Training Implications of Harmful Effects of Psychological Treatments

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The goal of this article is to delineate training implications regarding harmful effects associated with psychotherapy. The authors strongly recommend that trainees be made aware of (and encouraged to examine carefully) the potentially harmful treatments that have been recently identified (Lilienfeld, 2007). Consistent with a broad perspective on evidence-based practice, it is also argued that additional guidelines for the prevention and repair of harmful impacts can be derived from psychotherapy research on process (technique and relationship) and participant (client and therapist) variables. For example, rigid adherence to the application of psychotherapy techniques can be a potentially harmful therapist behavior that necessitates careful training on the nature and flexible use of interventions. Furthermore, the authors suggest that trainers and supervisors tentatively consider training implications linked to clinical observations and theoretical assertions, such as the premature use of clinical interpretations, with the assumption that more confidence in such therapeutic guidelines can be gained when they are supported by multiple knowledge sources (empirical, clinical, conceptual). Finally, training implications related to the monitoring of harmful effects in terms of treatment outcome and process are demarcated.

Keywords: training, psychotherapy, harmful effects

There is clear evidence that psychotherapy works. Research has demonstrated that individuals with various clinical problems will, on average, benefit more from psychotherapy than from no treatment or a psychological control treatment (Cooper, 2008; Lambert & Ogles, 2004). However, there is also evidence that some clients fail to benefit from psychotherapy and that some (approximately 5–10%) actually deteriorate during treatment (Lambert & Ogles, 2004). This deterioration rate is even higher (approximately 10–15%) in substance abuse work (Lilienfeld, 2007).

Although psychotherapists tend to underestimate the occurrence of negative treatment outcomes (Boisvert & Faust, 2006), deterioration in psychotherapy has long been recognized as an alarming clinical reality. For example, Allen Bergin, who ironically provided one of the most convincing rebuttals to Eysenck's (1952) challenge of psychotherapy's effectiveness (Bergin, 1971), also offered the first systematic analysis of psychotherapy deterioration (Bergin, 1966; see also Lambert, Gurman, & Richards, in press). Subsequently, several landmark publications have alerted the field to negative outcomes across different psychotherapy approaches and diverse clinical populations (e.g., Foa & Emmelkamp, 1983; Mays & Franks, 1985; Strupp, Hadley, & Gomez-Schwartz, 1977). More recently, the potentially deleterious effect of psychotherapy has received renewed attention as a neglected but crucial aspect of evidence-based practice in psychology (Lilienfeld, 2007). Although the field has devoted considerable energy to identifying empirically supported therapies (ESTs; Chambless & Hollon, 1998; Chambless & Ollendick, 2001), Lilienfeld has cogently argued that more urgent attention needs to be paid to identifying potentially harmful treatments (PHTs).

However painful it may be, it is important for those of us who are psychotherapists to recognize that we have all likely harmed one or more of our clients. To the extent that a harmful effect in psychotherapy includes either a decelerated rate of improvement that is the direct effect of the treatment or an opportunity cost reflected in participating in an unhelpful or protracted versus a helpful and parsimonious treatment (Lilienfeld, 2002, 2007), we would venture to guess that all experienced psychotherapists have, at one point or another in their careers, failed to meet the most basic and ethically important principle guiding the profession: First, do no harm (American Psychological Association, 2002).

Considering the challenge and complexity of clinical problems and the psychotherapy process, psychotherapists' isolated missteps in clinical strategy and/or a momentary lack of attunement to a client's needs are unavoidable. However, what might be preventable—or at least attenuated—are systematic sources of harmful effects. Put differently, the fields of clinical and counseling psychology need

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to devote substantial attention to the factors that (across numerous occasions and various situations) appear to enhance the risk of or contribute directly to stagnation and deterioration in psychotherapy. We also argue that an explicit emphasis on such factors should occur at the very first step in the professional career of clinical and counseling psychologists. Thus, we believe that one of the mandates of graduate training in clinical and counseling psychology should be to raise awareness of and to prevent, to the extent possible, predictable sources of harm in psychotherapy.

Our goal in this article is to present what we view as central implications for psychotherapy training derived from the extant literature on potentially harmful effects in psychotherapy. These implications are not restricted to PHTs. Inasmuch as ESTs should not be viewed as the exclusive source of evidence-based practices (see APA Presidential Task Force on Evidence-Based Practice, 2006), one should recognize that specific techniques, relationship factors, and participant characteristics and the interactions among them can interfere with change or promote harm. In fact, we focus on several variables that Lilienfeld (2007) identified as potential contributors to harmful effects; thus, the implications we advance in this article can be viewed as a set of complementary guidelines to PHTs with the common goal of preventing or repairing negative outcomes. Considering the current knowledge base regarding psychotherapy change processes, we also believe that training implications and guidelines should not rest exclusively on empirical findings. Although robust research evidence may provide psychotherapists with the most reliable markers of or contributors to harmful events, theoretical principles about helpful and hindering psychotherapy change processes (especially if linked with approaches that are based on a strong conceptual tradition and/or have received empirical support) and clinical observations (particularly if repeated over numerous occasions and contexts) may, at a minimum, alert psychotherapists to possible detrimental events and processes. Of course, confidence in the predictive ability of any training guideline would be increased if support was found across more than one knowledge source.

Presently, we propose two clusters of clinical training guidelines. The first directly addresses the implementation of psychotherapy and the second focuses on the identification of harmful effects in psychotherapy. Needless to say, some of our proposed guidelines are already included in good training practices. We argue, however, that the more that these guidelines are integrated explicitly and systematically across different phases of therapists' training, the more likely it will be that training programs will produce psychotherapists who are effective in preventing harm and promoting therapeutic change.

We also hasten to add that providing a comprehensive and detailed list of training guidelines pertaining to harmful effects is beyond the scope of this article. Instead, our intention is to raise trainers' consciousness about the responsibility to monitor, address, and ultimately prevent harmful effects and to convey that rich sources of empirical, conceptual, and clinical knowledge can be tapped to assist trainers in meeting this responsibility. Providing an exhaustive list of training guidelines, as well as suggesting new directions for their refinement, should be an evolving and central focus in the field.

Training Guidelines for the Implementation of Psychotherapy

The unavoidable reality that harm occurs in psychological treatments should force graduate programs in clinical and counseling psychology to recognize the need to train students not only about what to do but also about what not to do in psychotherapy. Fortunately, research can help guide this imperative training mission.

Empirical Guidelines

Outcome findings. By establishing and publishing a list of empirically based PHTs, Lilienfeld (2007) provided an invaluable service to the field. Similar to ESTs (and, for that matter, the empirically supported therapy relationships; see Norcross, 2002), students should be exposed to the PHT list and kept abreast of its modification or expansion. Whereas ESTs might provide clinicians with a first line of intervention for some specifically defined disorders (e.g., when working with clients with generalized anxiety disorder, especially those without major interpersonal problems, it is indicated to use cognitive–behavioral therapy; Newman, Castonguay, Borkovec, & Molnar, 2004), the PHT list should be viewed as providing clear warning signals of harm for certain populations or contexts (e.g., it is contraindicated to use critical incident stress debriefing immediately after a traumatic event, as there is heightened risk for posttraumatic stress symptoms and/or a disruption of the natural recovery process; see Lilienfeld, 2007).

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Concomitantly, and as is the case for ESTs and empirically supported therapy relationships, students should be encouraged to approach the PHT list carefully and to examine seriously how extensive, specific, and valid the evidence is that supports a particular procedure's detrimental impact. For example, the fact that relaxation induces anxiety in some generalized anxiety disorder clients (Heide & Borkovec, 1984) does not imply that this intervention should be proscribed when treating this clinical population. In fact, relaxation, as one of several available strategies to replace early worry cues with an antagonistic response, remains a crucial component of the most empirically established cognitive–behavioral treatment for generalized anxiety disorder (Borkovec, Newman, Pincus, & Lytle, 2002; Newman et al., 2004).[1] Consistent with Paul's (1967) pledge for a greater specification of the positive effects of psychotherapy, students should be made aware that some interventions may be harmful mostly, if not only, when used under specific circumstances or interpersonal contexts or when delivered by particular therapists to particular clients. Furthermore, as described below, when training clinicians about what not to do in psychotherapy, it might be particularly helpful to identify possible harmful interventions or mechanisms that are common to several PHTs.

Process findings. In addition to deriving important lessons from the outcome findings that have led to the identification of PHTs, training programs and therapists in training can benefit from exposure to and understanding of the psychotherapeutic change process related to relationship and technical variables. It is important to note at the outset that much of the research on process (as well as studies on participant characteristics reported later) is based on correlational studies that demonstrate associations between certain predictor variables and various outcomes. As such, the findings addressed in the following sections do not imply causation (except as noted in experimental designs). In addition, because the outcomes often reflect variability that may not capture actual deterioration in psychotherapy, it is important to caution the reader that these findings may identify associations based on variability between no change and improvement, thus neglecting true deterioration.[2] However, we believe that negative associations between predictors and adaptive outcomes can be markers for potentially harmful effects and, thus, we make the assumption that such findings can help inform current training guidelines for avoiding harm in psychotherapy. Of course, such guidelines, as noted above, should be evolving, especially in response to research that highlights causal connections between certain variables and client deterioration.

Process findings about relational variables. With the above caveats in mind, we note that a facet of psychotherapy process research focuses on *relational* factors, or the manifestation of feelings and attitudes that the client and therapist have for one another and the work in which they are engaging (Gelso & Carter, 1985). For example, the consistent link between client–therapist alliance quality and client improvement found across therapies, treatment modalities, and client problems (Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000) suggests that client outcomes are likely hindered by a weak bond and/or poor collaboration between client and therapist. Although the causal effect of the alliance on outcome has yet to be firmly established (Castonguay, Constantino, & Holtforth, 2006), the current empirical evidence nonetheless suggests that clinical supervisors should systematically and explicitly focus on teaching their supervisees skills to enhance the client–therapist relationship (above and beyond vague advice such as, "It is important that you establish a rapport with your client"), as well as to observe and to respond effectively to processes that jeopardize the alliance.

Fortunately, several innovative research programs have shown that training therapists in specific interpersonal skills may facilitate the development and enhancement of the alliance. For example, in a pilot-feasibility training study, Crits-Christoph et al. (2006) examined the efficacy

[1] It should be clearly stated that Lilienfeld (2007) has not recommended that relaxation should be eliminated from the treatment repertoire for anxiety disorders. In fact, on the basis of controlled research evidence, he argued that relaxation is likely to be helpful for some patients with such disorders. Our concern here is about misguided training implications that could be derived about this and other treatments (e.g., process experiential) if trainers simply inform their students that there is a PHT list that dictates what they should never do in therapy. This would be the equivalent of saying to trainees, "All you need to know when treating anxiety disorders is the list of empirically supported treatments." Although this has not been the contention of those involved in the identification of ESTs (see Chambless & Ollendick, 2001), statements to that effect are not unheard of in the field.

[2] We are grateful to one of the reviewers of a previous version of this article for pointing out this issue.

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Photo by Gary Ferrigno

of a 16-session alliance-fostering therapy. Although the small sample of five trainees (with one to three years of postdoctoral experience in the specific alliance treatment) precluded statistical significance, moderate to large effect sizes were observed for client-rated alliance favoring the posttraining versus pretraining cases. In a training study of advanced doctoral students, Hilsenroth, Ackerman, Clemence, Strassle, and Handler (2002) examined the efficacy of a structured clinical training, which included specific strategies for building rapport, developing collaboration, establishing empathic connections, being optimally responsive to client needs, socializing the client to the psychotherapy process, exploring client relational problems, focusing on the client–therapist interaction, and setting collaborative treatment goals. Compared with clinical trainees delivering treatment as usual (and receiving supervision as usual), doctoral students who underwent the training produced higher early alliance ratings with their posttraining clients.

A number of studies have also demonstrated that specific therapist behaviors toward clients, as manifested in the ongoing relational exchange, are linked to poorer outcomes. Such empirical investigations are likely to help supervisors in teaching students about how not to relate with their clients. For example, in a series of studies focused on time-limited dynamic psychotherapy, therapists in poor-outcome cases relative to good-outcome cases exhibited more hostile control (i.e., belittling and blaming), hostile separation (i.e., ignoring and neglecting), and complexity (i.e., messages simultaneously conveying contradictory information), as well as less affiliative autonomy granting (i.e., affirming and understanding) in their communications (Henry, Schacht, & Strupp, 1986, 1990). Such dissaffiliative processes have also been shown to differentiate poor- versus good-outcome cases in cognitive–behavioral approaches (e.g., Constantino, Maramba, DeGeorge, & Dadlani, 2007). Although the poor-outcome cases in the above studies did not necessarily deteriorate, they failed to improve to a substantial success criterion (e.g., diagnostic recovery status). Thus, it is important not to overemphasize the direct impact of these specific therapist behaviors on the process of deterioration. However, as noted above, harmful effects in psychotherapy may not only reflect a decelerated rate of improvement but also an opportunity cost reflected in participating in an unhelpful treatment or, in this case, interacting with an unhelpful therapist. Furthermore, as Henry et al. (1990) have argued, even a low frequency of such toxic or negative therapist behaviors can interfere with a client's improvement. Given that these measurable, yet frequently subtle, negative processes are present in different forms of psychotherapy, they should receive systematic and competent attention, irrespective of the theoretical orientation guiding a particular training program (Binder & Strupp, 1997). Again, fortunately, recent investigations have provided preliminary support for such transtheoretical guidelines as the therapist's exploration of his or her contributions to negative interactions in the service of repairing alliance ruptures and improving the therapeutic outcome. For example, Castonguay et al. (2004) developed an integrative cognitive therapy, a treatment that assimilates humanistic and interpersonal alliance rupture-repair strategies into standard cognitive therapy for depression. Promising preliminary support for the integrative cognitive therapy's efficacy was demonstrated in comparison to a wait-list control (Castonguay et al., 2004) and to standard cognitive therapy (Constantino et al., 2008). The latter study, albeit a pilot trial, suggested a causal role of the alliance strategies in augmenting cognitive therapy's efficacy.

Taken as a whole, the primary training implication of the previous process and outcome studies on alliance is that supervisors, irrespective of their preferred theoretical orientations, can help trainees acquire specific skills that might prevent and help repair relationship problems and thus possibly reduce the risk of harmful effects in psychotherapy.

In addition to the alliance as a quality of the therapeutic relationship, psychotherapy process research has identified a number of other relationship factors that may interfere with or negatively impact therapeutic change. For example, specific relational skills of the therapist, such as the inadequate management of countertransference reactions (Gelso, Latts, Gomez, & Fassinger, 2002) and the use of confrontational self-disclosures (Hill, Mahalik, & Thompson, 1989), may be noxious psychotherapy occurrences. In contrast, recent reviews of empirical literature have found very few instances of negative correlation between therapist empathy, positive regard, and congruence and client-rated outcome (see Norcross, 2002). Thus, although research has not confirmed Rogers's (1957) hypothesis that these interpersonal attitudes are necessary and sufficient for change, there is hardly any empirical ground to suggest that clinical graduate students should be trained to be rude, cold, and/or disingenuous with their clients.

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Process findings about techniques. Relationship variables, however, are not the only type of variable that has been linked with poor outcome. For example, the therapist's focus on central aspects of the cognitive therapy rationale and techniques (e.g., impact of clients' thoughts on emotion) has been found, in some studies, to be negatively related to client improvement (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; A. M. Hayes, Castonguay, & Goldfried, 1996). It is interesting that additional quantitative and content analyses conducted in one of these studies (Castonguay et al., 1996) suggested that it is not the prescribed techniques per se that may be detrimental but, rather, it is their rigid or preservative use in particular contexts that may interfere with change. Specifically, the relationship between the therapist's focus on prescribed cognitive therapy techniques and outcome was no longer significant once the influence of the therapeutic relationship quality was statistically controlled. Furthermore, content analyses suggested that therapists frequently increased their adherence to prescribed cognitive interventions when confronted with alliance ruptures, wherein the more the client voiced reluctance to accept the cognitive therapy rationale and/or engage in cognitive interventions, the more therapists emphasized the need to do so. This, in turn, appeared to promote further reluctance toward the prescribed rationale and tasks. Thus, rather than resolving the emerging alliance ruptures, such increased adherence may have exacerbated relationship problems and contributed to poorer outcome.

Such complex findings regarding the interaction of relational and technique factors in globally effective treatments are not unique to cognitive therapy. For example, evidence suggests that therapist interpretations need to be used cautiously in psychodynamic psychotherapy. As Crits-Christoph and Gibbons (2002) noted, "studies specifically of transference interpretations have recently converged toward the conclusion that high rates of transference interpretations can lead to poor outcome" (p. 294). It is interesting that some evidence suggests that such negative findings may be explained, at least in part, by the same type of complex interaction between relationship and technical variables that was observed in cognitive therapy. In a study of psychodynamic therapy for personality disorders, Schut et al. (2005) found that the frequency of therapist interpretations was negatively associated with outcome. In addition, they found that (a) the level of dissaffiliative processes before, during, and after the interpretations was negatively linked with improvement; (b) the concentration of interpretations was positively associated with dissaffiliative processes before and during interpretations; and (c) the concentration of interpretations was negatively associated with clients' affiliative responses to interpretations. The authors argued that "the results suggest that therapists who persisted with interpretations had more hostile interactions with patients and had patients who reacted with less warmth than [did] therapists who used interpretations more judiciously" (Schut et al., 2005, p. 494). Put more generally, these findings—like those found with cognitive therapy—suggest that therapists' increased adherence to a core technique in psychodynamic therapy might be in response to and/or contribute to alliance difficulties.

Additional illustrations of the complex interaction of relational and technical factors can be found in two other studies of psychodynamic therapy. To understand what might have gone wrong for clients who terminated therapy prematurely, Piper et al. (1999) conducted content analyses of their last session. It is interesting that the typical interaction sequence observed for patients who received the highest focus on transference themes was similar to the aforementioned interaction pattern in cognitive therapy (Castonguay et al., 1996). Specifically, clients' disclosures of frustration with therapy were interpreted by the therapist as a transferential reaction. Such interpretations were followed by client resistance (e.g., verbal disagreement, silence) and therapists' persistence with transference interpretations, which in turn led to a power struggle (at times marked by therapists "being sharp, blunt, sarcastic, insistent, impatient, or condescending" [Piper et al., 1999, p. 120]). These findings are consistent with those of a previous study (Piper, Azim, Joyce, & McCallum, 1991) that found that interpretations were negatively associated with both alliance and outcome. As noted by Piper et al. (1999), the "examination of the therapy process in that study also revealed that experienced therapists at times got caught up in a negative cycle involving patient resistance and transference interpretation" (p. 121).

Fortunately, researchers have begun examining what may be more effective ways of dealing with patient resistance, or perhaps ambivalence, to change or the treatment process. For example, in addition to the alliance-based research programs described above, researchers have examined the effectiveness of motivational interviewing to more effectively address patient resistance and ambiva-

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lence, and such work has been met with promising results across various conditions (e.g., substance abuse, anxiety, posttraumatic stress, obsessive-compulsive disorder, depression; see Arkowitz, Westra, Miller, & Rollnick, 2008). Thus, it would seem that training programs should implement methods for training clinicians that identify crucial process markers—such as instances when patients do not react to an intervention in a way the therapist would like them to—and that respond to such markers in clinically responsive ways based, for example, on patient needs for both communion and autonomy, as well as their readiness to change. As Goldfried and Davison (1994) have noted, rather than blaming the patients for not responding to interventions, psychotherapists need to remember that when it comes to responsiveness to change, "*the client is never wrong"* (p. 17).

As discussed earlier, the aforementioned research findings do not imply that the techniques or processes of change prescribed in effective treatments are harmful in and of themselves. In fact, the use of accurate interpretations in psychodynamic therapy (Crits-Christoph & Gibbons, 2002), concrete interventions (e.g., homework assignments) in cognitive therapy (Burns & Nolen-Hoeksema, 1991; DeRubeis & Feeley, 1990; Feeley, DeRubeis, & Gelfand, 1999), and depth of experiencing in client-centered therapy (Elliott, Greenberg, & Lietaer, 2004) have all been associated with positive outcome. What such findings suggest, however, is that therapists need to be trained to use potentially helpful interventions in a clinically flexible and sensible way, with good timing and in appropriate contexts.

As we have indicated earlier, however, some specific interventions may be harmful for most clients and across many contexts. As emphasized by Lilienfeld (2007), one of the major benefits of having a list of PHTs is that it allows for the potential identification of procedures or mechanisms that cut across different treatments (PHTs and some that are typically effective) and may be partly responsible for harmful effects. A glance at the description of the PHTs offered by Lilienfeld suggests, for example, that a number of these involve common harmful ingredients. For instance, critical incident stress debriefing, scared straight programs, grief counseling for normal bereavement reactions, boot camp interventions for conduct disorder, and drug abuse and resistance education programs all may involve pressured confrontation with intense emotion (which one could argue may be experienced as emotional abuse). In addition, a number of PHTs (facilitated communication, recovered memory techniques, and dissociative identity disorder–oriented therapy) may involve the unguarded use of powerful persuasion and suggestion. Unskilled or inappropriate use of specific (and potentially effective) interventions may also be responsible, at least in part, for harmful effects. For example, observed deterioration in expressive-experiential therapies could be the result of improper or unsafe use of emotional deepening techniques. In other words, it may not be that these therapies are harmful per se but that some patients' symptoms may worsen when therapists foster emoting for sake of emoting, rather than for the goals of raising awareness of one's needs and facilitating new meaning about self and others. In fact, one of these treatments (emotion-focused or process experiential therapy) has been recognized by Division 12 of the American Psychological Association as an EST for depression (Greenberg, 2006). Moreover, the increase in anxiety experienced by some clients when engaging in relaxation training may be due to an insufficient exposure to unpleasant sensations and/or an inadequate explanation of the treatment rationale. As Goldfried and Davison (1994) noted, "It is not uncommon for clients to react to the beginnings of relaxation in a fearful way because they are concerned that something bad is happening to them. On the contrary, such different sensations (tingling of fingers, floating sensation) seem to be signposts of incipient relaxation" (p. 83; see also Lilienfeld, 2007, p. 65). Accordingly, therapists in training should not only be made aware of the toxic processes that may be involved in some specific procedures, but they should also be trained to use appropriately and competently interventions that are likely to contribute to the positive impact of effective treatments.

Participant characteristics findings. Although current psychotherapy research shows that some treatments are effective and others harmful and that relational and technical process variables can have positive and negative impacts, it also reveals that both the persons who provide and the persons who receive psychotherapy are likely to influence its results. Wampold (2006), for example, has provided evidence that psychotherapist effects may be more predictive of outcome than the alliance. This suggests that some psychotherapists are better at facilitating change, whereas others tend to cause more harm, at least with some of their clients. What is less clear, from a research perspective, is what types of psychotherapists are likely to have a detrimental impact on their clients (either through directly influencing deterioration or through impeding progress that might otherwise take place with a

different, more effective psychotherapist). However, although correlational (and thus subject to the caveats described in the Process Findings section), some studies have begun to provide potentially useful information. For example, therapists with more anxious attachment styles (characterized by low self-esteem, as well as high levels of emotional expressiveness, worry, and impulsiveness in their relationships) have been shown to be vulnerable to less empathic exchange. This is especially the case with clients who present with a secure attachment style (characterized by positive views of self and others, as well as comfort with both intimacy and independence) or a dismissive attachment style (characterized by a positive, self-sufficient view of self; negative views of others; and a defensive lack of intimacy; see Beutler, Blatt, Alimohamed, Levy, & Angtuaco, 2006). Furthermore, Henry, Strupp, Butler, Schacht, and Binder (1993) found that therapists who were hostile toward themselves, possibly as a result of having been treated that way by others in their formative years, tended to be hostile toward their clients, even when extensively trained on a treatment designed to pay particular attention to negative interpersonal processes. As noted above, research has suggested that such disaffiliative processes can interfere with change. Other studies have expanded on this finding in demonstrating that therapists' recollections of negative perceptions of parents during childhood were associated with negative interpersonal processes in session (Christianson, 1991; Hilliard, Henry, & Strupp, 2000) and that such interpersonal processes were negatively related to treatment outcome (Hilliard et al., 2000). As Henry and Strupp (1994) have cogently argued, such findings point to "a theoretically coherent link between early actions by parents toward the therapist, the therapist's adult introject state, vulnerability to countertherapeutic process with their patients, and differential outcome" (p. 66).

The potential training implications of the above findings, especially if subsequently substantiated with cause-and-effect relationships, are both clear and important. Clinical supervisors need to help trainees to know themselves, such as their strengths, limitations, interpersonal vulnerabilities, and countertransferential blind spots. Moreover, they need to develop the ability to monitor the impact of their internal experience, especially their hostile and negative feelings, on the therapeutic relationship. As suggested by Sullivan (1953), trainees should be trained in acquiring and/or developing an attitude of participant–observer, allowing them to be collaboratively present and engaged in the therapeutic relationship while simultaneously being able to keep a distance from the personal and interpersonal dynamics that are being enacted in treatment, especially during therapeutic impasses. Although these metacognitive or metaexperiential skills may not be easily categorized as technical or relational, their refinement and mastery are likely to facilitate the competent use of prescribed interventions (especially vis-à-vis any therapist factors that present countertherapeutic risk), the skilled management of the therapeutic relationship, and the complex act of balancing acceptance and change procedures (S. C. Hayes, Strosahl, & Wilson, 1999; Linehan, 1993).

Without falling into the trap of blaming clients for the harmful effects they can experience as a result of therapy, it is important for trainees to recognize that some clients may be more difficult to treat than others. Research does show that some individual characteristics independent of psychiatric diagnosis are associated with negative process and poorer outcome—even in the treatment of problems for which there are effective treatments (e.g., depression). For example, avoidance (Gaston, Marmar, Thompson, & Gallagher, 1988) and interpersonal difficulties (Constantino & Smith-Hansen, 2008) have been found to be negatively related to alliance. Studies have also shown that perfectionism relates negatively to improvement in different forms of therapy for depression (see Auerbach, Levy, & Schaffer, in press). Furthermore, we have evidence that particular types of clients respond less well to some types of treatments than others. For example, depressed clients with a high level of reactance (i.e., high sensitivity and resistance to being controlled by others) benefit less from directive approaches, such as cognitive therapy and gestalt therapy, than from nondirective approaches, such as supportive or self-directive therapies (see Beutler et al., 2006). In addition, clients with depression who also tend to externalize their problems fare less well in insight-orientated approaches (such as gestalt therapy) than in cognitive–behavioral therapy, which focuses on active cognitive and behavioral change (see Beutler et al., 2006). On the basis of these findings, trainees should be informed that if their work with a client is not going as well as one might expect, this may not mean that they are incompetent and/or using a flawed or harmful treatment. Rather, these results suggest that psychotherapists need to be trained to integrate a variety of empirically based information sources in their case formulations and treatment plans that can help them determine the intensity and length of therapy and/or choose the optimal intervention for particular clients, especially within the available ESTs. Having done so, they also need to accept the fact that even the best interventions may not work in all cases.

Training programs should also pay attention to what the research reveals about the potentially detrimental consequences of matching or failing to match patients and therapists on various personal dimensions. For example, some evidence suggests that lesbian, gay, and bisexual patients report poorer treatment outcomes when working with male heterosexual therapists as opposed to female heterosexual therapists or lesbian, gay, or bisexual therapists (see Cooper, 2008). Furthermore, a lack of match between client and therapist on age and religion has been shown to be negatively related to alliance quality (see Constantino, Castonguay, & Schut, 2002). Therapists should be trained to integrate such findings as they develop their case formulations and treatment plans and as they communicate with their patients about elements of their work that may pose a risk for poorer process and outcome.

As a whole, the empirical guidelines described above show that in addition to PHTs, there are research findings

that can help psychotherapists train other psychotherapists to become aware of, avoid, and repair inadequate or detrimental interventions. Consistent with a suggestion made by Lilienfeld (2007), most of these findings can be formulated in terms of principles of change. In fact, many of the aforementioned training implications reflect various principles of change that were derived from the empirical literature (based on a task force cosponsored by the American Psychological Association's Division 12, Clinical Psychology, and the North American Society for Psychotherapy Research) on technical factors, relationship variables, and participant characteristics in the treatment of four types of disorders: depression, anxiety, substance abuse, and personality disorders (Castonguay & Beutler, 2006). Because these principles of change are not tied to particular orientations, they are likely to be viewed as relevant heuristics by training programs open to a broad contribution of evidence-based practices.

Conceptual and Clinical Guidelines

Numerous guidelines about what works and what interferes with change can be generated from the research literature, such as the 61 empirically anchored principles of change delineated by the task force just mentioned (Castonguay & Beutler, 2006). We also suggest, however, that training implications for potentially harmful effects can be derived, cautiously, from theoretical models of psychopathology and psychotherapy, as well as clinical experience of treatment failures. Such implications, as the ones described in the previous section, pertain to different dimensions of psychotherapy and can be clustered, more or less adequately, around relational, technical, and participant variables. Some of these conceptual and clinical observations have been confirmed by the empirical work described earlier, whereas others have not. As previously mentioned, one's confidence about the reliability of any training implication is likely to increase as converging support is obtained from different sources of knowledge acquisition, such as conceptual or clinical sources and empirical findings.

Relational variables. On the basis of their clinical experience, psychotherapists have long maintained that a good relationship is necessary for therapeutic benefit to take place. Long before it could be supported by substantial data, both humanistic (e.g., Rogers, 1951) and psychodynamic (e.g., Fenichel, 1941; Freud, 1912/1958; Greenson, 1967) scholars warned against the danger of therapists' lack of empathy toward their clients. On the basis of clinical observation, Rogers (1951) speculated that most cases of treatment failure could be linked by the inability to build a therapeutic relationship. While acknowledging that an overemphasis on emotional involvement can be problematic, Greenson (1967) warned against the dangers of psychoanalysts becoming simply "data collectors or interpretation dispensers" (p. 16) and went on to argue, "Generalized emotional withdrawal and uninvolvement with the patient are much more ominous signs and make for an inability to perform psychoanalysis except as a caricature of the true procedure" (p. 400).

Even in the behavioral tradition, which has been slow to fully recognize, let alone test, the importance of relationship variables, therapist empathy or the lack thereof has been identified as a factor responsible for treatment failure (Eysenck, 1985; Foa & Emmelkamp, 1983; Foa, Steketee, Grayson, & Doppelt, 1983; Goldfried & Davison, 1976; Rachman, 1983). Foa et al. (1983) argued that a lack of warmth on the part of the therapist would likely adversely impact the successful treatment of obsessive-compulsive disorder and emphasized the particular importance of not ignoring relationship-facilitative conditions in the implementation of exposure procedures. As Goldfried and Davison (1994) wrote, the "truly skillful behavior therapist is one who can both conceptualize problems behaviorally and make the necessary translation so that he interacts in a warm and empathic manner with his client" (p. 56).

Prior to and consistent with some of the previously presented research findings, psychodynamically oriented therapists have also held responsible psychotherapist hostility, blaming, and poor management of countertransference for negative outcome and/or premature termination (Ferenzi & Rank, 1923; Freud, 1910/1958, 1937/1964; Gelso & Hayes, 2007; Greenson, 1967; Kernberg, 1965, 1975; Kohut, 1979; Strupp, 1973; Wile, 1984; Winnicott, 1949). For example, Freud (1937/1964) and others (e.g., Greenson, 1967) have highlighted the potential danger that exists when the psychotherapist is engaging in psychotherapy and pursuing certain interventions as means of reparation for his or her own feelings of guilt or hostility. Consequently, psychotherapy becomes more about the psychotherapist's issues than the client's. On the basis of his own clinical observations and those of colleagues, Greenson (1967) stated that negative therapist traits, such as the tendency for hostile withdrawal, are likely to produce realistic reactions in the patient that are detrimental to the treatment. Additionally, in his article on accusatory interpretations, Wile (1984) noted that aside from a particular countertransference issue or the therapist's actual intent, many traditional analytic interpretations can be perceived by clients as harsh criticism.

The fact that the potentially detrimental effects of particular relationship attitudes and behaviors have emerged from both clinically/conceptually and empirically converging sources of knowledge should be emphasized in clinical training. With more caution, supervisors should also consider clinical observations and theoretical guidelines that have yet to receive sufficient, if any, empirical attention. For example, Safran and Muran (1996) have delineated a number of principles that could help trainees to anticipate and/or avoid deterioration of the therapeutic alliance, such as maintaining a balance between activity and receptivity, being aware of specific types of alliance ruptures that are likely to emerge in particular forms of therapy, and carefully preparing clients for termination. Faced with a paucity of relevant research, supervisors can, fortunately, take into account the recommendations of experts to help their trainees avoid relationship pitfalls and treatment failures when working with clients from a different cultural background (e.g., Draguns, 1996, 1997).

Technical variables. After years of clinical and training experience, astute psychotherapists and scholars have observed and no doubt themselves committed technical mistakes. Informing trainees, in an explicit and systematic manner, of these painfully learned lessons might reduce the probability of the unnecessary repetition of inefficient, unhelpful, and potentially harmful interventions. As we suggested earlier, the problems associated with some PHTs might not rest with the therapy procedure but rather the failure to use it in a clinically astute and/or theoretically sound way.

Some of these technical faux pas cut across divergent theoretical orientations. For example, prior to the empirical observations in cognitive therapy and psychodynamic therapy described above, clinicians of different orientations have ascribed negative effects to therapists' technical rigidity (Strupp & Hadley, 1985). In addition, both psychodynamic (e.g., Greenson, 1967) and cognitive–behavioral (e.g., Foa & Rothbaum,1998) clinicians have argued that treatment failures are occasionally attributable to inadequate assessment, either because psychotherapists have misidentified the client's most critical problem and/or because they failed to evaluate carefully important aspects of the client's traits or personality (see also Strupp & Hadley, 1985). It is interesting that different theoretical principles underlying these two approaches can lead to converging practical guidelines. Psychodynamic scholars (e.g., McWilliams, 1999) have warned that helping clients to stop engaging in maladaptive behaviors without fostering more adaptive coping alternatives can be detrimental to outcome. Behaviorally oriented therapists have argued that constancy of behavioral covariation in human functioning should lead clinicians to predict that any modification of a specific behavior will increase and/or decrease other behaviors (Barbrack, 1985; Goldfried & Davison, 1994). The training implication of these two diverging theoretical and clinical perspectives is that to prevent nonresponsiveness, relapse, or unintended impact, trainees need to become aware of the importance of a comprehensive evaluation of the client's deficits, impairment, resources, and coping repertoire.

In addition to technical mistakes that cut across different orienations, clinicians and scholars of specific theoretical persuasions have identified procedural errors that can jeopardize change or lead to worse outcome. For instance, Freud (1913/1993) warned against the use of interpretation until a favorable rapport had been established with the patient, given that premature interpretations might trigger resistance, especially if they are accurate: "Usually the therapeutic effect at the moment is nothing; the resulting horror of analysis, however, is ineradicable" (p. 187). He further stated that therapists should remain prudent even as treatment progresses and offer interpretations only when the client is about to discover for him- or herself the meaning of a symptom or desire. Such a wise guideline may shine a "new" light on the finding that high levels of interpretation have sometimes been associated with worse outcome (Crits-Christoph & Gibbons, 2002).

From a humanistic orientation, Greenberg, Rice, and Elliott (1993) argued that the use of interpretations in experiential therapy can set the therapist up as an expert on the client's experiencing, causing the client to feel disempowered. On the basis of extinction theory, behavior therapists have argued that treatment failure (i.e., increased frequency of behavioral avoidance) is likely to result from too brief an exposure to fear stimuli (Foa & Kozak, 1986). As Lilienfeld (2007) has suggested, the theoretical principle of optimal exposure duration, which has received support in the basic research literature and is supported by numerous clinical observations (Foa et al., 1983; Rachman, 1983), most likely captures the mechanism of change (or deterioration) underlying several PHTs (i.e., expressive experiential therapies and relaxation treatments for panic-prone clients). It is interesting to note that Freud (1919/1955) once stated, "Cruel though it may sound, we must see to it that the patient's suffering, to a degree that it is in some way or other effective, does not come to an end prematurely" (pp. 162–163).

As a complement to PHTs, the identification of both common and unique technical errors can provide specific guidelines that go above and beyond the proscription of (or warning against) global treatment packages. We suggest that the development of a comprehensive list of such mistakes, similar to the initial attempt offered by Kepecs (1979), would provide a contribution that would be as worthy to the field as Lilienfeld's (2007) PHT list. Supervisors and trainees could begin to construct such a list by first identifying mechanisms of change assumed to underlie major theoretical orientations (see Boswell et al., in press) and thereby derive from them those procedures and interventions that might hinder positive change or worsen outcome (e.g., procedures that prevent the exploration of previously unconscious wishes and fears, deepen emotional experience, or promote full exposure to fear structures). Another strategy, which may well lead to a convergent and complementary list of errors, is to collect clinicians' experiences and observations regarding what has prevented therapy, including treatments that have received empirical support, from working in their clinical practice.

Participant variables. Scholars and therapists have also warned against the detrimental or interfering impact of numerous participant variables long before empirical findings confirmed this clinical observation. A classic example is the client who first appears to be suitable for psychoanalytic treatment but, as the treatment progresses, appears unable to sustain the work required and displays clear signs of psychological deterioration (Fenichel, 1945; Greenacre, 1959). Freud's (1916/1963) initial distinction between transference and narcissistic neuroses and the observation of patients who appear to fall between neurotic and psychotic psychological structures helped pave the way for the contemporary diagnosis of borderline personality disorder (Gunderson & Singer, 1975; Stern, 1938). There is now substantial evidence, across a number of Axis I disorders, that individuals with borderline personality disorder (and other personality disorders) tend to have poorer psychotherapy outcomes and have a higher risk for prematurely dropping out (see Clarkin & Levy, 2004). Thus, even when using an empirically supported therapy, psychother-

apists must carefully assess whether a personality disorder is present and take the disorder into account when helping trainees to anticipate and prepare for treatment modifications, less than optimal change, nonresponsiveness, or even deterioration of some of the clients that they will be treating. For example, Greenberg et al. (1993) suggested that individuals with borderline personality disorder require a modified form of process experiential therapy, with less focus on the specific use of tasks, especially early in treatment, and more emphasis on relational conditions.

Clinicians' assertions, made across divergent theoretical perspectives (Foa & Emmelkamp, 1983; Strupp, 1973; Strupp & Hadley, 1985), that client lack of motivation is a predictor of poor outcome have now also received empirical support (see Clarkin & Levy, 2004). Other client characteristics also potentially pose obstacles to therapeutic benefit and can be derived from the theoretical and clinical literatures, such as lack of depression and anxiety, an extreme level of interpersonal dependency, and low ego strength, as well as high degrees of antisocial, paranoid, psychotic, and masochistic features (Aichhorn, 1925; Cleckley, 1976; Kniskern & Gurman, 1985; McWilliams, 1999; Strupp & Hadley, 1985; Wolberg, 1967). This is not to say that a list of these and other conceptually and clinically derived variables should be adopted by training programs as definite counterindications for psychotherapy interventions. As cogently argued by Strupp (1973), although a psychotherapist should take into account indicators of a less than favorable prognosis, he or she must not "let irrational personal attitudes about the treatability or non-treatability of certain patients and clinical conditions influence the best technical efforts he [or she] might otherwise put forth" (p. 499). Nevertheless, assuming that some of these variables have been observed by different therapists, it might be wise, especially considering the less than optimal state of current empirical knowledge about how psychotherapy works, to expose trainees to lessons learned by their more experienced colleagues. As we noted earlier, psychotherapist trainers also need to help trainees be prepared for particularly difficult clients, such as by adopting reasonable expectations about therapeutic gains, anticipating alliance ruptures and difficulties in implementing treatment plans, and planning for extra supervision sessions.

Experienced scholars and therapists have also identified client characteristics that may be indicated for particular types of treatment to work. For example, relying in part on his "four decades of reading of the professional literature" (p. 258), Bohart (2007) described several client characteristics that may facilitate or impede insight in psychotherapy. Most of these still await specific and strong empirical support, such as psychological mindedness, experiencing, creativity, and cognitive development.

Likewise, not all psychotherapists are optimal agents or facilitators of change. As we mentioned above, although it is known that psychotherapist effects are a strong predictor of change (Wampold, 2001), research has yet to establish, strongly and unambiguously, what are the personal characteristics that make some psychotherapists more effective than others, across different forms of therapy or within specific approaches (Wampold, 2006). Moreover, what may be particularly troubling is that there has been a drastic decline over the last two decades in research on psychotherapist traits (e.g., personality, well-being, values, race or ethnicity; Beutler et al., 2004).[3]

Accordingly, supervisors and trainers are more or less left to rely on the clinical and theoretical literatures to help them identify trainees who may be at risk for or prone to less than optimal or harmful effects in therapy. Many warning signs have been voiced in these literatures. According to Wolberg (1967), for example, therapist traits or characteristics that "have been shown by experience to be damaging to good therapy" (p. 390) include, among other things, a tendency to be domineering, pompous, authoritarian, detached, passive, oversubmissive, or lacking in or not compensating for basic satisfaction in living (related to issues of sexuality, hostility, or prestige); an excessive need to be liked or admired; perfectionism; creative inhibition; a poor sense of humor; an inability to receive criticism, accept self-limitation, or tolerate blows to self-esteem (e.g., when faced with resistance); and a low level of personal integrity. To this list, one could add a broad array of personal, interpersonal, intellectual, and professional deficits, such as restricted self-awareness (Freud, 1910/1958; Greenson, 1967), difficulty tolerating negative emotion (Strupp & Hadley, 1985), and an inability to address appropriately and to correct errors committed during treatment (Greenson, 1967). Although they should be considered cautiously until supported by solid empirical evidence, some of these warning signals might help trainers raise their awareness of and/or become more explicit about the criteria they are using in making some of the most important decisions for their respective programs and the future of the field: Who are the students who should be selected and retained?

The clinically and/or conceptually derived guidelines mentioned above are only a few examples of a rich diversity of recommendations that, when considered cautiously and used flexibly, may help trainees reduce or prevent harm that can result from their efforts to help clients. The time might be right for a more systematic and comprehensive identification of such guidelines, which could be derived from consensus among experienced clinicians of diverse theoretical persuasions about what works and what interferes with psychotherapy. Guided by the infrastructure of the task force previously mentioned (Castonguay & Beutler, 2006), this effort could focus on the role that participant, relationship, and technical variables play in the treatment of different disorders (i.e., depression, anxiety disorders, personality disorders, and substance use disorders). A comparison of the findings of such a consensus-building effort with the results of the previous task force may not only highlight points of convergence between clinicians' observations and empirically derived principles

[3] We are grateful to Bruce Wampold for pointing out this important conclusion from the recent empirical literature.

of change but also suggest an agenda for future research aimed at resolving discrepancies among conclusions derived from different sources of knowledge, as well as addressing questions that have yet to be answered satisfactorily by these different epistemological pathways.

Training Guidelines for Evaluation of Harmful Effects

In addition to training students on how to prevent and/or repair harmful effects of psychotherapy, supervisors and trainers need to help students learn how to assess signs of improvement, the lack thereof, and deterioration. Lambert's (2007) research has established that providing therapists with simple and limited feedback about treatment outcome on a session-by-session basis can actually decrease the rates of deterioration. Lambert, Hansen, and Finch (2001) have made effective use of session-by-session color-coded markers signaling that the client is progressing adequately, that his or her rate of change is not adequate, or that he or she may terminate treatment prematurely or have a negative outcome.

Although research on such feedback has been conducted in different settings (e.g., counseling centers, outpatient clinics), it stands to reason that routinely gathering outcome data would be particularly relevant and helpful in training clinics. What better way to help an inexperienced psychotherapist learn what he or she is doing—or failing to do—that might facilitate or interfere with change than by monitoring, on a weekly basis, client change, positive or negative? Fortunately, a number of instruments have been designed to evaluate outcome in day-to-day practice, such as the Outcome Questionnaire (Lambert, 2007) and the Treatment Outcome Package (Kraus, Seligman, & Jordan, 2005). In addition, experts in the field have identified a list of optimal characteristics of outcome batteries that can help training programs decide which one to adopt. Optimally, the instrument(s) should be relatively brief and user friendly and acceptable to clients and therapists. The instrument(s) should assess strengths and resources, measure change in different problem areas and in different treatments, allow for repeated administration across or within clients and therapists, reflect bidirectional scores and changes that have real-life references (compared with normative data), and take into account the influence of pretreatment or case-mix variables (see Achenbach, 2005; Kazdin, 2005; Mash & Hunsley, 2005).

In addition to using outcome measures, trainers should consider having their trainees use, again on a weekly basis, instruments that can assess processes of change that are assumed to be predictive of improvement. For example, valid measures are available to provide feedback about the quality of the therapeutic relationship, the therapist's level of engagement, or the client's openness to his or her experience (see Greenberg & Pinsof, 1986; Hill & Lambert, 2004). Furthermore, brief and user friendly instruments have been developed to identify critical incidents during therapy. The Helpful Aspects of Therapy form (Llewelyn, 1988), for instance, can be used by both the client and the therapist to report (and later process in supervision and/or therapy) particularly helpful or hindering events that took place during the session. These and other process and impact measures can be optimal tools to help trainees become aware of when and how therapy is not working productively before poor outcome becomes a fait accompli. It should also be mentioned that clinicians and scholars have systematically delineated a number of indicators of detrimental and effective processes of change, which can help trainees to correct mistakes and/or to seize on critical opportunities to foster change. Examples of such helpful guidelines are Safran, Crocker, McMain, and Murray's (1990) markers of alliance ruptures and Mahrer, White, Howard, Gagnon, and MacPhee's (1992) list of good moments in therapy.

Both outcome and process measures should, of course, be used during the entire duration of students' training. As the trainees progress through their training careers, one would expect to see them increase their ability to foster effective processes of change (e.g., establish and repair alliances) and facilitate clients' improvement. In addition to providing a general and gradual assessment of therapeutic skills, the routine collection of process and outcome data could also be used to monitor trainees while they are working with clients and/or issues with which they are particularly unskilled and/or uncomfortable. All therapists have their own deficits and vulnerabilities, and one of the responsibilities of supervisors is to help trainees become aware of and show improvement in dealing with such difficulties. The use of both process and outcome measures could help trainers and trainees to examine, specifically and systematically, whether particular deficits or vulnerabilities (e.g., addressing sexual issues, working with an authoritarian client, confronting resistances) actually interfere with client progress and well-being. The continual use of such assessments during the course of his or her graduate career could reveal whether strategies used by a student (e.g., personal therapy, additional and systematic training in a particular approach) have had a corrective impact and led to fewer toxic interventions and/or harmful effects. Needless to say, the use of such empirical data to improve one's personal and therapeutic skills, as well as to facilitate clients' improvement, allows for an intrinsic and simultaneous combination of science, training, and clinical goals. Moreover, fostering such seamless and synergistic integration as early as possible in the careers of current and future trainees might also have positive effect on the future of the scientist–practitioner model.

Conclusion

For the most part, students who enter graduate programs in clinical and counseling psychology believe that psychotherapy works. Indeed, we chose to enter such programs because we believed then (as we believe now) that psychotherapy is effective. One of the main things that many faculty members do in these programs (as do the four of us who currently have such positions) is to make the students aware of the data that support this belief, as well as to teach them about how and under which circumstances psycho-

Table 1
Working List of Psychotherapy Training Recommendations for Minimizing Potentially Harmful Effects

General recommendations	Examples of specific recommendations
Overarching principles	Expose trainee to evolving list of potentially harmful treatments and encourage him or her to approach the list carefully (e.g., with an eye on specific interventions that may be particularly harmful, as well as on others that may not be detrimental for all clients) Help trainee learn to monitor change, lack of improvement, and deterioration Help trainee learn to conduct a comprehensive psychological assessment[a]
Enhance therapeutic relationship	Help trainee to establish and maintain a good therapeutic alliance Help trainee experience and communicate empathy for his or her client
Use techniques skillfully and appropriately, including interventions prescribed in empirically supported treatments	Help trainee to foster sufficient exposure to unpleasant situations when conducting behavioral therapy Help trainee learn to deliver interpretations after establishing a good working alliance in psychodynamic therapy[a] Help trainee to avoid providing interpretations when conducting experiential therapy[a]
Prevent and repair toxic relational and technical processes	Help trainee learn to measure the alliance and to explore his or her own contribution to alliance problems (e.g., hostility toward his or her client) Help trainee become a participant–observer of the therapy process and to metacommunicate about the unfolding therapy process, especially during impasse Help trainee avoid relationship pitfalls when working with clients from different cultural backgrounds[a] Help trainee increase self-awareness and countertransference management skills Help trainee avoid using confrontational self-disclosure Help trainee become aware of instances where inflexible adherence to techniques threatens the alliance. He or she should be trained to use potentially helpful interventions in a clinically flexible and sensible way
Treatment choice, implementation, and expectation should be adjusted to client characteristics and/or problems	Help trainee be aware that some clients (e.g., clients with a diagnosis of personality disorder, depressed clients with high level of perfectionism) are likely to require longer and/or modified forms of psychotherapy Help trainee be aware that other client characteristics (e.g., lack of depression and anxiety, extreme level of dependency) may require him or her to adopt reasonable expectations about outcome and anticipate alliance ruptures[a] Help trainee be aware that clients with high levels of reactance are not likely to benefit from directive forms of therapy and that clients with low levels of reactance are not likely to benefit from nondirective treatments Help trainee be aware that some clients (e.g., with low levels of cognitive development) may not benefit from treatments aimed at fostering insight[a]
Some therapists may be less effective (and/or produce more harmful effects) than others	Help trainee with anxious attachment style become aware that he or she may be vulnerable to engage in less empathic exchanges Help trainee increase self-awareness of his or her hostility toward him- or herself and potentially steer toward own personal psychotherapy Help trainee be aware that other vulnerabilities (e.g., excessive need to be liked or admired, inability to receive criticism, difficulty tolerating negative emotion) may reduce his or her ability to help the client and/or damage the client's well-being[a]

[a] Clinical–theoretical recommendation for which we are not aware of empirical support.

therapy works best. However, with the evidence of deterioration reported over several decades, it is also imperative to inform students that all psychotherapists are at risk of observing, and in some cases being in part responsible for, harmful effects experienced by clients. On the basis of a thoughtful and systematic review of outcome findings, Lilienfeld (2007) is allowing trainers to go one step further. Trainers now can and should inform students that several forms of treatments currently used by mental health professionals have been identified as potentially harmful for some clients. If considered carefully and flexibly (as should also be done with empirically supported treatments), the list of PHTs can provide valuable guidelines about what not to do with some clients and/or under some circumstances. The primary goal of the present article was to develop (on the basis of research, clinical observations, theoretical premises, and the combination of these different sources of knowledge) a set of training implications complementary to

PHTs. Far from being exhaustive, the implications that we discussed above can be clustered within one set of overarching principles and five general guidelines that emphasize the importance of (a) enhancing the therapeutic relationship, (b) learning to use techniques skillfully and appropriately, (c) preventing and repairing potentially toxic technical and relational processes, (d) adjusting treatment (selection of approach, implementation, and/or expectation about its outcome) on the basis of client characteristics and/or problems, and (e) identifying and addressing therapist characteristics that may make them less effective (and/or produce more harmful effects) than others. These recommendations, as well as specific examples for each of them, are listed in Table 1. Because the variables highlighted in these recommendations may be responsible for or contribute to deterioration observed in both potentially harmful and effective treatments, they should receive attention in all scientist–practitioner–based training programs.

What we have not done in this article, however, is describe how to select students on the basis of these implications, nor have we focused on how to train students. It is undoubtedly important, for instance, to train beginning students in helping skills (Hill, 2009; Hill & Lent, 2006) and self-awareness (Williams, 2008) to promote self-efficacy and mastery of techniques before they go on to learn psychotherapies, manualized or not (see Hill et al., 2008, for preliminary evidence of the efficacy of helping skills training). Considering the increasing pressures of accountability in the field of mental health, it should be a priority for clinical and counseling psychologists to develop and test training initiatives that are specifically aimed at reducing harmful effects. Among other things, these efforts will need to rest on theories of training that can guide trainers and trainees of different theoretical allegiances, such as Bandura's (1986) four components of effective training (instruction, modeling, practice, and feedback), as well as on relevant contributions of basic research (e.g., cognitive psychology's insights and findings about how individuals develop from novice to expert status; e.g., Dreyfus & Dreyfus, 1986).

To learn about and competently deal with potential harmful impacts, programs should carefully delineate the tasks involved in supervision and the required expertise of supervisors, as well as the personal and professional experiences that might be required for some trainees (e.g., personal therapy) or for all (e.g., experiential learning of such negative processes as the effect of empathic failure). Although daunting, the task of building such training programs is dictated by psychotherapists' first ethical responsibility to do no harm.

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