THERAPIST'S FACILITATIVE INTERPERSONAL SKILLS AND PERSUASIVENESS IN PSYCHOTHERAPY

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RESUMO

A evidência empírica demonstra uma associação robusta entre as competências interpessoais do psicoterapeuta e os seus resultados clínicos. No entanto, existe um foco predominante no estudo de algumas competências interpessoais (por exemplo, empatia) em detrimento de outras. Especificamente, existe uma falta de contributos teóricos e científicos focados na persuasão do psicoterapeuta, uma competência interpessoal que engloba os comportamentos verbais e não-verbais do terapeuta que influenciam as expectativas e credibilidade do cliente quanto à intervenção psicológica. Os estudos aqui apresentados visam aumentar a base de conhecimento teórico e empírico para as competências interpessoais do terapeuta no geral, e para a persuasão terapêutica em particular.

No primeiro estudo, revemos os principais contributos teóricos e literatura empírica sobre a persuasão do psicoterapeuta. Com base na investigação disponível, apresentamos um consenso sobre os principais comportamentos verbais e não-verbais do terapeuta que parecem influenciar as expectativas e credibilidade do cliente em relação à psicoterapia. Este estudo sugere que o fornecer de racionais clínicos dentro de sessão, tanto para a origem dos problemas do cliente como para a sua solução, é a tarefa persuasiva mais relevante no qual os terapeutas poderão ser treinados de modo a aumentar a eficácia clínica. Concluímos com implicações para o treino e investigação de persuasão psicoterapêutica. Destacamos a necessidade de desenvolver diretrizes de prática deliberada para persuasão clínica, e a análise de processo das competências interpessoais do terapeuta dentro de sessão.

No segundo estudo, propomos diretrizes com suporte empírico para o treino de psicoterapeutas focado no fornecer de racionais clínicos convincentes. Apresentamos critérios para o treino sistemático desta competência, bem como um exemplo de implementação dessas diretrizes. Concluímos com implicações sobre como os métodos de prática deliberada poderão contribuir para o treino tradicional de psicoterapeutas.

No último estudo, investigamos as competências interpessoais e persuasão terapêutica numa amostra de 18 psicoterapeutas de três modalidades clínicas e 54 sessões gravadas em vídeo. Os resultados indicam que as competências interpessoais do terapeuta são um preditor positivo significativo do envolvimento emocional e cognitivo do cliente

(“experienciação”) dentro de sessão. Foi também encontrado que fornecer racionais clínicos foi um preditor negativo significativo da experienciação do cliente. Nenhuma diferença foi encontrada para as competências interpessoais do terapeuta entre diferentes modalidades, mas diferenças foram encontradas para a experienciação do cliente e o fornecer de racionais clínicos.

Os contributos decorrentes destes estudos fornecem implicações para o treino de psicoterapeutas e investigação empírica futura, sugerindo próximos passos que poderão, em última instância, contribuir para o aumento da eficácia clínica de psicoterapeutas.

ABSTRACT

There is robust evidence that psychotherapist's facilitative interpersonal skills are a significant predictor of client outcomes. However, there has been a prevalent focus in the study of some interpersonal skills (e.g., therapist's accurate empathy) to the detriment of others. Specifically, therapist's persuasiveness, an interpersonal skill encompassing the verbal and nonverbal therapist behaviors that influence client's treatment expectations and credibility, has lagged in theoretical, training, and research contributions. The studies presented aim at increasing the theoretical and empirical knowledge base for therapist's interpersonal skill in general, and therapeutic persuasiveness in particular.

In the first study, we reviewed the theoretical and empirical literature on psychotherapist's persuasiveness. Based on the available research, we present a consensus on the main verbal and nonverbal therapist behaviors that might influence therapy client's treatment expectations and credibility. Our review found that the delivery of cogent treatment rationales, both for the origin of client's distress and tasks to alleviate said distress, is arguably the most supported persuasiveness-related task therapists can train to increase treatment outcomes. We conclude with therapy training and research implications, namely, that deliberate practice training guidelines are a necessary next step in the development of therapist's persuasiveness, and that process analysis on therapist's in-session interpersonal skills is warranted. The remaining studies presented here address these two issues.

In the second study, we propose empirically supported guidelines for therapist training in providing cogent treatment rationales. We provide step-by-step description and criteria for systematic training, as well as a case example implementing these guidelines. We conclude with implications for how deliberate practice methods augment traditional therapist training.

In the last study, we investigated therapist's in-session interpersonal skills and persuasiveness for a sample of 18 therapist and 54 videorecorded sessions from three treatment modalities. Results indicate that therapist's interpersonal skills are a significant positive predictor of client's emotional and cognitive engagement ("experiencing") in session. We also found that providing cogent treatment rationales was a significant negative

predictor of client experiencing. No differences were found for therapist's interpersonal skills across modalities, but differences were found for client experiencing and provision of treatment rationales.

The novel contributions stemming from these studies provide implications for future therapist training and empirical research, thereby suggesting next steps that may ultimately aid in increasing psychotherapy training effects and client outcomes.

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Chapter I

General Introduction

The research problems addressed in this thesis stem from a recent trend in psychotherapeutic research, which currently seeks to understand the so-called "therapist effects", i.e., the great variability in treatment outcomes found across individual therapists, regardless of their therapeutic approach and years of clinical experience (Johns et al., 2019; Baldwin & Imel, 2013). The therapist's "facilitative interpersonal skills" (FIS) construct has been shown to significantly predict some of this variability (Anderson et al., 2020). However, there is still much to learn on these skills. Among the interpersonal skills shown to impact client outcomes, one of them is rarely discussed and empirically investigated: therapist's *persuasiveness*. Briefly stated, our main research problems are the following: what are the theoretical, training and research implications of therapist's persuasiveness? And how do therapist's interpersonal skills in general, and therapist's persuasiveness in particular, influence the in-session therapeutic process?

Great scientific debate is currently underway regarding therapist effects and the characteristics that define effective therapists (Castonguay & Hill, 2017). The study of the therapist's effects is a relatively recent area of investigation, with the therapist historically being considered a "neglected variable" in the scientific literature (Garfield, 1997). However, the available meta-analyses reveal significant differences in results between therapists and few or no differences between theoretical approaches (Wampold & Imel, 2015). When the specific ingredients of therapy approaches are dismantled, treatment is generally equally effective (Ahn & Wampold, 2001; Bell et al., 2013). Moreover, adherence to manual treatments does not seem to correlate with clinical outcomes (Webb et al., 2010; Owen & Hilsenroth, 2014). This accumulated research led to a renewed interest in the psychotherapist as a variable worthy of intensive study (Heinonen & Nissen-Lie, 2020). Recent research suggests that therapist's effects contribute between 5 to 9 times more to clinical outcomes than the variance explained by the model or techniques used by the therapist (Johns et al., 2019; Wampold & Imel, 2015). Essentially, the therapist's gender, age, theoretical approach and years of clinical experience have not been shown to predict clinical results and explain these therapist effects (Goldberg et al., 2016; Okiishi et al., 2003).

The therapist's facilitative interpersonal skill (FIS) construct is a recent and influential contribution to this scientific impasse, offering an operationalization and method for evaluating a set of therapist's behaviors with the potential to be strong predictors of clinical outcomes (Norcross & Lambert, 2019). Based on the common factors outlined by Jerome Frank (Frank & Frank, 1991) and later systematized in the contextual model of psychotherapy (Wampold & Imel, 2015), Anderson and colleagues developed the therapist's FIS construct and rating method to study the aforementioned therapist effects. The method developed by these authors studies the following therapist characteristics: verbal fluency, emotional expression, persuasiveness, warmth, hopefulness, empathy, and alliance-bond capacity (Anderson et al., 2013). In a series of empirical studies using this rating method, therapist's FIS demonstrated to be a significant predictor of client outcomes (Anderson et al., 2009, 2016, 2016b, 2020), far exceeding the predictive values of other variables such as the treatment modality used and therapist's years of clinical experience. In two recent reviews on the characteristics and actions of effective therapists, Wampold and colleagues (2019) and Heinonen and Nissen-Lie (2020) highlight the therapist's FIS as one of the most promising constructs in contemporary psychotherapy research. Still, few theoretical and empirical investigations have explored this construct's potential. Namely, one variable studied in the FIS method stands as particularly lacking in theoretical and empirical contributions, that of therapist's *persuasiveness*. Moreover, no published study currently exists testing the impact of FIS in general, and therapist's persuasiveness in particular, on the therapeutic process, thereby limiting our understanding of these constructs and their effects.

The three studies presented in this thesis aim to contribute to the theoretical and empirical understanding of therapist's facilitative interpersonal skills and persuasiveness. In the first study, we present the empirical basis for the study of therapist's persuasiveness. We define this construct, reviewing the available literature on its effects on the therapeutic process and outcomes. We arrive at a discrete number of empirically supported therapist verbal and nonverbal behaviors that are associated with therapeutic persuasiveness and likely influence the therapeutic process. Results of this review also suggest that the therapist's delivery of cogent treatment rationales is a primary persuasiveness-related therapist task that may account for the clinical effects of this construct.

In the second study, based on the previous review and the emerging literature on deliberate practice for psychotherapists (Rousmaniere et al., 2017; Miller et al., 2020), we propose preliminary guidelines for the implementation of systematic therapist training focused on therapeutic persuasiveness. This study also presents a case example showing the implementation of these guidelines, along with theoretical discussion for how a deliberate practice training methodology might augment traditional therapist training and supervision.

In the third empirical study, and following other influential authors (e.g., Greenberg, 1999), we propose that the intensive process research of videotaped psychotherapy sessions can be instrumental in deepening the field's understanding of therapist's facilitative interpersonal skills and persuasiveness. To better understand to the impact of therapist's FIS and persuasiveness on the therapeutic process, we sought to investigate the impact of these variables on a client process variable that has been extensively shown to predict outcomes, that of client's *experiencing* (Pascual-Leone & Yeryomenko, 2017). This variable accounts for the client's emotional and cognitive engagement during the treatment process, which had been proposed to be associated with therapist's interpersonal skills and persuasiveness (Frank & Frank, 1991; Wampold, 2007), but never empirically investigated. This is, to our knowledge, the first empirical study on the impact of therapist's FIS and persuasiveness on the treatment process across different therapeutic modalities (cognitive behavioral therapy, emotion-focused therapy, and accelerated experiential dynamic psychotherapy). Results showed that therapist's in-session interpersonal skills significantly predicted client's experiencing. We also found that the provision of treatment rationales negatively predicted client experiencing. This study is also the first empirical demonstration, to our knowledge, that therapists from different theoretical modality vary significantly in their provision of treatment rationales. Consistent with previous studies (Anderson et al., 2009; Castonguay et al., 1996; Watson & Bedard, 2006), therapist's facilitative interpersonal skills were not associated with therapist's treatment modality, while client's experiencing did vary across modalities.

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Chapter II

The Psychotherapist's Persuasiveness, A Still Under Investigated Common Factor

Abstract

Psychotherapy has been conceptualized as a process of social influence (Frank & Frank, 1991; Wampold, 2012). Therapists play a crucial role in co-creating new adaptive meanings and expectations that mobilize clients towards an increased sense of agency and mastery. We argue that these tasks depend on the persuasive power of the psychotherapist. The goal of this paper is to provide a brief overview on the literature and research on therapist's persuasiveness, and theoretical contributions for future directions. We define therapist's persuasiveness as the major verbal and nonverbal therapist skills that facilitate positive treatment expectations and credibility. Accumulated research on the placebo effect, client's expectancies, charisma, and therapist's interpersonal skills gives new empirical depth to the construct of therapeutic persuasiveness. In light of these findings, we discuss implications and provide recommendations for therapist training and future research.

Key words: Psychotherapy, therapist's persuasiveness, treatment rationales, placebo effect, expectations, credibility

Introduction

"Nothing is surely more intangible and unreal than fictions, illusions and opinions; and yet nothing is more effective in the psychic and even the psychophysical realm" (Jung, 1956, p. 29)

Persuasiveness has a bad reputation. In one of the earliest attempts to connect the practice of psychotherapy to ancient persuasive rethoric, Erling Eng emphasizes that the prevailing attitude towards the latter was to consider it "dishonest, and to the detriment of reason" (1973, p. 493). These pejorative connotations were not lost on the influential psychotherapy researcher Jerome Frank, who pointed out that the study of therapist's persuasive ability involved "grave threats to the researcher's reputation as a sober scientist, so their pursuit can be recommended only to the most intrepid" (Frank, 1979, p. 314). This perhaps explains, at least in part, why the field of psychotherapy has largely strained away from directly addressing the issue of psychotherapist's persuasiveness. Instead, research has accumulated on variables likely to be related to this topic, the most important of these being the study of client's treatment expectations and credibility. This has led to an important breath of findings demonstrating the reliable impact of such factors on clinical outcomes (Constantino et al., 2019, 2019b).

Client's expectations and perceived treatment credibility have long been argued to be co-created by the therapist and his skillful use of persuasive social influence (Strong, 1968; Frank, 1961; Corrigan et al., 1980; Heppner & Claiborn, 1989). In other words, therapists play an active role in shaping these factors throughout the therapy process. However, Constantino et al.'s (2019b) recent meta-analysis on the topic concludes that "research examining what therapists can do specifically to foster more positive patient credibility belief remains virtually nonexistent" (p. 513). The lack of specific research and training on expectancy and credibility-inducing therapist skills constitute an important gap in the literature and in fostering more effective psychotherapy services.

More than fifty years ago, Jerome Frank (1961) argued cogently and extensively over the direct link between therapist's persuasive ability and their clinical effectiveness. He later summarized his views when stating that:

> "The crucial determinant of [therapy] outcome may be the persuasiveness of the particular therapist and his rationale and procedures to the particular patient – that is, the relative ability of the therapist and the meaningful connections he provides to inspire the patient's hopes, strengthen his sense of mastery, arouse him emotionally, and so on." (Frank, 1986, p. 344)

There is now ample evidence that some therapists are reliably more effective than others, regardless of their therapy model and years of professional experience (Castonguay & Hill, 2017). Despite these well-established therapist effects, little attention has been given to the possible role therapist's persuasiveness might play in contributing to these effects. In this paper we will argue that the verbal and nonverbal skills connected to psychotherapist's persuasiveness are likely to be operationalizable, measurable and trainable, and that these efforts might still wield important contributions for the enhancement of psychotherapy training and client outcomes.

Social influence in psychotherapy

A discussion on the importance of therapist's persuasiveness may take us back to the very origins of the field. Freud repeatedly argued that psychoanalysis was a discipline *not* based on suggestion and rethoric, perhaps conscious that his own case studies could be interpreted as powerful examples of the therapeutic impact of a well-constructed narrative or rationale (Spence, 1982; Esterson, 1993). Donald Spence's incisive comments on this issue could apply equally well to any other therapeutic modality:

> "[Freud] was a master at taking pieces of the patient's associations, dreams, and memories and weaving them into a coherent pattern that is compelling, persuasive, and seemingly complete. … Freud made us aware of the persuasive power of a coherent narrative – in particular, of the way in which an aptly chosen reconstruction can fill the gap between two apparently unrelated events and, in the process, make sense out of nonsense. There seems no doubt but that a well-constructed story possesses a kind of narrative truth that is real and immediate and carries an important significance for the process of therapeutic change." (Spence, 1982, p. 21)

Regardless of therapy model, clinicians are tasked with co-creating a mutually satisfactory story that influences clients to transform important meanings and assumptions (Frank & Frank, 1991; Locher et al., 2019). However, the role clinicians have in actively attempting to influence the client has historically been a controversial issue. For instance, the relative importance of therapist's *neutrality* – a stance seemingly at odds with attempts to directly influence the client – remains a topic of scholarly discussion (e.g. Gelso & Kanninen, 2017).

An early critique by Abroms (1968) on the role of therapist's persuasiveness also highlighted that this variable could not be investigated without taking into consideration the client's own pretreatment beliefs, expectations and values. This marked a trend in social influence research in counselling and psychotherapy for the coming decades. Strong's (1968) landmark paper suggested that therapists' perceived expertness, attractiveness and trustworthiness were crucial in that they established a base for influence that facilitated the treatment process and outcomes. Strong's proposition was followed by a large number of studies investigating client factors that led to perceptions of counselor expertness, attractiveness, and trustworthiness (Heppner & Claiborn, 1989). The study of these factors became one of the primary counseling research topics in the mid-70's to early-80's (Wampold & White, 1985). Clearly, there was hope that such research would lead to the enhancement of client outcomes. However, much of this research produced a series of largely inconclusive and mixed results (Corrigan et al., 1980; Heppner & Claiborn, 1989; Kelly, 1990; Beutler & Bergan, 1991). Ironically, the shift towards investigating client's expectations, values, and pretreatment variables, also marked a trend in neglecting the study of therapist's in-session skills that might relate to social influence processes. In so doing, little research contributed to identifying factors therapists could train to enhance outcomes (Constantino, 2019b; Heppner & Claiborn, 1989). In this sense, the study of social influence processes in counseling and psychotherapy did not wield its original promise. One notable exception is Larry Beutler and colleague's study of client's *reactance*, a variable related to client's sensitivity to external persuasion or social influence. Meta-analytic findings, spanning a sample of 1208 clients in 13 controlled studies, demonstrate that responsively tailoring therapist's degree of in-session directivity to this variable reliably predicts client improvement (Beutler et al., 2018). In their analysis, these authors also warned that "direct

measures of the therapist's actions are even less frequently used than measures of individual patient behavior in research" (p. 136). In other words, measurement of therapist's actions or skills related to effective persuasive influence is still sorely needed.

Frank & Frank (1991) argued that the success of any psychotherapy depended on the ability of one person to influence another. Indeed, it is difficult to imagine any effective psychotherapy without the client being in some way influenced to expect, or already coming into therapy expecting, that the tasks of therapy *will* be helpful in increasing their well-being. Wampold (2012) has equally argued that the effective therapist tends to be particularly skilled in using their social influence to induce the acceptance of tailored treatment rationales, that will in turn have a crucial impact on client engagement and final therapy outcomes. A contextual model of psychotherapy provides a framework to understand the important connection between client expectancies, therapist's persuasiveness, and treatment outcomes.

A contextual approach to social influence in psychotherapy

Client's expectations and belief in therapy are robust predictors of psychotherapy outcomes (Constantino et al., 2019, 2019b). Given this, it is relevant to understand how might one account for the importance of these factors, and how might therapists maximize their effects. From their comprehensive review of the literature, Bruce Wampold and colleagues (2015, 2012) developed a contextual model that sheds light on these processes. This model proposes three main pathways responsible for psychotherapeutic change. The first pathway is the development of a real relationship between therapist and client, with all the associated benefits of social connection and belonginess (Gelso, 2011). The second pathway is the creation of positive expectations through cogent rationales, providing conceptual schemes to explain the client's distress, and building credibility for therapeutic tasks. Finally, the third pathway entails the active collaboration between client and therapist on treatment goals and tasks, with client's engagement in adaptive and health-inducing actions. These three pathways are hypothesized to work in conjunction to facilitate client's symptom reduction and increased quality of life.

Most psychotherapy theorizing tends to focus either on Wampold et al.'s first change pathway (i.e. the real relationship) or on the third pathway (i.e. treatment goals and enactment of tasks). Broadly speaking, humanistic and psychodynamic modalities tend to place greater emphasis on the therapeutic potential of the real relationship *per se*, whereas cognitive-behavioral therapies tend to attribute greater importance to the enactment of specific tasks or techniques (Gaston et al., 1995; Gelso, 2011). Contemporary approaches have made these distinctions less pronounced (e.g. Gilbert & Leahy, 2007; Elliott & Greenberg, 2007). What is more relevant for our discussion is the lesser emphasis on client's expectations and the importance of cogent treatment rationales (the "second pathway" proposed by Wampold and colleagues). This absence seems to persist despite the fact that these variables are likely to constitute an important contributor to treatment outcomes across modalities (Wampold, 2007).

To find more in-depth discussion on this expectancy-focused change pathway, one needs to look beyond the psychotherapy literature. Specifically, that client's belief and expectations for change can constitute one of the main sources of actual therapeutic change is understandable through placebo and response-expectancy research (Bohart & Tallman, 2010; Shapiro & Shapiro, 1997; Frank & Frank, 1991; Kirsch, 1990). Shapiro and Shapiro (1996) and Kirsch (2019, 1990), for example, argued cogently that many religious, psychological and medical treatments throughout the centuries derive most of their efficacy from placebo and response-expectancy effects. Placebo effects have been found to robustly contribute to outcomes in clinical medical trials and, when properly designed, these same effects also appear present in psychotherapy trials (Kirsch, 2019, 2005; Wampold et al., 2005). One review found only a negligible difference ($d = 0.15$) when calculating the difference in effectiveness between structurally equivalent active and so-called placebo psychotherapies (Baskin et al., 2003), and two meta-analysis found little to no support for the therapeutic effect of specific interventions or techniques *per se* (Bell et al., 2013; Ahn, & Wampold, 2001). In summary, it seems that to believe deeply in the curative power of a relationship, an intervention, or a technique, might effectively *instill it* with part of its therapeutic effects.

The tendency to "dismiss expectancy as somehow less legitimate a psychological factor" (Kirsch, 2005, p. 798) is evidenced through its relative absence in most psychotherapy theory, research and training. That the placebo effect might explain psychotherapy outcomes "is not popular among psychotherapists, many of whom believe that psychotherapy is a modern treatment based on scientific principles and view the placebo effect as a suggestion-related response to a drug" (Shapiro & Shapiro, 1997, p. 96). Perhaps it is uncomfortable to squarely face just how important our client's treatment expectations are – and, conversely, just how important are clinician's skills to influence these expectations. For all the challenges in bridging placebo research with psychotherapy – and there are many (Rosenthal & Frank, 1956; Wampold et al., 2016; Gaab et al., 2018) –, it is nonetheless widely regarded that psychotherapist's interventions *can* facilitate client expectations in a way that crucially influences client engagement and outcomes (Kirsch, 1990, 2005; Constantino et al., 2019, 2019b; Doering et al., 2018; Gaab et al., 2018; Wampold, 2018). Given this, it seems surprising how little has been studied and discussed on the topic of trainable therapist skills that might facilitate client's hope, expectations and treatment credibility. To date, specific therapist actions identified to contribute to these factors include the assessment and tailoring of therapy to client's pretreatment expectations and preferences, influencing these variables at pretreatment through role induction, and during therapy through cogent rationales (Constantino et al., 2012). Some of these activities, namely pretreatment assessment and role induction, have received empirical support as reliable predictors of outcomes and client dropout (Swift & Greenberg, 2015). We will focus on the other, equally important and often neglected issue of therapist's in-session skills that might influence client's expectations and treatment credibility.

From client's expectations to therapist's persuasiveness

Clients come into therapy with widely varied explanations for their problems. They also present equally varied expectations for, and belief in, psychological treatments. As we have discussed, the success of any psychotherapy rests, in part, on the ability to persuasively transform client's meanings and expectations into more adaptive ones (Wampold, 2012; Locher et al., 2019). We must now arrive at a clearer understanding of the distinctive features of the persuasive psychotherapist.

Early research attempted to investigate therapist's persuasiveness without clear definition of the concept. In two pioneering studies, Truax et al. (1968, 1970) investigated the impact of therapist's "persuasive potency" in individual and group psychotherapy. For a total of 71 clients, tape recordings were rated using a simple three-point scale to assess therapist's persuasive potency, which was broadly defined as their perceived ability to communicate in a socially influential manner. The raters had no prior knowledge of therapists, clients, or treatment outcomes. What is most fascinating is that, even under these naïve measurement conditions, therapist's persuasiveness ratings significantly predicted final client improvement. Moreover, the effects of persuasiveness seemed to operate independently of other interpersonal qualities such as the therapist's level of accurate empathy and warmth.

An attempt at establishing the core competencies of the persuasive therapist was devised by Packwood and Parker (1973). These authors used a sample of 900 3-minute segments from counseling interviews to provide statistical corroboration of a newly-devised rating scale for therapist's persuasiveness. Priority was ultimately given to the clinician's *conviction* when communicating, which was defined as "the intensity or strength of belief the counselor has in what he says"; and the therapist's explicit *appeal to client's reason and/or emotion*. While this rating method represented a more nuanced measurement of therapist's persuasiveness, it failed to produce further research on the subject. The elusive issue of defining and measuring therapist's persuasiveness persisted.

Frank & Frank (1991) proposed three main qualities shared by the persuasive psychotherapist and rhetorician: ethos, stimulating emotional arousal, and argument. The psychotherapist's ethos is synonymous to their professional credibility, and related to the aforementioned social influence research regarding their perceived expertness, attractiveness, and trustworthiness (Heppner & Claiborn, 1989). Stimulation of emotional arousal and the use of argument were the two main *in-session* therapist skills argued to be the prerequisite to client change. The ability to evoke emotional arousal in clients was argued to facilitate therapist's persuasive potency and overall client engagement. The assertion that emotional arousal and persuasive potency are intrinsically linked has since been repeatedly demonstrated experimentally (Petty & Briñol, 2015; Angie et al., 2011). On the other hand,

the use of "argument" includes any verbal exchange with the purpose to influence the client to adopt a novel meaning or worldview. Since Frank's original proposal on these core characteristics of persuasive therapists, the field of psychotherapy remained for the most part somewhat vague or uninvested in regards to defining, measuring and training therapist's persuasiveness.

However, recent research on therapist's facilitative interpersonal skills (FIS) has renewed interest and scientific credibility in the role of therapist's persuasiveness. The FIS method is a psychometrically-sound observer-rated system that evaluates therapist's competency in eight empirically-supported interpersonal skills: verbal fluency; hope and positive expectations; persuasiveness; emotional expression; warmth, acceptance, and understanding; empathy; alliance-bond capacity; and alliance rupture-repair responsiveness (Anderson & Patterson, 2013). In a number of studies, this measure has been demonstrated to reliably predict psychotherapy outcomes and therapist effects (Anderson et al., 2009, 2016, 2016b). As part of this work, Anderson and colleagues provide a rare and particularly useful contemporary definition for therapist's persuasiveness:

> "Persuasiveness is the capacity to induce the other to accept a view that may be different from his or her own view. It involves that ability to convey a clear, organized understanding about the meaning of the other's source of distress. Persuasiveness implies an ability to communicate what Jerome Frank called a "believable myth." This capacity implies that the persuasive therapist must be convincing in communicating this belief-system. … It is necessary that the rationale be relevant to the other's problems and at least somewhat novel to the other's experience." (Anderson & Patterson, 2013, p. 14)

This definition is accompanied by a rating system specifying observable therapist's actions that serve as criteria to rate a clinician from very high to very low on persuasive ability. The importance of this recent development in the study of therapist's persuasiveness cannot be overstated. While these studies have not reported the predictive effect of the "persuasiveness" rating in isolation, this body of work constitutes the first rigorous attempt at systematically measure therapist's persuasiveness in the psychotherapy literature.

Moreover, it provides a way to correlate this interpersonal skill to other therapy processes (e.g. working alliance) and outcomes. Finally, it sets observable criteria from which to train therapists on this skill. In this connection, two recent studies found that therapist's FIS skills can be reliably enhanced through deliberate practice training methods (Perlman et al., 2020; Anderson et al., 2019).

To benefit further research and therapist training, it seems equally relevant to define some of the distinctive nonverbal skills of persuasive therapists. Therapists nonverbal cues have been found to consistently determine perceptions of therapist expertness and credibility, often surpassing the influence of verbal behaviors (Hoyt, 1996). Relevant charismatic nonverbal behaviors include the therapist's degree of attentiveness, verbal fluency, posture, and higher degrees of direct eye contact. Heide (2013) and Otterson (2015) reviewed charismatic nonverbal behavior empirically linked to persuasive success, and extended implications of such research to psychotherapy practice. In their reviews, therapist's overall *emotional expressiveness*, or "the transmission of emotion via voice, facial expressions, body movements, and gestures" (p. 308), seemed to account for a significant portion of nonverbal persuasive influence. Greater therapist eye contact and forward trunk lean also tend to enhance perceived treatment credibility (Dowell & Berman, 2013). In general, displays of charismatic nonverbal behavior have been found to increase affective arousal and influence in others through a process of "emotional contagion" (Bono & Ilies, 2006; Hatfield et al., 1994). Perhaps the implications of such research are best understood looking at the opposite end of the spectrum: uncharismatic therapists are likely to talk in a flatter tone of voice, be less verbally fluent, be facially inexpressive, present in a stiff upright body posture, make less frequent eye contact with clients, and use less expressive gesturing. Further, they are less likely to stimulate client's affective arousal, attention and engagement. Finally, research supports that these nonverbal charismatic skills are measurable and trainable (Antonakis et al., 2016), leading Heidi (2013) and Otterson (2015) to argue that these findings have important implications for the training of psychotherapists.

The research presented so far suggests that both verbal and nonverbal persuasiveness-related therapist skills are measurable, trainable, and are likely to influence the therapy process and outcomes. That the persuasiveness of psychotherapists is probably connected to

client outcomes is receiving increasing attention in the scientific literature. For instance, two recent reviews on empirically identified characteristics of effective therapists conclude that therapist's persuasiveness is likely to be one such characteristic (Heinonen & Nissen-Lie, 2020; Wampold et al., 2019). Despite this recent acknowledgement from prominent researchers, research and training of therapeutic persuasiveness is still rare. Given the mounting evidence, it now seems to be increasingly relevant to address more thoroughly the issue of therapist's persuasive ability in clinical research and training settings.

Following the contributions presented so far, we propose that *psychotherapeutic persuasiveness includes all of the therapist's empirically identified verbal and nonverbal characteristics and skills that facilitate client's hope, positive expectations and treatment credibility*. Chief amongst these skills is the particularly well supported yet understudied ability to co-create cogent therapeutic rationales.

Organizing chaos: The importance of cogent rationales

Humans have a hardwired need to make sense of their external world and internal experience (Wampold, 2012, 2007; Locher et al., 2019). Feeling that the world or one's experience is overly unpredictable or not understandable are core characteristics of what Frank (1961) termed "demoralization", a distinctive feature of those seeking psychotherapy. Pascual-Leone and Greenberg (2007) describe this common beginning client presentation as *global distress*, a state "with little or no substantive meaning elaboration", where "the specific concern at hand is often very vague and global", and "clients explicitly state that they do not know why they are feeling so inundated with distress" (p. 876, 877). As such, the therapeutic process of meaning making and transformation sets order into the perceived chaos of one's experience. Cogent therapeutic rationales aid in this process as they "relieve patients' distress in part by relabeling their emotions to make them more understandable" (Frank, 1961, p. 59). This, in turn, tends to create hope and positive expectations that will influence the collaborative engagement in treatment tasks (Kirsch, 1990).

Research on treatment rationales provides support for their importance for clinical outcomes. In a meta-analysis for anxiety treatments, expectations created by therapeutic rationales appeared to be more predictive of outcomes than any model-specific interventions

(Yulish et al., 2017). The same authors found that rationales more directly focused on addressing the client's problems tend to be more efficacious. This finding is consistent with Fish's suggestion that "the persuasive value of a ritual … stems from its intrinsic believability or its intriguing quality. A ritual clearly related to the goals of therapy is likely to be more believable than one which is not" (Fish, 1973, p. 42). Therapeutic rationales also provide a structure to psychological treatments. In this regard, Ametrano et al. (2017) argue that "the provision of a treatment rationale may be a quintessential transdiagnostic factor early in psychotherapy that forms the conceptual backdrop of the subsequent treatment process" (p. 201). Interestingly, in the influential NIMH Treatment of Depression Collaborative Research Program, therapist's ability to structure the treatment was the skill most highly related to treatment outcomes, surpassing any technique or model specific interventions (Shaw et al., 1999). This would suggest that the structure in part provided by treatment rationales may constitute a distinctive feature of effective psychotherapy. Fennell and Teasdale (1987) equally found that clients who responded favorably to a treatment rationale and homework assignments benefited more from short-term cognitive therapy than those who did not. In another analogue study by Ahmed and Westra (2009), 77 participants with high fear of negative social evaluation were presented a videotaped CBT rationale for the causes and treatment of social anxiety. As a result, a medium to large effect size was found for increases in anxiety change expectancy and for changes in exposure confidence and exposure helpfulness. At one-month follow-up, positive response to the treatment rationale was also related to an increase in participant's frequency in engaging in exposure tasks. Ametrano et al. (2017) replicated these findings with 178 undergraduates screened for elevated social anxiety. Consistent with previous studies, provision of a CBT rationale was related to participants increased anxiety change expectations, and perceived confidence and helpfulness in exposure tasks. These studies provide further support for treatment rationale's contribution to client outcomes, through their engendering of positive expectations for therapeutic tasks and promoting self-efficacy for engaging in these tasks. Outside of the psychotherapy setting, placebos were also found to be significantly more effective if a plausible rationale was provided upon administration (Locher et al. 2017).

Safran and Zindel (1990) also suggested the crucial role of therapy rationales in the development of the therapeutic alliance, one of the most robust predictors of treatment

outcomes across therapy modalities (Flückiger et al., 2018). These authors contended that rationales facilitate belief in, and agreement on, treatment tasks and goals, while also enhancing the therapeutic bond through reassurance and creation of positive expectations. Later, Safran and Muran (2000, p. 17) noted that "one of the more basic intervention for addressing alliance ruptures consists of outlining or reiterating the treatment rationale. When therapist detect strains in the alliance, they can check to see if patients are clear about the rationale, and if not, they can reiterate it and clarify any misunderstanding."

While the importance of providing treatment rationales is increasingly emphasized across therapy models, the crucial issue of *cogency* is addressed much less often. Yet to simply provide a rationale may be insufficient, since clients who do not believe in the treatment rationale are less likely to benefit from therapy (Davis & Addis, 2002; Swift & Greenberg). This underscores the need to determine factors that are likely to enhance a rationale's given cogency or persuasive potency. Available research suggests some basic principles to enhance rationales' perceived cogency across clients, and to tailor rationales to the particular client in order to maximize influence. In general, the presence of nonverbal charismatic behaviors on part of the therapist (Heide, 2013) and the concomitant stimulation of emotional arousal in clients (Petty & Briñol, 2015; Frank & Frank, 1991) are likely to enhance at least some rationales' perceived cogency. Three analogue studies also found that rationales might be perceived as more cogent if they emphasize credibility cues such as the use of jargon and presenting scientific research supporting said rationale (Kazdin & Krouse, 1983). However, these findings are likely to be culturally-bound and potentially incongruent with the worldviews of certain ethnic and minority groups (Benish et al., 2011). Furthermore, cogent rationales tend to transmit hopeful yet realistic expectations for the therapeutic change process (Constantino et al., 2012). As Irving Kirsch (1990) writes:

> "Rationales accompanying treatments should not promise too great an initial change. Instead, the aim should be to support a high degree of confidence that *some* change in the desired direction will be experienced, so that relatively small fluctuations in a client's condition can be interpreted as evidence of improvement. This provides the client with experiential feedback indicating therapeutic effectiveness, feedback that is likely to promote greater change." (p. 51).

In terms of individualizing rationales to the particular client, cogency can be enhanced by into consideration the client's own attributional theories, culture and folk psychology regarding the causes and potential solutions for their problems (Benish et al., 2011; Soto et al., 2018; Tracey, 1988; Meyer & Garcia-Roberts, 2007; Wampold, 2007). An implication is that more persuasive therapists are likely to be more skilled at assessing their client's preexisting beliefs regarding their presenting problems, and adapt treatment rationales accordingly (Wampold, 2012; Coyne et al., 2019; Frank & Frank, 1991). Other client variables are likely to influence rationale credibility, such as the client's readiness for change and level of reactance (Krebs et al., 2018; Beutler et al., 2018). Further research on the interaction between client variables and the perceived cogency of rationales is needed.

A more controversial topic is the relative importance of the scientific rigor or so-called objective "truth" of the rationale. Many authors have argued that the "truth" or scientific validity of a therapeutic rationale or explanation is unimportant to the outcome of psychotherapy (Locher et al., 2019; Wampold, 2007; Frank & Frank, 1991; Fish, 1973). One could argue that if scientific truth of a psychotherapy theory were correlated with client outcomes, our widely different therapy models and specific techniques would have probably reported more widely variable effect sizes (Wampold & Imel, 2015; Bell et al., 2013; Ahn & Wampold, 2001). Interestingly, this idea was suggested as early as 1936, in Saul Rosenzweig's seminal paper on the existence of common factors across therapeutic modalities. In it, Rosenzweig writes a footnote stating that "complete or absolute truth (of the theory of personality upon which a method of therapy is based) is by no means necessary for therapeutic success" (Rosenzweig, 1936, p. 414). This contextual perspective suggests that rationales are effective in facilitating positive expectations so long as they are accepted and mobilize the client towards new adaptive meanings, emotions and behaviors (Wampold, 2012, 2007; Frank & Frank, 1991). While specific therapy tasks and techniques vary widely across treatment modalities, it is the therapist's ability to persuasively instill the *belief* in their potential usefulness that might be of paramount importance. As Jerome Frank put it:

> "Despite their differences, all therapeutic rationales and rituals have certain effects in common. They heighten the patient's sense of mastery over the inner and outer forces

> assailing him by labeling them and fitting them into a conceptual scheme, as well as by supplying success experiences." (Frank, 1974, p. 272)

We propose that two main types cogent rationales are needed for effective psychotherapy. The first type of rationales are re-organizations of the client's presenting problems and their internal experience. At a meta-level, the therapist is here communicating: "Your problems and distress *make sense*, are *understandable*". This general message is manifested explicitly or implicitly through the co-construction of cogent explanations for the likely causes of the client's problems or distress. The second type of rationales needed are those conveying positive expectations that change *is* possible, namely through the engagement in tasks that will be facilitated throughout the therapy process. This type of rationale implicitly or explicitly metacommunicate: "Your distress *is changeable*, and now that we have a clearer understanding for its reasons, we can collaborate to help you overcome it". This general message will often be accompanied by the delineation of specific tasks that are assumed to help in overcoming the client's presenting problems. The degree to which the client genuinely believes, or is genuinely persuaded to believe, in these two major types of persuasive rationales, the more likely they are to lead to positive treatment expectations and engagement in adaptive therapeutic tasks. Wampold summarizes this process when writing:

> "Whereas the patient's original explanation created an expectation that action would not alleviate the distress, acquisition of a functional explanation creates the expectation that if the treatment protocol is followed, the difficulties experienced by the patient are not inevitable and, therefore, are resolvable. … What is critical to psychotherapy is understanding the patient's explanation (i.e., the patient's folk psychology) and modifying it to be more adaptive." (Wampold, 2007, p. 863)

Three last remarks should be made on the important relation between persuasive therapeutic rationales and appropriate therapeutic responsiveness (Stiles et al., 1998). Each of these adds considerable complexity to the study of therapist's persuasiveness and its impact on client outcomes, and would likely warrant further discussion and research in their own right. The first is the common misconception that therapeutic rationales are almost exclusively educational interventions on part of the therapist. In reality, cogent therapeutic

rationales can be delivered somewhat indirectly or implicitly (Locher et al., 2019). Take, for instance, the potential persuasive effects of the therapist's use of validation. Validation is the active communication that the client's experience "makes sense", a message that is often at odds with client's demoralizing meanings (Linehan, 1997). For example, a therapist might validate a client's anxiety, framing it as an understandable and healthy signal for perceived danger in one's environment. In so doing, the therapist is instilling a new adaptive explanation for the client's distress, one that could lead to a lessening of said distress and further therapeutic engagement to ensue. This is one example of a persuasiveness-related act taking place through a medium other than purely didactical or psychoeducative rationale giving. Indeed, "schools of therapy differ primarily in their preferred ways of attempting to influence the patient's attitudes and behaviors" (Frank, 1978, p. 61). We suspect that many empathy-based and other nondirective therapist skills might account for a significant portion of the therapist's more subtle persuasive communication and meaning making (Locher et al., 2019).

A second note regards the interplay between client's emotional arousal and persuasive meaning making. Many discussions on treatment rationales tend to focus on the early in therapy provision of relevant information and explanations. However, these discussions might disregard that persuasive meaning making is an ongoing therapy process. Importantly, it might be the case that rationales' persuasive potency might be significantly enhanced *after* appropriate levels of client emotional arousal are stimulated. Emotional arousal reliably influences one's engagement in, and elaboration of, persuasive messages (Petty & Briñol, 2015; Frank & Frank, 1991; Petty et al., 1988). For instance, the experiencing of discrete emotions has been found to wield moderate to large effects on judgement and decision-making outcomes (Angie et al., 2011). Applied to psychotherapy, this suggest that emotional arousal may play a fundamental role in enhancing the cogency of any novel meaning making or treatment rationale. As Greenberg and Pascual-Leone put it, "psychotherapeutic interventions need to go beyond techniques that simply encourage emotional expression or self-disclosure; they also need to focus clients on the creation of new meaning from the aroused emotional material" (p. 177). Future research must address when and how stimulating client's emotional arousal influences client's positive treatment expectations and credibility.

Thirdly and finally, we should mention there are some counterindications to excessive explicit provision of explanations or rationales. As Clara Hill writes:

> "Sometimes clients need to explore how they feel about situations without being told what is "normal" or expected. Other clients need to seek out information themselves rather than having the investigative work done for them. Some clients need to be challenged to think about why they do not already have the desired information and to think about what motivates them to rely on others to give them information." (Hill, 2014, p. 363)

In other words, rationales should not deter from encouraging client's self-exploration and agency in the therapy process. There is certainly the risk of turning otherwise adaptive rationales into inadvertent interventions that foster client's dependency and further demoralization.

Assuming that these factors are taken into consideration, it seems highly plausible that effective psychotherapy includes the appropriate co-creation of relevant psychotherapeutic rationales. It also stands to reason that the *content* of the rationale is not the sole factor for accounting to its power, but also *how* and *when* it is delivered. Table 1 brings together the theoretical and research contributions presented thus far, showcasing persuasiveness-related therapist skills that we believe to be important for psychotherapy training and amenable to future research.

Table 1. Empirically supported therapist in-session persuasive skills.

Co-creation of preconditions for therapeutic rationales
Therapist (T) explores Client's (C) preexisting beliefs regarding their presenting problems
T explores C's preexisting expectations and beliefs regarding therapy and therapeutic change
T stimulates C's emotional arousal
Co-creation of therapeutic rationales
T validates and/or reframes C's problems as understandable
T offers cogent explanations for the factors creating or perpetuating C's problems
T offers cogent explanations as to how therapy and therapeutic tasks might help resolve C's problems
Nonverbal charismatic behavior
T is *emotionally expressive* through a consistently affectively-responsive tone of voice, facial expression, body movement and gestures
T is *verbally fluent* (i.e., communicates with confidence, ease, and clarity)
T maintains considerable *direct eye contact* with C
T makes ample use of *forward trunk lean*

Recommendations for psychotherapy training and research

Therapist's interpersonal skills are trainable and robustly related to client outcomes (Anderson et al., 2009, 2016, 2016b, 2019; Schöttke et al., 2017; Perlman et al., 2020). Therapist's persuasiveness is one such interpersonal skill whose importance has been repeatedly recognized yet rarely trained or investigated. Based on our review, we propose that at least three persuasiveness-related skills are likely to be important for therapist training: the ability to assess client's pretreatment beliefs, expectations and folk psychology regarding their problems and psychotherapy itself; the ability to co-construct cogent explanations that

transform the meaning of client's experience, problems, and therapy itself; and that the therapist intervenes in a nonverbally charismatic manner.

Therapists are typically trained in a number of core skills such as alliance-focused skills and accurate empathy. However, trainee's persuasiveness is frequently unmentioned as an active ingredient to consider during training (Gaab et al., 2018). For example, while a trainee may declaratively know a theoretical rationale for why exposure might aid an anxious client, the same trainee might nevertheless feel unskilled in actually providing said rationale in a cogent manner. This would suggest that therapists should be trained not only in the content of rationale giving, but also in the process of how persuasively these communications are carried out. To this end, effective psychotherapy training should include a didactical and an experiential component, providing trainees with the knowledge *and* procedural learning necessary to carry out clinical services (Rousmaniere, 2016). We will first discuss some didactic recommendations for addressing persuasiveness and its importance during clinical training.

In an effort to first provide a conceptual framework from which to understand psychotherapeutic persuasiveness and its importance, we propose some major contributions in Table 2. This list does not represent a comprehensive reading recommendation for psychotherapy training, as we are only concerned with filling a common educational gap by directly addressing therapist's persuasiveness as a likely common factor of effective psychotherapy.

Table 2. Suggested didactic readings for therapist in-session persuasive skills.

Therapist skills	**Suggested readings**
Therapist (T) assesses Client's (C) relevant pretreatment beliefs and expectations	Coyne et al. (2019), Constantino et al. (2012, 2019, 2019b), Benish et al. (2011), Kirsch (1990), Wampold (2012, 2007)
T co-creates cogent therapeutic rationales	Frank & Frank (1991), Wampold (2012, 2007), Kirsch (1990), Locher et al. (2019), Anderson & Patterson (2013), Fish (1973)
T displays nonverbal charismatic behaviors	Heide (2013), Otterson (2015), Anderson & Patterson (2013), Dowell et al. (2013), Hoyt (1996)

Discussions emphasizing the role of client's expectations and therapist's persuasiveness can sensitize trainees to the importance of these factors in therapy. We suggest the following recommendations to approach this topic in training settings:

- Trainees should be encouraged early on to read, discuss, and reflect on the importance of client's expectations and treatment credibility as distinct contributors to clinical outcomes.
- Trainees should be encouraged to monitor and discuss not only their *knowledge* of therapeutic rationales and tasks, but also their personal *belief* in their clinical usefulness, and attributed *reasons* for such usefulness.
- Trainees should be encouraged to reflect on and discuss the issue of therapeutic persuasiveness in a nonpejorative fashion. Namely, persuasiveness should be differentiated from negative treatment processes such as therapists exerting undo control over their clients; or from grandiosely believing in themselves, their model, or their therapeutic performance. Appropriate therapeutic persuasiveness should not be at odds with therapeutic humility, ethical considerations, and appropriate responsiveness.
- Trainees should be encouraged to discuss critically the distinctive characteristics of persuasive therapists. For instance, while watching videotapes of renowned psychotherapists, trainees and teachers can discuss the persuasive verbal and nonverbal skills observed in their performance, and how these might influence therapist's credibility and influence.
- Trainees should be mindful that knowledge of and belief in any given rationale does not necessarily translate into their ability to deliver said rationale in a cogent, charismatic manner in real-life clinical practice.

Armed with these conceptual schemes and critical thinking, trainees are still faced with perhaps the hardest challenge: the procedural aspect of conveying or "translating" this knowledge in a cogent fashion in session. Purely didactical or passive learning methods, such as reading or attending lectures, are unlikely to effectively increase trainee's confidence in the actual performance of clinical skills, such as the delivery of a treatment rationale (Rousmaniere, 2016). Recently, deliberate practice (DP) has been proposed as a promising framework to fill this procedural gap in psychotherapy training (Rousmaniere & Vaz, in

press; Rousmaniere et al., 2017; Miller et al., 2020). DP is defined as "individualized training activities especially designed by a coach or teacher to improve specific aspects of an individual's performance through repetition and successive refinement." (Ericsson & Lehmann, 1996). Preliminary research suggests that DP principles can be successfully applied to psychotherapy training and supervision, and predict therapist's skill development and client outcomes (Westra et al., 2020; Anderson et al., 2019; Hill et al., 2019; Goldberg et al., 2016; Chow et al., 2015). Applying these principles to the repeated procedural training of persuasiveness-related skills might wield important benefits for the trainee's future clinical effectiveness. We propose two main foci for trainee's DP of persuasiveness-related skills:

1. Deliberate practice of trainee's ability to assess client's pretreatment beliefs and expectations.
2. Deliberate practice of trainee's provision of therapeutic rationales in a cogent manner (i.e. emphasizing verbal fluency, emotional expressiveness, and others).

Resources reviewed so far can be used to create experiential exercises for the repeated deliberate practice of these skills (e.g., Anderson & Patterson, 2013; Heide, 2013; Constantino et al., 2012). In a future contribution we will provide specific guidelines for implementing a DP program focused on enhancing trainee's skill in providing cogent treatment rationales.

We can also derive from our discussion some main recommendations for future research on therapist's persuasiveness. Further research should go into the development, validation and refinement of measures to assess therapist's observer-rated verbal and nonverbal behaviors related to therapeutic persuasiveness. Likewise, future research should study how other important process variables such as client's emotional arousal and quality of the working alliance are related to or influenced by therapist's persuasiveness. Future research can also investigate how different therapy models deliver or co-create cogent treatment rationales. Therapist's in-session persuasiveness should also be investigated from the perspective of the client. Specifically, future efforts could explore what therapist persuasive behaviors were experienced by the client as particularly significant in the

acceptance of a new adaptive explanation. Finally, future contributions can provide guidelines for the deliberate practice of therapeutic persuasiveness, so as to test and refine training methods with the goal to reliably increase this therapist skill.

Conclusion

We have argued that therapist's persuasiveness can be defined, measured, and trained. We also contend that psychotherapeutic persuasiveness is likely to influence the transformation of client's treatment expectations and, ultimately, clinical outcomes. Despite its continuing to be an understudied and underdiscussed variable, persuasiveness is thus a probable common factor of effective psychotherapists (Frank & Frank, 1991). Indeed, its study and training come with challenges beyond the scope of our discussion (but see Annoni, 2018; Gaab et al., 2016; Locher et al., 2019). Yet, to not face these challenges is to avoid harnessing an increasingly empirically supported variable that may characterize effective therapy.

The renowned analyst Frieda Fromm-Reichmann is credited with saying that "what the patient needs is an experience, not an explanation". In this paper we have argued for a both/and perspective: We suggest that what many, if not most, therapy clients need are corrective experiences *and* cogent explanations, particularly those that remoralize them to pursue their own valued goals and needs. The time seems right to establish progressive lines of research for the advancement of our understanding of persuasiveness and its implications for therapist training and client outcomes.

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Chapter III

Deliberate Practice Training of Psychotherapy Treatment Rationales

Abstract

Traditional therapist training and supervision has provided mixed to unremarkable results in accounting for trainee's skill acquisition and clinical effectiveness (Hill & Knox, 2013; Watkins, 2011). Deliberate practice (DP; Ericsson & Pool, 2016) has been suggested as a promising methodology to augment traditional therapy training for increased effects (Rousmaniere, Goodyear, Miller, & Wampold, 2017). Recent research suggests DP methods can reliably increase clinical skills' acquisition and client outcomes. Preliminary guidelines are needed for implementation and further refinement of these methods. We argue that provision of cogent treatment rationales is an important target for ongoing deliberate practice and provide preliminary guidelines for systematic training. A case example is presented to illustrate a DP-informed therapy training session on this skill.

Key words: Psychotherapy training, psychotherapy supervision, deliberate practice, therapeutic persuasiveness, treatment rationales

Introduction

Some psychotherapists are more effective than others (Castonguay & Hill, 2017). These "therapist effects" account for 5% to 9% of the client outcome variance, a significant effect size given the 0% to 1% of variance attributed to the practice of specific treatment modalities (Wampold & Imel, 2015; Baldwin & Imel, 2013). Therapist effects significantly predict premature client dropout and nonattendance (Zimmerman et al., 2017; Xiao et al. 2017), treatment length (Goldberg et al., 2018), and the quality of the therapeutic alliance (Del Re et al., 2012). Moreover, variance in therapist's clinical outcomes can be dramatic. An influential study by Okiishi et al. (2003), analyzing data collected on 1,841 clients seen by 91 therapists, concluded that "the therapists whose clients showed the fastest rate of improvement had an average rate of change 10 times greater than the mean for the sample." (pp. 361). Since therapists do not necessarily improve their effectiveness with accumulated years of work experience (Goldberg et al., 2016), it seems particularly relevant to investigate and refine therapist training methods that might more reliably increase skills acquisition and client outcomes over time.

Deliberate practice (DP) is a training methodology defined by Ericsson and Lehmann (1996) as "the individualized training activities specially designed by a coach or teacher to improve specific aspects of an individual's performance through repetition and successive refinement" (pp. 278 –279). DP has been extensively studied across different fields such as music, sports, and medicine, demonstrating that lengthy engagement in it is associated with the achievement and maintenance of expert performance (Ericsson & Pool, 2016; Ericsson et al., 2018, 1993; Ford & Williams, 2012; Hodges et al., 2004). DP contrasts with and augments traditional training methods in several ways. While traditional learning methods often focus on passive methods such as reading and hearing lectures, DP focuses on the more procedural components that promote the state-depended learning (Ericsson & Pool, 2016). Research indicates that active or procedural learning procedures seem to be reliably more effective than passive methods at changing behavior (McGaghie et al., 2011; Cross et al., 2011; Beidas & Kendall, 2010; Beidas, Cross, & Dorsey, 2014; Herschell et al., 2010). DP is also distinctive in that it focuses on direct observation and monitoring of one's work performance, provision of ongoing expert feedback from a supervisor or coach, and tailored

behavioral rehearsal aimed at increasing one's performance (Ericsson & Pool, 2016; Rousmaniere et al., 2017).

Prominent psychotherapy authors have argued that clinical training should include a procedural component. For instance, Safran and Muran (2000) write that:

> "training needs to go beyond the didactic presentation of declarative knowledge if therapists are going to develop the combination of procedural knowledge, self-awareness, and reflection-in-action skill necessary to respond to patients in a flexible and creative way. It is important for therapist training to include a substantial experiential component and to emphasize the process of personal growth." (pp. 206)

It is also noteworthy that psychotherapy trainees consistently report that hands-on *practice* is the most helpful component of their skills training (Hill & Knox, 2013). Despite these findings, most clinical training continues to emphasize passive and unsystematic learning methods (Hill & Knox, 2013; Lambert & Ogles, 1997).

Another distinctive feature of deliberate practice is its use of simulation-based mastery learning (Ericsson & Pool, 2016; Rousmaniere, 2016). These are 'devices, trained persons, lifelike virtual environments, and contrived social situations that mimic problems, events, or conditions that arise in professional encounters' (McGaghie et al., 2014, p. 375). Simulation-based methods help professionals acquire skills by training in contexts that resemble those presented in real-life work performance. These methods provide the opportunity to practice and experiment with skills in the face of increasingly more challenging stimuli, which gradually enhances the professional's ability to perform effectively under stress. For the deliberate practice of psychotherapy skills, therapist should use any form of simulation that closely resembles actual clinical performance (Rousmaniere, 2016). The four main methods therapists and trainees can use as simulation for real-life therapy are: use of videorecorded sessions; use of standardized client videos portraying common clinical challenges; use of standardized client statements that can be roleplayed; use of imagery exercises (Vaz & Rousmaniere, 2021). DP of therapy skills requires a balance between repetition and novelty, in that trainees should be repeatedly exposed to the same stimuli for behavioral rehearsal, while also being presented with new stimuli so they can

experiment using the same skill in different contexts and increasing levels of challenge (Rousmaniere, 2016). Supervisors and teachers should collaboratively negotiate with their supervisees and trainees which skills and clinical stimuli are most relevant for their current clinical challenges.

There is growing consensus from prominent psychotherapy authors that deliberate practice methods might constitute an important advance in the future of therapy training and supervision (Miller, Hubble, & Chow, 2020; Wampold et al., 2019; Anderson & Perlman, 2020; Rousmaniere et al., 2017; Norcross & Karpiak, 2017). A recent number of studies provide preliminary support that DP methods reliably increase therapist's and trainee's skill acquisition (McLeod, 2021; Perlman et al., 2020; Westra et al., 2020; Di Bartolomeo et al., 2020; Anderson et al., 2019; Hill et al., 2019; Nikendei et al., 2019), and that engagement in such activities is related to client outcomes (Goldberg et al., 2016b; Chow et al., 2015). To realize the potential of DP in the field of psychotherapy, specific practice guidelines must be created and refined, so that these methods may be further investigated and disseminated. Recent guidelines have been proposed for the practice of emotion-focused therapy skills (Goldman, Vaz, & Rousmaniere, 2021) and therapist's internal skills (Rousmaniere, 2019). An American Psychological Association Press book series on the "Essentials of Deliberate Practice" is currently creating DP exercises for different therapeutic modalities (Rousmaniere & Vaz, 2021). Based on prior DP literature, and testing of skills for this series, preliminary guidelines can be proposed for the creation and implementation of DP skills for psychotherapists. Table 1 presents these guidelines, which can theoretically be applied for any relevant clinical skill.

Table 1. Guidelines for creation and implementation of deliberate practice exercises.

Creating DP exercise
1. Choose a relevant clinical skill for practice
2. Provide a brief skill description that includes the defining characteristics of the skill and why it is relevant for effective psychotherapy.
3. Establish skill criteria, i.e., the observable verbal and nonverbal therapist behaviors that define said skill
4. Create client stimuli (scripted prompts or videos) presenting common clinical challenges relevant for the use of the chosen clinical skill
Implementing DP behavioral rehearsal of skill
1. A client stimulus is presented (via roleplay or video).
2. Trainee playing the therapist improvises a response based on skill criteria.
3. Supervisor provides brief and actionable feedback on therapist's performance, based on skill criteria. Optionally, the supervisor may model an example response.
4. Therapist again improvises an intervention; supervisor again provides feedback.
5. Repeat this process with different client stimuli.
6. Supervisor facilitates ongoing difficulty assessments and adjustments to tailor practice to the trainee's zone of proximal development.

Deliberate practice of cogent treatment rationales

Deliberate practice methods tell us *how* to practice more effectively, but not *what* to practice. As Clements-Hickman and Reese (2020) point out, one of the main difficulties in applying DP methods to the field of psychotherapy regards identifying which skills warrant practice. Other prominent authors have in turn argued that therapists should focus their practice on skills demonstrated through research to reliable predict client outcomes (Wampold et al., 2019; Rousmaniere, 2016). Several transtheoretical variables have been identified in this regard, including the therapeutic alliance, therapist's facilitative interpersonal skills, among others (Norcross & Lambert, 2019; Anderson et al., 2020). Of these, the provision of cogent treatment rationales stands as one of the most often-quoted necessary skills for effective psychotherapy (Wampold & Imel, 2015; Frank & Frank, 1991).

Essentially, clients are more likely to benefit from psychological services if a rationale for their problems and their treatment is provided. Failure to do so may result in strains or ruptures in the therapeutic alliance and, ultimately, hindered results (Safran & Muran, 2000). Empirical research supports the notion that delivery and acceptance of a treatment rationale is significantly related to clinical outcomes (Constantino et al., 2019, 2019b; Ametrano et al., 2017; Yulish et al., 2017; Ahmed & Westra, 2009). While the specific content of the treatment rationale is usually informed by the therapist's theoretical modality of choice, what is most important is that some cogent rationale does exist, and that the clinical procedures implemented in session are congruent with the provided rationale (Wampold, 2007). As Jerome Frank put it, "ideally, a therapist should master as many rationales and procedures as possible and try to select those which are most appropriate for different patients" (Frank, 1974, p. 274). Constantino and colleagues (2012) also emphasized that therapists should be able to "deliver the rationale of the treatment in which they intend to engage in a manner that is *clear* and *convincing* [emphasis added]" (p. 562). This highlights that the deliberate practice of treatment rationales should consider the issue of *cogency*, i.e., how verbally fluent, emotionally engaging and logically persuasive is the trainee's delivery. These factors likely account for a significant portion of the intervention's effects (Heide, 2013; Frank & Frank, 1991).

This literature suggests that there are at least two main therapeutic rationales needed for effective psychotherapy (Wampold, 2007; Frank & Frank, 1991). The first are rationales re-organizing or reframing the client's presenting problems. These provide novel ways for understanding the client's experience, which implicitly or explicitly communicates to the client that their problems are valid and understandable. The second type of rationales are those conveying positive treatment expectations by communicating to the client that change *is* possible through the engagement in treatment tasks. Concrete delineation of these tasks can further increase the perceived cogency of these rationales (Constantino et al., 2019b). On the importance of these rationales, Wampold (2007) states that:

> "Whereas the patient's original explanation created an expectation that action would not alleviate the distress, acquisition of a functional explanation creates the

expectation that if the treatment protocol is followed, the difficulties experienced by the patient are not inevitable and, therefore, are resolvable." (p. 863)

Following the previously presented preliminary guidelines for DP exercise creation, the choosing of a clinical skill for practice should be followed by a brief description of said skill. This facilitates the DP implementation for students and professionals, orienting participants to a shared understanding of the targeted skill and a concise rationale for its relevancy for practice. Below we provide an example skill description that may be presented for introducing DP for the provision of treatment rationales.

Skill description for providing treatment rationales:

Treatment rationales are explanations for the tasks, purpose, and mechanisms involved in the treatment process. Rationales often include descriptions of the hypothesized origins and perpetuating factors for the client's presenting problems. Providing rationales is an essential skill for effective psychotherapy, namely for its importance in establishing the therapeutic alliance and instilling positive treatment expectations. Therapists may use this skill in response to client's questions related to their presenting problems, how therapy works, what methods are used, and what will happen during the treatment sessions.

Having established the delivery of cogent treatment rationales as an important skill for therapist's deliberate practice, we must now define the *skill criteria* that will inform said practice. Skill criteria define the concrete verbal and nonverbal behaviors that therapists attempt to master with practice. Skill criteria also promote therapist's flexibility and responsiveness during skills practice, since the behavioral rehearsal will be guided more by the distinctive *principles* of the skill, and not predetermined words that the trainee should memorize. With the guidance from skill criteria and a supervisor providing concrete, actionable feedback, trainees can experiment performing a skill in a manner that is technically accurate and personally congruent.

Skill criteria for the DP of psychotherapy treatment rationales:

• For the purposes of this exercise, do not interpret or question the client's concerns.

• Provide a brief rationale for the origin and/or maintenance of the client's concerns, *and* concrete steps that can be taken to resolve these concerns. Rationales should be hopeful without setting unrealistic or grandiose expectations for therapy.

• Practice verbal fluency and emotional expressiveness: communicate ideas clearly and briefly, without significant signs of anxiety (e.g. broken speech, awkward pauses).

Given these skill criteria that will guide practice, the psychotherapy trainee now requires a simulation-based method for repeated rehearsal of the targeted skill (McGaghie et al., 2014). Below are some examples of standardized client stimuli that may be used for repeated rehearsal of providing treatment rationales. These examples focus on social anxiety disorder and its treatment. Different stimuli should be created to directly address other treatment foci and clinical challenges.

Client stimuli for the DP of treatment rationales for social anxiety disorder:

- "I don't get why I feel so anxious around people. Why is that?"
- "How can therapy help with my social anxiety?"
- "Does my anxiety over other people make me sound crazy?"

Client stimuli provide an important structure for practice in that they promote standardized repetition during behavioral rehearsal, a key component for effective deliberate practice (Ericsson & Pool, 2016). By being repeatedly presented with the same challenging stimulus, trainees can experiment and consolidate their skills in a controlled environment (Goldman, Vaz, & Rousmaniere, 2021). This helps prevent behavioral rehearsal of skills to drift into a free-form roleplay where systematic refinement and consolidation of skills becomes less likely (McGaghie et al., 2011).

An example of DP training implementation

The following transcript comes from a DP-informed training session with two psychotherapy trainees. The first trainee was struggling with a client experiencing severe social anxiety. This trainee reported that no rationale for treatment had been presented up to that point. When asked why no rationale had been presented, the trainee reported that he had difficulty expressing in commonsense, clinically meaningful language the many books and articles he had read on the treatment of social anxiety. Having identified the lack of shared treatment rationale as a potential problem for the therapeutic alliance, the supervisor asked the second trainee to repeatedly present predetermined client stimuli for the purposes of behavioral rehearsal. The first trainee's task was to "play the therapist" and improvise the provision of a rationale for the client's concerns, and concrete steps that can be taken to resolve these concerns. This trainee was particularly interested in a cognitive-behavioral approach for social anxiety (Hofmann, 2007), so it was agreed that the rationales for practice would follow this modality. The exercise could, of course, be similarly implemented from the perspective of any other treatment approach. The supervisor's task was to monitor how

competently and fluently the trainee was able to do these tasks, following the previously defined skill criteria, and provide actionable feedback to refine the trainee's interventions.

Supervisor: Great, let's move on to rehearsal then. Could you give us the first client stimuli?

Client (played by trainee 2): I don't get why I feel so anxious around people. Why is that?

Therapist (played by trainee 1): I think that… [*Long pause, then turns to supervisor*] This is where I block. [*Laughs*]

Supervisor: Okay, great! So, right on schedule, here is a good representation of the problem you're facing in session. Is that fair to say?

Therapist: Yeah, definitely.

Supervisor: Even though we both know you know a lot about cognitive therapy for social anxiety. Still, it's hard to put into words.

Therapist: It's like I have all this theory in my head, but sometimes it's so hard to translate it into words.

This is a common presentation for a trainee who might benefit from deliberate practice. Trainees and therapists often have extensive conceptual clinical knowledge while lacking the procedural skill to utilize it fluently in session with clients.

Supervisor: Could you start by trying to share your ideas about what social anxiety is, according to your model? I can help along the way to help put the pieces together. Let's try it again. [*Signals trainee playing client to repeat stimuli*]

Client: I don't get why I feel so anxious around people. Why is that?

Therapist: You know, social anxiety is a problem a lot of people face. And we know a fair amount about it from research. [*Pause*] Essentially, when you're with other

people your cognitions get turned inwards in such a way that you start having unrealistic appraisals of what others think of you. [*Pause*] This makes you feel more anxious, and it's like a vicious cycle.

Supervisor: Okay, great. You notice you were using some jargon-y language like "cognitions" and "appraisals"? This is fine for scientific writing, and maybe later when describing therapy tasks, but let's try again and use more common-sense language to make sure your client gets it.

The supervisor's task in deliberate practice should focus on providing concrete, actionable directives that encourage the trainee to continue rehearsing. This is a distinctive feature of this method in that traditional supervisory feedback often focuses on variables outside therapist's performance (e.g., client case formulation, theoretical discussion). While these other variables are also seen as essential for professional development, procedural development of the therapist depends on receiving direct performance feedback, as described in observable behaviors. To sustain the effortful behavioral rehearsal, the supervisor discourages conceptual discussion during practice. After a few rounds of rehearsal and feedback, the trainee in our example was able to provide a more fluent rationale for the maintenance factors of social anxiety.

Therapist: Social anxiety is usually the result of an inherited predisposition for anxiety, usually coupled with difficult early life experiences. These experiences may have influenced you to create certain beliefs about yourself and others, such as "I'm not good enough" or "others will look down on me". These negative beliefs color how your current social interactions are interpreted. They may lead you to avoid people or perform poorly. Ironically, that means that these negative beliefs help cause the type of social interactions that confirm your negative beliefs. It's a vicious cycle.

Supervisor: Wow, okay! That was great, much clearer. How did it feel for you?

Therapist: I feel much better about it! It's a big difference to be able to actually repeat the intervention and think through it better.

Supervisor: Okay, great. Let's help you now with the other rationale you'll need, which is addressing how therapy might help. [*To client*] Could you prompt us with this stimulus? [*Shows client a prewritten stimulus for practice*]

Client [*to therapist*]: How can therapy help with my social anxiety?

Therapist: That's a great question. [*Pause, laughs*] I got stuck again. There are so many places I could go…

Supervisor: Okay, you see, this is important, because you need rationales not just to explain social anxiety but also for how therapy might help. This will motivate and strengthen the alliance. We hope!

Therapist: Right!

Supervisor: Since we're working from a cognitive therapy framework, how about starting by naming three main tasks you'll be doing in treatment? For example, try starting your intervention by saying: "We have a lot of research on how to treat social anxiety. The three things we will be doing to help you are gradual exposure, cognitive restructuring, and homework assignments".

Psychotherapy teachers and supervisors can utilize modeling in deliberate practice to help refine trainees' intervention. Extensive research suggests that modeling is one of the most effective and underused methods for positive training and supervision effects (Hill & Lent, 2006; Watkins & Scaturo, 2013). This strategy should be balanced with encouraging the trainee to find their own style and words when rehearsing interventions. In our example, repeated rounds of rehearsal focused on helping the trainee briefly and cogently present the three components of treatment. With each repetition, the trainee received feedback on his performance and further opportunities for refinement.

Supervisor: Great work. From zero to ten, how hard is this exercise?

Therapist: Maybe a solid 6 or 7. [*Laughs*] It's definitely a challenge.

Another key component of effective DP is the use of difficulty assessments to make sure practice is at the trainee's zone of proximal development (Goldman, Vaz, & Rousmaniere, 2021). This may be done using a formal numeral assessment or informal verbal report (e.g. "does this practice feel too easy, too hard, or the right amount of challenging?"). Difficulty assessments are a necessary component of DP in that they provide useful information for difficulty adjustments. If an exercise is deemed too easy for the trainee's current skills, adjustments should be made to make it harder; and vice versa. In our example, a reported difficulty to 6 to 7 would usually account for a "challenging but not overwhelming" difficulty, which is ideal for ongoing practice with no necessary adjustments.

> Trainee 2: It's interesting how different treating social anxiety can be for different models. I trained in psychodynamic therapy and I can see some overlap to some of these cognitive procedures, but there are also a lot of differences.
>
> Supervisor: Yeah, that's a great point. Let's hold on to that thought and address it later, okay? We want to make sure to protect our time for rehearsal.

It is often easy to detract from behavioral rehearsal during practice. One common pitfall for effective practice is the encouragement of conceptual discussion. Teacher and supervisors must help keep a flexible focus on rehearsal without getting detracted into conceptual debate.

In our example, a final client stimulus ("Does my anxiety over other people make me sound crazy?") was then used to practice providing a rationale for both the origins of social anxiety and *treatment components. This provides a developmental stepwise training, giving trainees increasingly more challenging scenarios for practice. As behavioral rehearsal came to an end, we arrived at a recommended last step for any DP-informed training session: providing a homework for solitary practice.*

> Supervisor: That was great, congrats on hanging in there. Can we quickly discuss a deliberate practice homework for you to try out during this week? You won't have the luxury of a practice partner and supervisor whenever you need it, so I'm going to

suggest a system that will let you keep practicing this skill even without our help. It'll also help "keep things fresh" for when you actually go meet your client in real life.

Trainee 1: Sounds good.

Supervisor: So I want you to record these client stimuli on your phone. [*Hands a sheet with the client stimuli used during rehearsal*] Feel free to create new stimuli as well. After you record each one, imagine you are in session with a client, and play back these recordings "as if" you are with the client right now. For each stimulus, improvise a treatment rationale. Do this at least three times per stimulus. As you're practicing, try to monitor how fluently you're able to do it. Hopefully, the more you do this, the more confident and competent you'll become at this skill. If you want, you can also take notes of any recurring difficulties and bring them to us next time so we can help with more practice.

Assigning a DP homework and engaging in solitary practice is significantly related to training outcomes across professions (Ericsson et al., 1993, 2018). While conceptual homework is often ascribed to clinical trainees, training effects can be augmented by also assigning procedural homework for trainees to keep practicing (Rousmaniere, 2016).

Conclusion

In this paper we have argued that psychotherapy training can be augmented with deliberate practice methods for increased effects, and that the provision of cogent treatment rationales is a particularly relevant focus for ongoing practice. DP's extensive research on professional expertise make it a convincing candidate to complement the largely conceptual and passive learning methods most often used in the field of psychotherapy. In our case example we presented several core tasks when implementing DP for therapy training, such as the use of simulation-based methods (via roleplaying of standardized client stimuli), repeated behavioral rehearsal, actionable feedback, difficulty assessments, and provision of homework for solitary practice.

It is important to restate that psychotherapy is as much a science as a craft, and that procedural skills training plays an important, and often underappreciated, role in increasing clinical effectiveness (Hill & Knox, 2013; Beidas, 2014; Young & Heller, 2000). Lorna Smith Benjamin cogently made this point when writing that:

> If psychotherapy is a craft, then we should train therapists as craftspeople. It is not the case that if trainees learn the science, such as it may be, then they will know how to deliver the treatment effectively. … Observing teachers delivering the service, followed by active participation alongside the teachers is the method. Students also are expected to answer questions relevant to a given patient's presentation, and, in front of peers and supervisors, demonstrate skills on the job. That is how it is for the carpenters who build our homes or plumbers who make kitchens, bathrooms, and heating and cooling systems work. All who are certified in their trade must have actively demonstrated learning-by-doing over several years alongside masters of the trade. (pp. 1074)

Deliberate practice may be an important missing piece of the puzzle to increase the mixed to unremarkable effects reported from decades of training and supervision literature. While research still needs to address concerns regarding this implementation (Clements-Hickman & Reese, 2020), further testing and refining DP methods such as those presented here holds promise to the field. We are reminded that almost half a century ago, Gordon Paul (1967) proposed a core question for the field of psychotherapy to address: "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under *which* set of circumstances?" (p. 111). We suggest that a core question for psychotherapy training could be stated as: "*What* skills training, by *whom*, is most effective for *this* trainee with *that* specific skill deficit, and under *which* set of circumstances?".

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Chapter IV

An Empirical Analysis of Psychotherapist's Interpersonal Skills and Provision of Treatment Rationales and Client's Experiencing in Three Treatment Approaches

Abstract

Psychotherapist's interpersonal skills significantly predict final therapy outcomes (Anderson et al., 2020; Norcross & Lambert, 2019). One interpersonal skill in particular, therapist's *persuasiveness*, has been theorized as relevant for clinical effectiveness (Frank & Frank, 1991; Wampold, 2007). However, little empirical work exists on this variable. In this study we investigated the in-session interpersonal skills and one aspect of therapeutic persuasiveness, the provision of cogent treatment rationales, for a sample 18 psychotherapists from three treatment modalities (cognitive-behavioral therapy, emotion-focused therapy, and accelerated experiential dynamic psychotherapy). We also investigated if these therapist skills predicted client's depth of processing and meaning-making ("experiencing") during sessions. Results indicated that therapist's in-session interpersonal skills significantly predicted the client's level of experiencing. Contrary to our expectations, the provision of treatment rationales negatively predicted client's experiencing. Moreover, therapist's interpersonal skills were not shown to be significantly different across treatment modalities, but providing treatment rationales and client's experiencing were significantly different across modalities. Implications for understanding the complexity of therapeutic persuasiveness are discussed.

Key words: Facilitative interpersonal skills, treatment rationales, experiencing, psychotherapy process research

Introduction

Psychotherapists differ significantly in the clinical effectiveness (Johns et al., 2019; Castonguay & Hill, 2017). One recent trend in psychotherapy research is an increased effort to investigate the characteristics of effective therapists (Heinonen & Nissen-Lie, 2020). Perhaps the most robust finding is this regard is that therapist's transtheoretical interpersonal skills account for a significant portion of their effectiveness (Norcross & Lambert, 2019; Anderson et al., 2020; Schöttke et al., 2017). These skills seem to be better predictors of client outcomes than other variables such as the therapist's treatment modality and years of clinical experience (Wampold & Imel, 2015).

A particularly influential research program on therapist's facilitative interpersonal skills (FIS) has been devised by Tim Anderson and colleagues (2020). In a series of studies, these authors have shown that therapist's observer-rated FIS significantly predict psychotherapy outcomes (Anderson et al., 2009, 2016, 2016b). The FIS rating method involves the objective measurement of seven therapist interpersonal skills: verbal fluency, emotional expressiveness, persuasiveness, warmth, hopefulness, empathic accuracy, and alliance-bond capacity. Most of these interpersonal skills are drawn from extensive psychotherapy process research findings accounting for their effects across treatment modalities (Norcross & Lambert, 2019). For example, there is substantial empirical data supporting the clinical effects of therapist's accurate empathy and alliance-bond capacity (Elliott et al., 2018; Flückiger et al., 2018; Eubanks et al., 2018). However, some constructs evaluated through the FIS method have more empirical support than others. Perhaps the most often theorized but least empirically studied interpersonal skill included in this list is that of the therapist's *persuasiveness*.

Prominent researchers have long suggested that therapist's persuasiveness might significantly impact outcomes in that it promotes client's positive treatment expectations, emotional engagement, and novel meaning-making (Wampold, 2007; Frank & Frank, 1991; Kirsch, 1990; Fish, 1973). Jerome Frank was particularly influential in arguing that "the crucial determinant of [therapy] outcome may be the persuasiveness of the particular therapist and his rationale and procedures to the particular patient" (Frank, 1986, p. 344).

Several studies have since found that therapist's charisma and perceived credibility can positively impact treatment process and outcomes (Constantino et al., 2019; Heide, 2013; Dowell & Berman, 2013; Hoyt, 1996). However, the literature on therapist's persuasiveness has for the most part remained theoretical rather than empirical. To facilitate the objective measurement of therapist's persuasiveness, Anderson and colleagues recently provided a useful definition for this interpersonal skill:

> "Persuasiveness is the capacity to induce the other to accept a view that may be different from his or her own view. It involves that ability to convey a clear, organized understanding about the meaning of the other's source of distress. Persuasiveness implies an ability to communicate what Jerome Frank called a "believable myth." This capacity implies that the persuasive therapist must be convincing in communicating this belief-system. … It is necessary that the rationale be relevant to the other's problems and at least somewhat novel to the other's experience." (Anderson & Patterson, 2013, p. 14)

One common thread in the discussion of therapeutic persuasiveness is thus the importance given to the therapist's provision of cogent treatment rationales. This has been repeatedly theorized to be one of the main venues from which therapist's persuasiveness impact client outcomes (Frank & Frank, 1991; Wampold, 2007; Anderson & Patterson, 2013). It has also been speculated that cognitive-behavioral therapies may make for overt use of this persuasive skill than other therapy models. For instance, Safran and Segal (1990) wrote that:

> "In cognitive and behavioral therapies a strong emphasis is placed on conveying the therapeutic rationale to the patient (Beck, Rush et al. 1979; Bums 1980; McMullin 1986). We believe this is an extremely useful component in any therapy approach and one that other approaches toward psychotherapy tend to underestimate. It may be useful, then, to examine the role that conveying the therapy rationale plays in the therapy process, because in doing so, we may discover considerations that would allow us to use this strategy in more refined and differentiated ways." (p. 206)

Despite this call to attention for psychotherapy researchers, little is known empirically on how therapy models may differ in their use of treatment rationales, and its concurrent impact on the therapy process.

Another important research question is understanding how therapist's interpersonal skills in general, and persuasiveness in particular, influence outcomes. One promising process variable to help explain these effects may be the client's depth of *experiencing* (Klein et al., 1986). This construct assesses the client's level of emotional engagement and novel meaning-making during sessions. A recent meta-analysis demonstrated that client's depth of experiencing is a significant predictor of clinical outcomes, and is a likely common factor of effective therapy across treatment modalities (Pascual-Leone & Yeryomenko, 2017). Client experiencing has been suggested to be influenced by therapist's persuasiveness, in that therapist's persuasive maneuvers (e.g., providing cogent treatment rationales) should contribute to client's novel meaning-making and motivate clients to engage in emotionally evocative therapeutic tasks through the creation of positive treatment expectations (Frank & Frank, 1991; Wampold, 2007; Kirsch, 1990; Fish, 1973). To this date, no empirical study has attempted to investigate therapist's FIS and persuasiveness in relation to client's depth of experiencing.

The goal of this study was to investigate for the first time therapist's in-session FIS and provision of treatment rationales across a sample of therapists from different clinical modalities. More specifically, we sought to investigate if (1) therapist's FIS and provision of treatment rationales significantly predicts client's in-session depth of experiencing, and (2) if therapist's FIS, provision of rationales, and client's experiencing significantly differ across treatment modalities.

Method

Sample

This study consisted of a convenience sample of 18 therapy dyads from three clinical trials for the following modalities (6 dyads per model): cognitive-behavior therapy for generalized anxiety disorder (Westra et al., 2016), emotion-focused therapy for depression

(Greenberg & Watson, 1998), and accelerated dynamic experiential psychotherapy as part of a transdiagnostic study (Iwakabe et al., 2020). Details on sample and ethical considerations can be found in these studies. The therapists in our study (12 female, 6 male) received official certification or manual-based training for their provided treatment approach, and were monitored through videotapes for treatment adherence during therapy sessions. Three therapy sessions per dyad were selected for analysis, for a total sample of 54 videorecorded therapy sessions. Sessions were selected based on availability and phase of the treatment process, with all sessions being part of the intermediate phase of treatment, i.e., between the sixth and tenth therapy session.

Measures

Facilitative Interpersonal Skill – In Session (FIS-IS). Based on an extensively validated analogue measure (Anderson et al., 2020), the Facilitative Interpersonal Skills In-Session (FIS-IS) Coding Manual was developed to code therapist's in-session FIS (Uhlin & Anderson, 2011). Seven behavioral variables are rated on a 5-point Likert type scale: Verbal Fluency, Emotional Expression, Persuasiveness, Warmth, Hopefulness, Empathy, and Alliance-Bond Capacity. Operational definitions for each of these constructs were developed, based on previous common factors literature (e.g. Norcross & Lambert, 2019). Coding procedures instruct raters to start with a baseline rating of three (3) for each item, a neutral rating representing a therapist exhibiting the skill in a moderate manner that is neither particularly strong nor particularly poor. The observer-rating system then provides qualitative descriptions of very poor, poor, average, good, and very good manifestations of each skill, with ratings of 1 to 5 assigned respectively. If the coder assesses that the skill is not observable in the coded segment, a neutral rating of 3 is maintained. These seven individual scores are then summed together to produce the FIS-IS Total Score. Uhlin and Anderson (2011) reported a high internal consistency for the FIS-IS Instrument (Cronbach's Alpha = .94).

Therapy Rationale Scale (TRS). This two-item measure was developed by the authors of this study to rate the existence of two behavioral variables on a 3-point Likert type scale. The first item rates therapist's provision of cogent explanations for the source of client's

concerns, while the second item rates the provision of explanations for therapeutic procedures expected to alleviate these concerns. A rating of zero (0) in one of these items indicates that the therapist did not provide the described rationale in the rated segment; a rating of one (1) indicates that some rationale was loosely provided; a rating of two (2) indicates that rationales were clearly and explictly provided by the therapist. A total TRP score for each observed segment is derived from the mean of these items.

Experiencing Scale (EXP). The EXP Scale (Klein et al., 1986) measures the degree to which clients symbolize and create new meaning for their internal experience and distress, in such a way that this can be used as new information to solve of their problems. The measure is composed of 7 points, each describing a level of the depth of client's emotional and cognitive involvement in therapy. Lower levels of EXP represent the client describing events in a detached manner, without expression of emotional of personal relevancy. At higher levels of EXP, the client demonstrates greater depth of meaning-making and integration of emotions in a novel manner, gaining awareness of previously implicit meanings and feelings relevant for psychotherapeutic purposes. The EXP measure currently stands as one of the most studied and validated observational measures in psychotherapy research (Pascual-Leone & Yeryomenko, 2017).

Procedure

The primary investigator of this study and another licensed clinical psychologist with psychotherapy research experience served as coders. Inter-rater reliability of at least 80% was achieved for the three observational measures (FIS-IS, TRP and EXP) after a total 37 hours of training and rating of videorecorded therapy sessions not part of this study's sample.

For our main analysis, three videorecorded therapy sessions from 18 therapy dyads (6 per therapeutic modality) were selected, for a total of 54 rated sessions. Each therapy session was then divided into three segments (roughly 20 minutes each), each segment receiving a score for each observational measure. A total session score was derived from the mean of these three segments ratings. Finally, total therapist / dyad scores were arrived at from the mean of the three total session scores.

The second rater coded all 54 sessions (162 segments) and the primary investigator coded every second session from each therapy dyad for the purpose of inter-rater reliability checks. All rating was done blind to other variables such as final treatment outcome. Final inter-rater reliability between the two coders for each measure was found to be strong with a Intraclass Correlation Coefficient (ICC) of at least 0.89. The ratings of the second rater were designated as the criterion data and constitutes the FIS-IS, TRP and EXP values that were used in the analyses of this study.

Results

Results indicated that therapist's in-session interpersonal skill significantly predicted the client's level of experiencing ($F_{(1;73)}$= 10.312; p<0.01; R^2=0.124). This prediction was found to be positive, meaning that higher levels of therapist's FIS correspond to higher levels of client experiencing ($t_{(73)}$= 3.211; p<0.01; r=0.352). Contrary to our expectations, the provision of treatment rationales negatively predicted client experiencing ($F_{(1;73)}$= 18.529; p<0.001; R^2=0.202), meaning that higher levels of providing treatment rationales correspond to lower levels of client experiencing ($t_{(73)}$=-4.305; p<0.01; r=-0.450).

Therapist's interpersonal skills were not shown to be significantly different across treatment modalities ($F_{(2;15)}$= 0.464; p>0.05). However, providing treatment rationales ($F_{(2;8)}$= 28,481; p<0.001) was shown to be significantly different across treatment modalities. Cognitive-behavioral therapists had significantly higher scores of providing treatment rationales than emotion-focused therapists (p<0.05) and even more so than accelerated experiential dynamic psychotherapists (p<0.01).

Finally, client's experiencing ($F_{(2;8)}$= 6,589; p<0.05) was also shown to be significantly different across treatment modalities. Accelerated experiential dynamic psychotherapists had significantly higher scores of client experiencing than emotion-focused therapists (p<0.05) and even more so than cognitive-behavioral therapists (p<0.01).

Table 1. Descriptive statistics of final scores for the three measures across treatment modalities.

		Mean	Std. Deviation
Facilitative Interpersonal Skills	Cognitive-Behavioral Therapy (n = 6)	27,83333	1,101664
	Emotion-Focused Therapy (n = 6)	28,79617	1,743307
	Accelerated Experiential Dynamic Psychotherapy (n = 6)	28,66667	2,517075
	Total (n = 18)	28,43206	1,818512
Therapeutic Rationale Scale	Cognitive-Behavioral Therapy (n = 6)	2,14817	,389088
	Emotion-Focused Therapy (n = 6)	1,18533	,879704
	Accelerated Experiential Dynamic Psychotherapy (n = 6)	,79650	,163388
	Total (n = 18)	1,37667	,788532
Experiencing Scale	Cognitive-Behavioral Therapy (n = 6)	2,44433	,211030
	Emotion-Focused Therapy (n = 6)	2,75917	,354407
	Accelerated Experiential Dynamic Psychotherapy (n = 6)	4,03700	1,114930
	Total (n = 18)	3,08017	,958036

Discussion

This study is the first to our knowledge to investigate therapist's in-session interpersonal skills and provision of treatment rationales and its impact on client's depth of experiencing. Our results provide novel information on the relation between these process variables and bring about relevant questions for future studies on therapist's interpersonal skills in general, and therapeutic persuasiveness in particular.

Therapist's interpersonal skills were previously found to be a significant predictor of client outcomes (Anderson et al., 2020; Schöttke et al., 2017). Our study extends these findings in showing that therapist's in-session facilitative interpersonal skills also positively predict client's depth of experiencing, another significant variable for clinical outcomes (Pascual-Leone & Yeryomenko, 2017). In other words, greater levels of therapist's interpersonal skills predicted higher levels of client's novel meaning-making and emotional engagement in session. This study gives weight to a recent trend in the field emphasizing the

need to further investigate and train therapist's transtheoretical interpersonal skills (Wampold et al., 2019; Heinonen & Nissen-Lie, 2020). It also poses the question if part of the effects of therapist's FIS on outcomes might be *mediated* through client experiencing. Cuijpers and colleagues (2019) recently argued that demonstrating a correlation between common factors (such as therapist's interpersonal skills) and outcomes is not enough: we also need to understand the mechanisms that lead these variables to said outcomes. It seems plausible that therapist's FIS, such as accurate empathy and alliance-bond capacity, might influence final treatment outcomes *precisely because* they first influence client's meaning-making and emotional engagement, i.e., experiencing. Given the increasing support of therapist's FIS in the empirical literature, investigating variables that might help explain FIS's effects will be an important path for future studies. Also important to note is our finding that therapist's FIS scores were not associated to the treatment modality being used, supporting the contextual argument that relevant interpersonal skills are independent of specific theoretical models (Wampold & Imel, 2015).

Results also indicated that, contrary to our initial expectations, the provision of treatment rationales was a strong *negative* predictor of client's experiencing. In other words, the more therapists conveyed rationales for the origin of client's distress and tasks to alleviate said distress, the lower was client's depth of meaning-making and emotional engagement (experiencing) in session. Our initial prediction was based on previous theoretical suggestions that the provision of cogent rationales should increase the likelihood of client's motivation to engage in novel meaning-making and engagement in emotionally evocative therapeutic tasks (Frank & Frank, 1991; Wampold, 2007). To add to these theoretical considerations, studies have found that delivery and acceptance of a treatment rationale is significantly related to clinical outcomes (Constantino et al., 2019, 2019b). There are several ways to interpret our findings. The first and perhaps most straightforward is that therapist's delivery of rationales might actually interrupt client's exploration and elaboration of their own internal experience. Secondly, our results may highlight the difficulty in evaluating the cogency and acceptance of a treatment rationale from an observer-rated perspective. In this sense, a limitation of this study was the use of an unvalidated measure developed by the authors, the Therapeutic Rationale Scale (TRP). This scale evaluated the two behavioral variables that have arguably been the most theorized to account for therapist's

persuasiveness: providing rationales on the origin of client's distress, and providing rationales for tasks to alleviate this distress (Wampold & Imel, 2015; Frank & Frank, 1991). While the literature on therapist's persuasiveness supports the measurement of these variables, other persuasiveness-related factors were left out. Hence, a limitation of our study lies in the attempt to evaluate therapist's delivery of cogent rationales without measuring the perceived credibility or "fit" of said rationale to the particular client. This suggests that future research and measurements should include investigating client markers for the engagement and acceptance of treatment rationales, instead of focusing solely on the therapist's actions. Furthermore, our findings suggest that providing verbal rationales for treatment is unlikely to be enough for client's emotional and cognitive engagement, and that this task might actually deter from meaningful client engagement and novel meaning-making. This further highlights the need to investigate clinical *responsiveness* when studying the impact of treatment rationales (Stiles et al., 1998). In essence, we must ask *what* and *how* treatment rationales should to be delivered, *when*, and for *what* client characteristics.

Finally, and perhaps most importantly, our findings may suggest an overemphasis in the clinical persuasiveness literature on the provision of treatment rationales. Much empirical research shows that persuasiveness occurs in many different forms other than verbal rationales. Indeed, credibility, charisma and social influence processes usually occur *more* through nonverbal means than verbal means (Heide, 2013; Hoyt, 1996). Our study seems to support this literature, suggesting that the discussion and study of therapeutic persuasiveness should also target nonverbal components and clinical tasks other than providing treatment rationales. For instance, Vaz and Sousa (2021) suggested that common therapist skills such as accurate empathy and validation might include persuasive elements in that they aid in transforming or co-creating new adaptive meaning for one's experience. Future studies should focus on investigating what therapist's actions, other than providing treatment rationales, influence client's treatment expectations, credibility, and novel meaning-making.

Another finding in our study is the first empirical demonstration, to our knowledge, on the different prominence of treatment rationales across treatment modalities. Our study confirmed previous theoretical predictions (e.g., Safran & Segal, 1990) that cognitive behavioral therapists tend to provide significantly more amounts of rationales than their

affect-focused therapy counterparts. This result is understandable given the high priority placed in this model in explicitly conveying rationales for treatment (Beck, 2020). A related finding is that clients undergoing one of the affect-focused therapies in our sample (emotion-focused therapy or accelerate experiential dynamic psychotherapy) displayed higher mean scores of client experiencing than those in cognitive-behavior therapy, a result replicating previous studies on client experiencing across modalities (Castonguay et al., 1996; Watson & Bedard, 2006).

Conclusion

Psychotherapy research has long demonstrated that therapist's interpersonal skills are relevant for clinical outcomes. With the advent of more sophisticated study designs and findings on therapist effects (Johns et al., 2019), there is an increased interest in understanding therapist's interpersonal skills and their impact on the therapy process and outcomes. Therapist's persuasiveness continues to be perhaps the most elusive of these interpersonal skills, in that it is frequently cited as relevant for clinical effectiveness, with scant empirical research directly supporting this notion. Our study makes a small contribution to the understanding of therapist's interpersonal skills, pointing to its effects on client's in-session experiencing, as well as shedding further light on the complexity of studying therapist's persuasiveness. Empirically, it is still unclear how this interpersonal skill might impact the therapy process and outcomes, at least beyond what has already been demonstrated through the study of client's treatment expectations and credibility (Constantino 2019, 2019b). We believe the establishment of lines of research directly focusing on therapist's persuasiveness, including the measurement of relevant nonverbal behaviors, may still wield important implications for therapist training and client outcomes.

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Chapter V

General Discussion

Some therapists are more effective than others (Castonguay & Hill, 2017). This inescapable conclusion drawn from decades of psychotherapy research has led to considerable debate as to the reasons for this outcome variance across individual therapists. A particularly influential "contextual model" developed by Wampold and colleagues (Wampold & Imel, 2015; Wampold & Budge, 2012) sought to bring together the large empirical base of process and outcome therapeutic research, proposing three main empirically supported pathways to explain therapist's effectiveness. The first pathway regards the real relationship between therapist and client (Gelso, 2011); the second the creation of positive expectations in the client; and the third pathway focuses on the promotion of in-session and out-of-session therapeutic tasks and goals (Flückiger et al., 2018). Combined, these three pathways explain how psychotherapy leads to symptom reduction and increases the client's quality of life. While all three pathways are considered necessary for optimal psychotherapeutic results, the research base for each is varied. More specifically, less scholarly and empirical attention has been set on the proposed second pathway, focused on the importance of psychological interventions co-constructing credible rationales that explain the client's distress and how to alleviate it (Frank & Frank, 1991; Locher et al., 2019). The empirical foundations for this pathway have generally come from research done in related fields, most notably placebo research (Shapiro & Shapiro, 1997; Kirsch, 1990, 2005). And while specific psychotherapy research has established that client's expectations and treatment credibility do influence outcomes (Constantino et al., 2019, 2019b), much less has been investigated on specific therapist's actions that leads to these desired effects. However, the advent of a new trend in psychotherapy research, that of therapist's facilitative interpersonal skills (FIS; Anderson et al., 2020) has brought new opportunities to understand and investigate how this second contextual pathway might be influenced by therapist's verbal and nonverbal behavior. The ultimate goal of this line of research is to pinpoint empirically supported therapist's actions and characteristics that reliably lead to therapy outcomes (Heinonen & Nissen-Lie, 2020), so that these may be more systematically trained for increased therapeutic results. Of interest, Anderson and colleagues' work is currently the primary research program attempting to empirically investigate therapist's persuasiveness, arguably the interpersonal skill most directly related to the creation of client's expectations and treatment credibility.

The goal of this thesis was to provide theoretical and empirical contributions to the literature on therapist's facilitative interpersonal skills in general, and therapeutic persuasiveness in particular. The three studies presented contribute in novel ways to the understanding and research base for these variables. In our results we propose implications for future therapist training and psychotherapy research.

Our first study represents, to our knowledge, the first contemporary review on the empirical basis for the study of therapist's persuasiveness. Our study confirmed previous suggestions that the study of therapist's characteristics and skills has been a dormant area of research for the past decades (Garfield, 1997; Beutler et al., 2003; Hill & Lent, 2006), only to recently emerge with renewed empirical support (Heinonen & Nissen-Lie, 2020). The same is true for therapist's persuasiveness in particular, which once was a vibrant topic for scholarly discussion (Abroms, 1968; Strong, 1968; Packwood & Parker, 1973; Fish, 1973). As a result of our study, we arrived at a series of empirically supported therapist in-session persuasiveness-related skills that probably contribute to treatment outcomes. Namely, persuasive therapists are more likely to be able to accurately assess and responsively adapt to client's pretreatment beliefs and expectations (Benish et al., 2011; Coyne et al., 2019; Constantino et al., 2019, 2019b); they provide or co-construct cogent treatment rationales for the origins of their client's distress and ways to alleviate it (Frank & Frank, 1991; Wampold, 2007; Kirsch, 1990); and they display a set of nonverbal charismatic behaviors (Heide, 2013; Hoyt, 1996). Our review also pointed to two major future directions needed regarding therapist's persuasiveness. The first was a need for direct, systematic therapist training of this interpersonal skill. Some interpersonal skills tend to be addressed and procedurally training more than others. For instance, accurate empathy is a common target in therapist's training (Teding van Berkhout & Malouff, 2016; Hill, 2020). Given that our review and the research on therapist's FIS suggests that other interpersonal skills also account for therapist's outcomes, direct training of these skills is warranted. Our second study in this thesis addressed this need by proposing preliminary guidelines for the deliberate practice of cogent treatment rationales, the therapist action most often associated with therapist's persuasiveness (Frank & Frank, 1991). Finally, our first study suggested a need for more in-depth research on the impact of therapist's interpersonal skills in general, and therapist's

persuasiveness in particularly, on the in-session therapeutic process. The third study in this thesis contributes to this literature.

Our second study is the culmination of two recent trends in the field of psychotherapy: the training of therapist's facilitative interpersonal skills (Anderson et al., 2020b), and the use of deliberate practice methods for the increase of therapist's training effects (Rousmaniere et al., 2017). Having established the empirical basis for the study and training of therapist's persuasiveness, we proposed preliminary deliberate practice guidelines for the procedural training of this interpersonal skill. Deliberate practice methods have recently showed to reliably increase therapist's skill acquisition and client outcomes (Westra et al., 2020; Hill et al., 2020; Goldberg et al., 2016; Chow et al., 2015). Recent guidelines have been developed for the deliberate practice of several therapist skills such as emotion-focused skills (Goldman et al., 2021) and intrapersonal skills (Rousmaniere, 2019). However, no guidelines existed for the deliberate practice of therapist's persuasiveness. Our study is the first to propose guidelines for the therapist action most often associated with therapist's persuasiveness, that of providing cogent treatment rationales. The case example presented in this study also provides replicable supervisory procedures for the skill acquisition of this variable.

Our third study continues exploring the potential of the therapist's FIS construct by presenting the first empirical investigation of its impact on the in-session therapeutic process. It is the first study to demonstrate that therapist's in-session FIS significantly predict client's level of cognitive and emotional engagement in the therapy process. This finding gives further weight to the empirical support and relevancy of the FIS construct, given its predictive value for a process variable (client experiencing) already demonstrated to impact treatment outcomes (Pascual-Leone & Yeryomenko, 2017). Our findings also suggest that one possible mechanism from which therapist's interpersonal impact client outcomes is through first impacting client's depth of experiencing in session. We also found that therapist's provision of treatment rationales negatively predicted client's experiencing in our sample. This supports the hypothesis that the acceptance and "fit" of rationales to the individual client is likely to be more important than the delivery of treatment rationales *per se* (Benish et al., 2011). It also supports the notion that the theoretical literature might tend to emphasize the

verbal components of persuasives (i.e., provision of rationales) to the detriment of its nonverbal components (Heide, 2013). Moreover, our results showed that therapist's FIS are not associated with specific therapeutic modalities, supporting the contextual model's hypothesis that therapist skills related to treatment outcomes are transtheoretical in nature (Wampold & Imel, 2015). We also found that client's depth of experiencing did vary across treatment modalities, again replicating the results from previous studies (Castonguay et al., 1996; Watson & Bedard, 2006). Finally, differences across modalities were also found to exist for therapist's provision of treatment rationales, constituting the first empirical confirmation of a previously only theorized phenomenon (Safran & Segal, 1990).

Taken together, our studies provide novel theoretical and empirical contributions for the understanding of therapist's effects, therapist's interpersonal skills, and therapeutic persuasiveness. Importantly, they show that therapist's interpersonal skills and persuasiveness are amenable to empirical process research and therapist training. Still, much is left to be learned on these variables. If we are to understand the mediators and mechanisms that underly therapist effects (Cuijpers et al., 2019; Kazdin, 2007), then refinement of in-session process-outcome research and training methods for therapist's interpersonal skills is a likely necessary step. In the future, we would encourage the replication of our empirical study while also including other relevant process variables (e.g., the therapeutic working alliance) and outcome data for the therapists under investigation. We would also encourage the study of the deliberate practice guidelines presented in this thesis with a sample of trainees and therapists, comparing its effects to traditional didactical training. This would hopefully lead to refinement of these methods, providing a solid contribution viable to increase the field's overall therapeutic effectiveness over time.

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