had the first of a new genre of books when he wrote *The Confessions*. This book was all about his dark and horrible inner thoughts. It was his conception of grace, or redemption, in his spiritual journey that allowed him the boldness to put out his truth. This was the first book of its kind.

When you are connected to a supervisor who has the ability to see, value and appreciate you, even the darker sides, and to not respond to you with the same self-criticalness with which you respond to yourself is so utterly surprising. Find someone who embodies the opposite of shamingness.

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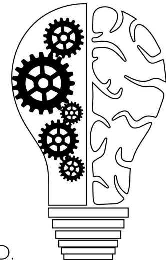

The Wounded Healer

Often, we find we have more in common than we do differences with those we treat; we can see ourselves as "the wounded healer" (coined by Jung).

The wounded healer was first expressed in the Greek myth of the centaur Chiron. He was concieved by rape, overcame and was able to give back, becoming the founder of medicine and a great teacher.

Consider this writing by Rumi:

"Trust your wound to a teacher's (God) surgery.

Flies collect on a wound.

They cover it, those flies of your self-protecting feelings,
your love for what you think is yours.

Let a Teacher wave away the flies and put a plaster on the wound.

Don't turn your head.

Keep looking at the bandaged place.

That's where

the Light enters you.

And don't believe for a moment that you're healing yourself."

— Mevlana Rumi—

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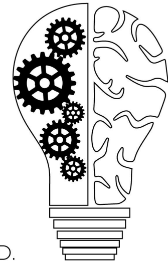

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Countertransference

Over forty percent of social workers report having experienced mental health problems before their social work careers and almost fifty-two percent indicate that they have experienced mental health problems over the course of their social work careers, with twenty-eight percent currently experiencing such problems (Straussner, 2018).

When a therapist’s own issues get triggered it is called countertransference. We should not feel bad that this exists within us; we should not run from the thoughts. We can be curious, we can observe, we can see where we associate.

Sometimes we get the clients we need the most. There have been times I felt I should be paying my clients because of how much growth that is occurring through working together.

Great psychotherapists and psychiatrists have faced their own psychological problems with courage, exploring their own complicated inner realities, finding a solution, and then giving that solution back to others.

Marsh Lyneham formed DBT through her struggles with suicide, hospital admissions and journey.

Victor Frankl sought for meaning in the concentration camps and formed logotherapy afterwards.

What makes a patient difficult?

For primary care doctors, I read an article that suggests a patient tends to be more difficult if they have five or more somatic symptoms, increased stress, depression or an anxiety disorder. Or they could have greater severity of symptoms or worse functional capacity, and potentially other mental disorders (Hinchey, 2010).

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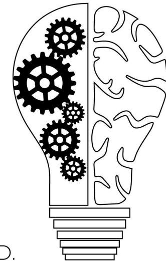

When I have a difficult patient that brings up my issues, they become my teachers. I bring that to my supervision sessions (I am still in), and get feedback. I try to explore what my contribution is, what the aspects of my personality are, and my ego thwartedness that is being stirred up; I try to grow.

We are not gurus giving advice from a place of superior wisdom, judgement and authority. We are in the trenches as wounded healers, going through our own journey.

Any tendency for narcissistic defenses, like blaming the other person, needs to be worked through or we will gaslight the patient when we are actually at fault. If they are picking up on that and we blame them for our negative reaction, we are essentially gaslighting them and teaching them to be the bad guy, in their relationship with us as well as others. If we can work through our own things, we can teach our patients that their perceptions are true and how they can better tune their perceptions to reality.

We bring learned expectations from past encounters to every relationship. We also react to what the patient is bringing to us– their transference. We should be conscious of this.

By attaching meaning to our reaction, we are changing our reaction. By processing through a strong reaction, we are changing the way we will interact in a similar situation in the future.

Feelings to check in with yourself about, especially when they are intense and not what you usually feel (idiosyncratic to a particular patient):

- Disgust
    - I dislike him/her.
    - I feel repulsed by him/her.
- Attraction
    - I have compassion for the patient.
    - If they were not my patient I would want to date him/her.
    - I feel sexually attracted to him/her.
    - If he/she were not my patient I would want to be their friend.
    - I look forward, with great pleasure, to sessions with him/her.
    - I wish I could give him/her what others never could, protect him/her like no one could.
    - I feel overly confident that I understand him/her.
    - I have warm, almost parental feelings towards him/her.
    - I self-disclose more about my personal life with him/her than with other patients.
- Sadness
    - I wish I had never taken the patient on.

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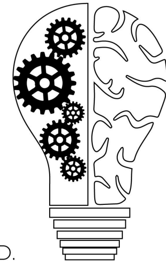

- I feel sadness/depression in sessions with him/her.
- I feel guilty about my feelings towards him/her.
- I feel guilty when she/he is distressed or deteriorates, as if I must be somehow responsible.
- I feel strongly disappointed in myself, like I should be helping much more.

- Anger
  - I feel dismissed or devalued.
  - I feel ineffectual and impotent– patient ignores my insights.
  - Patient is non-compliant, does not take his medication.
  - I feel annoyed in sessions with him/her.
  - I feel criticized in sessions with him/her.
  - I feel angry with him/her.
  - Patient compares me unfavorably with other therapists.
  - Patient is very dependent on me and blames me for not rescuing him/her.
  - I feel righteous indignation at his/her misdeeds, inconsideration of others, dishonesty, or callous treatment of his/her spouse or children.
  - I feel angry and disapproving of his/her exploitations of disability insurance, public assistance programs, and how he/she is selfish and self-indulgent.
  - I feel anger towards people in his/her life.
  - Patient is childish, demanding, has excessive expectations of me, feels entitled to special treatment, activates my judgmentalness that he/she should act more grown-up and mature because he/she is, in fact, an adult.
  - His/her narcissistic traits make me feel like angrily deflating his/her feelings of entitlement, specialness, and seemingly high self-regard.
  - I feel competitive with him/her.
  - I feel used or manipulated by him/her.
  - I have to stop myself from doing things that are aggressive or critical with him/her.
  - I feel pushed to set firm limits with him/her.
  - I feel resentful working with him/her.
  - Consider if the patient has unconscious anger, anger towards you that can not be expressed, anger towards a parent that has not been expressed.
  - "Rather than feeling angry, I would rather understand what is going on with you."
- Dissociation/Shut Down
  - I feel confused in sessions.
  - I feel lightheaded in sessions.
  - I feel nauseated and sick to my stomach.
  - I am overwhelmed by strong emotions with him/her.

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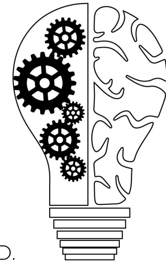

DAVID PUDER, M.D.
PSYCHIATRY & PSYCHOTHERAPY

    - I feel hopeless working with him/her.
    - I feel like my hands are being tied or that I have been put in an impossible bind.
    - Consider if the patient is feeling not understood, in a state of trauma, or if there has been a therapeutic rupture.
- Sensorium issue
    - I feel bored in sessions with him/her.
    - My mind wanders to things other than what he/she is talking about.
    - I feel sleepy when talking with him/her.
    - Consider if the patient is over-medicated, on opioids, benzos, in a state of delirium.
- Fear/Anxiety
    - I feel anxious/frightened working with him/her.
    - I fear I am failing to help him/her.
    - His/her sexual feelings towards me make me anxious or uncomfortable.
    - I fear being incompetent or inadequate to help him/her.
    - After treatment ends, I worry about him/her more than most patients.

In summary, I think the trials portion of our journey, as therapists, is about refining of our own internal inability to express empathy, working through our strong countertransference reactions, and leaning in to the difficulties that affect our ability to interpersonally connect in a way that is necessary for change to occur.

These things take some knowledge to identify within ourselves, but then they really require us to do our own work.

My hope is that if you have never been in your own therapy, your own supervising relationship, you will value this and be willing to invest time and treasure (money) to obtain it.

Episodes to dive further into topics discussed here:

Episode 107: Hero's Journey: Getting Rid of the Faulty Narratives

Episode 105: Vulnerability and Imposter Syndrome with David Burns

Episode 077: Getting Better Results from your Patients as a Psychotherapist

Episode 070: Connecting with the Psychotic Patient, Therapeutic Alliance Part 7

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Episode 110: **The Hero's Journey for the Mental Health Professional**

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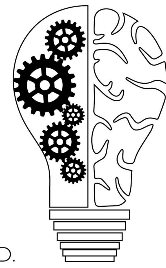

Episode 069: Therapeutic Alliance Part 6: Attachment Types and Application

Episode 062: Therapeutic Alliance Part 5: Emotion

Episode 055: How to Pick a Good Therapist

Episode 041: Therapeutic Alliance Part 4: What is Transference and Countertransference?

Episode 036: Therapeutic Alliance Part 3: How Empathy Works and How to Improve It

Episode 032: Therapeutic Alliance Part 2: Meaning and Viktor Frankl's Logotherapy

Episode 028: Therapeutic Alliance Part 1

Further reading:

Jennings, L., & Skovholt, T. M. (1999). The cognitive, emotional, and relational characteristics of master therapists. *Journal of Counseling Psychology*, *46*(1), 3.

Kluger, A. N., & DeNisi, A. (1996). The effects of feedback interventions on performance: A historical review, a meta-analysis, and a preliminary feedback intervention theory. *Psychological bulletin*, *119*(2), 254.

Hinchey 2010: A cohort Study Assessing Difficult Patient Encounters in a Walk-in Primary Care Clinic, Predictors and Outcomes

Miller, S. D., Hubble, M. A., Chow, D., & Wampold, B. E. (2019). More confusion about deliberate practice? Not really. *High Ability Studies*, *30*(1-2), 295-297.

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Straussner, Shulamith Lala Ashenberg, Evan Senreich, and Jeffrey T. Steen. "Wounded healers: A multistate study of licensed social workers' behavioral health problems." *Social work* 63.2 (2018): 125-133.

Teding van Berkhout, E., & Malouff, J. M. (2016). The efficacy of empathy training: A meta-analysis of randomized controlled trials. *Journal of counseling psychology*, *63*(1), 32.

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