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Wisdom-Based Approaches to Psychotherapy: Challenging the Dominant Psychotherapy Culture

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WISDOM-BASED APPROACHES TO THERAPY: CHALLENGING THE DOMINANT PSYCHOTHERAPY CULTURE

by

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Dedication

To Sophia and Henry: The wisest decisions I've ever made.

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ABSTRACT

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This research study explores the construct of clinical wisdom and the ways it is enacted by psychotherapists who are seen as wise by their peers. In previous research, clinical psychologists have outperformed other professionals in wisdom-related tasks, suggesting that there is an aspect of wisdom that might be imparted by clinical training and practice. There is, however, virtually no research specifically addressing the development and enactment of wisdom in psychotherapy practice. Seventeen psychologists who were nominated multiple times by their peers as being "wise" participated in an interview on their understanding of wisdom within psychotherapy practice and training. The qualitative methodology of grounded-theory was used to analyze the data. Results indicate that clinical wisdom requires tolerating ambiguity in therapy, which is difficult in a psychotherapy culture that prizes ready-made answers. However, wise exploration facilitates the formation of a safe therapy relationship and directs the exploration of clients' vulnerabilities and ambiguities.

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Introduction

The Relationship between Wisdom and Psychotherapy

The quest to understand and gain wisdom has persisted throughout the ages, capturing the fascination of ancient philosophers such as Socrates (470-399 B.C.), Plato (428-348 B.C.), and Aristotle (384-365 B.C.) (Sternberg & Jordan, 2005). Also important throughout the ages has been the pursuit of individuals who embody wisdom and can impart this quality to others. In contemporary times, individuals often seek wisdom in order to focus on their own personal development, which can be facilitated via psychotherapy. In pre-modern times, however, members of a community sought counsel from religious leaders who offered wisdom in the form of rulings on how to behave, guidance on personal development, and knowledge regarding a deeper understanding of the world (Bowie, 2006). Later, in the shift from the pre-modern era to the modern era, faith-based inquiries were supplemented, and in many cases supplanted, by scientific reasoning.

The secularization of knowledge began in the Renaissance (Robinson, 1990) and was marked by the flourishing of empiricism. This shift is illustrated in the writings of Francis Bacon, John Locke, and David Hume (Robinson, 1990). As such, religion was no longer perceived as the ultimate authority, and science became the accepted source of guidance regarding the ways of the world and how one should live in it. Theorists (e.g., Taylor, 1991) describe how this cultural change encouraged the transfer of the role of the counselor from religious to secular contexts.

Another shift occurred with the dawning of the post-modern era in Western society during the 1950s and 1960s. During this time, the public became skeptical of

science's ability to resolve social issues, such as war (e.g., Lyotard, 1984; Tester, 1993). As society became more cognizant of the limitations of and conflicting findings from science (e.g., Kuhn, 1962/1970) confidence waned in its abilities to explain and resolve the many issues surrounding human existence. This time period spawned what Taylor (1991) refers to as "individualism of self-fulfillment" in which people were "called to be true to themselves" (p. 14). In present day, members of our culture pursue "individual fulfillment" from various sources of wisdom, often from disconnected secular fields (e.g., Giddens, 1991; Taylor, 1988).

The writings of Philip Rieff (1966) suggest that the rise of therapy stems from the weakening of religious tradition. Thus, whereas wisdom was once sought primarily through religious means, today the therapist is often who one turns to in a time of need. Giddens (1991) links the rise of psychotherapy to the "reflexive project of the self" that is a "phenomenon of modernity's reflexivity" and individualism (p. 180). Rose (1998) describes people in today's world as making "projects of themselves" who "work on their emotional world" to "maximize the worth of their existence to themselves" (p. 157). In essence, psychotherapists are looked upon as individuals who can use their wisdom to help others emerge as the "sane self in a mad world, the integrated personality in the age of nuclear fission, the quiet answer to loud explosions" (Rieff, 1966, p. 34).

Though psychotherapy is a contemporary means of helping individuals wrestle through such existential and personal dilemmas, the methods of doing so are heavily influenced by wisdom from teachings through the ages. Albert Ellis developed his Rational Emotive Behavior Therapy by drawing upon the philosophic teachings of Marcus Aurelius, Epictetus, Confucius, Lao Tzu, Buddha, and the Stoics by tying their

ancient wisdom to behavior therapy (Ellis, Abrams, & Abrams, 2009; Mishlove, J. 1999). Contemporary psychotherapies such as Dialectical Behavior Therapy (Linehan, 1993), Acceptance and Commitment Therapy (Hayes, Strosahl, & Wilson, 1999), and Mindfulness-Based Stress Reduction (Kabat-Zinn, 1982) draw upon Buddhist principles (e.g., regulation of attention, nonjudgmental awareness) as tenants of their therapies. Carl Jung was influenced by the writings of Immanuel Kant, tying analytical psychology to Kant's critical philosophy (Bishop, 1996). Experiential-Humanistic therapies draw upon the works of existential philosophers such as Kierkegaard, Sarte, Husserl and Heidegger, to name a few (Greenberg, Elliott, & Lietaer, 2003). Therefore, it is evident that the wisdom of ancient and continental philosophers and spiritual leaders extends into contemporary psychotherapy where therapists use this wisdom to help individuals with their timeless difficulties.

Defining and Distinguishing Wisdom

Throughout these different eras, the puzzle of defining the elusive quality of wisdom has endured. Socrates perceived wisdom to be a quality that only God possessed, and believed that humans could only be "lovers of wisdom" (Adler, 1952). His student, Plato, understood wisdom as being concerned with the "ultimate meaning of life" and the "virtue of reason" (Adler, 1952; Sternberg, 2005). As Plato's student, Aristotle described wisdom as being the "highest form of knowledge" (Sternberg, 2005).These early understandings positioned the quest for wisdom as an important human goal.

Still in contemporary times, wisdom is not a concept easily understood, and there have been many attempts to define this construct within a psychological framework. Smith and Baltes (1990) have described wisdom as understanding the fundamental

pragmatics of life, including the areas of life planning, life management, and life review. Some theorists such as Kramer (1990) identify aspects of wisdom such as giving advice, as well as integration of emotion and cognition as being central to the construct (Clayton & Birren, 1980; Holliday & Chandler, 1986). Kitchener and Brenner (1990) understand wisdom as having characteristics of "reflective judgment" (p. 216). They also relate wisdom to solving ill-defined problems while Arlin (1990) associates wisdom with problem-finding ability. Interestingly, many of these definitions seem to describe common psychotherapy goals.

As illustrated by the many definitions of wisdom, the amorphous nature of this construct is difficult to pin down. Researchers have sought to understand wisdom by distinguishing it from a related construct -- intelligence. Sternberg (1998) is a leading researcher on wisdom, and has examined the associations and differences between this construct and intelligence. He defines wisdom as a deeper understanding of reality used towards the common good encompassing the defining characteristics of concern for others, psychological understanding of others, capacity for self-knowledge, the ability to reframe information, the ability to take the long view of problems, readily admitting to and learning from mistakes, maturity, intuition, and the ability to "see through" situations and circumstances (1990). However, Sternberg (2004) asserts that intelligent people are not necessarily wise. He also proposes that intelligent people are more likely to engage in egocentrism, omniscience, omnipotence, and invulnerability. Therefore, Sternberg suggests that students should be taught how to use their intelligence and knowledge in a wise way. He states that "The processes of wisdom, intelligence, and creativity are the same. What differs is their use" (Sternberg, 1990, p.153).

Hanna (1995) contrasts these modalities, describing wisdom as a metacognitive process and intelligence being a process attuned to analysis and recall of knowledge. Also, while wisdom is related to deeper understanding, intelligence is more related to breadth of understanding. Furthermore, ambiguity is tolerated within wisdom, but not intelligence, where ambiguity is a problem to be solved. Sternberg (1986) also notes that wisdom entails "sagacity", an element that is not essential to intellect (p. 186). In other words, those who are wise must be skilled in listening, weighing advice, and interacting with a variety of people. Furthermore, Sternberg (1990) recognizes that the wise person "*resists automatization of thought but seeks to understand it in others"* whereas the intelligent person "*welcomes*" such automatization (p. 153, italics preserved). Lastly, Sternberg (1998) proposes that while intelligence includes the ability to problem-solve and think within context, wisdom embodies the ability to move beyond this realm and surpass the contextual limits. He also underscores the relationship between emotional intelligence and wisdom, with the ability to regulate, judge, and understand emotions being an important part of this construct.

Wisdom in Psychotherapy

Hanna and Ottens (1995) surmise that psychotherapists need the capacity for intelligence, but that wisdom also is especially needed to help the therapist navigate through difficult situations in therapy, and to guide therapists' abilities to execute proper timing with clients. Furthermore, they theorize that traditional research measures in psychology are based on a model of intelligence, whereas psychotherapy often calls for a therapist to use wisdom-based knowledge. They argue that this incompatibility leads practitioners to rarely utilize research results (Cohen, Sargent, & Sechrest, 1986;

Morrow-Bradley & Elliot, 1986; Stricker, 1992) and instead seek counsel from colleagues when difficulties in therapy arise (Morrow-Bradley & Elliot, 1986). Hanna and Ottens suggest that qualitative research studies (as the one here) may help "close the gap" between psychotherapy research and practice (p. 211).

Though empirical research directly linking wisdom to psychotherapy is rare, Kramer (1990) and Pascual-Leone (1990) view wisdom as a trait that would be valued in a counselor, and Karasu (1992) states that wisdom is quite valuable within the therapeutic realm. Empirical support for these assertions can be found in the body of research conducted by Baltes and his colleagues, who have examined the link between professional expertise and wisdom. Their first study assessed wisdom-related responses of participants who were asked to think-aloud about a life-review task (Staudinger, Smith, & Baltes, 1992). Participants in the study included professionals from both human service and nonhuman service fields. Wisdom was assessed on the following criteria: factual and procedural knowledge about life, life-span contextualism (knowledge about how and why perspectives change across relationships and time), relativism of values (knowledge about how and why people hold different values, goals, and priorities), and management of uncertainty. Results demonstrated that participants in professions related to human services (including clinical psychology) were rated higher than their nonhuman service counterparts. However, it seems noteworthy to mention that overall scores in both groups ranged from low to average, with neither performing at a level considered wise (scores between 5 and 7 on a 7-point scale). The sample mean on the average wisdom score was 3.01 (SD = 0.96). Clinical psychologists' mean score was 3.63 (SD = 0.92) while the nonhuman service participants had a mean score of 2.74 (SD = 0.77). The

researchers stated that these findings were expected, as true wisdom is considered rare, with most individuals instead falling somewhere along the continuum of wisdom-related knowledge (Smith, Staudinger, & Baltes, 1994).

These findings were replicated in a subsequent study conducted by Smith, Staudinger, and Baltes (1994) when clinical psychologists and other professionals were rated on their responses to wisdom-related dilemmas. Once again, psychologists outperformed the control group of professionals with similar levels of education. This finding suggests that perhaps there is an aspect of wisdom-related knowledge that draws certain people to psychology or is taught to those in the psychology profession. Another finding in this study was that psychologists performed better on wisdom tasks in which the dilemmas were congruent with their own stage in life. Thus, older psychologists performed better on tasks related to late-adulthood, and younger psychologists answered more wisely about dilemmas of early-adulthood.

Further research by Baltes, Staudinger, Maercker, and Smith (1995) found that older clinical psychologists, as well as wisdom nominees outside of the field of psychology, outperformed the control group of young and old educated individuals. This study reaffirms previous findings regarding clinical psychologists' abilities on such tasks, but introduces the notion that lay persons who are nominated as wise perform as well – supporting the idea that nominators can recognize wisdom in others. In this case, the nominators were reputable journalists from various media who were asked to identify "wise" citizens of Berlin who were active in public life. The clinical psychologists in the study outperformed the wisdom nominees in the life planning task, however, which suggests that training in this area may be an advantage. Another study by Baltes and his

colleagues found that training and practice in clinical psychology was a predictor of wisdom-related performance (Staudinger, Maciel, Smith, & Baltes, 1998). In this same study of professionals and clinical psychologists, factors such as personality and intelligence also were explored in relation to wisdom. Findings showed that personality variables were stronger predictors of wisdom than intelligence variables. Personality predictors included openness to experience and midrange scores on the introversion-extroversion continuum. This finding lends credibility to Sternberg's model of wisdom in which ambiguity is welcomed and tolerated (1990).

Further research conducted by Staudinger and Baltes (1996) examined the relationship between interactive minds and wisdom-related performance. The construct of interactive minds "implies that the acquisition and manifestation of individual cognitions influence and are influenced by cognitions of others and that these reciprocal influences between minds contribute to the activation and modification of already available cognitions as well as to the generation (development) of new ones" (p. 746). This topic is of relevance to psychotherapy in that the therapist-client relationship is essentially a setting in which interactive minds are present and engaged. Staudinger and Baltes found that wisdom-related performance was enhanced by a social-interactive setting or an imagined social context. Thus, even imagining the opinions of valued others was important in increasing wisdom-related ability. Another factor highlighted in this study was the role of time for participants to reflect and review the input from another's mind, which also positively influenced wisdom-related performance.

Study Objectives

The aim of this research study is to provide an understanding of wisdom and how it functions within psychotherapy. Qualitative research is useful in this endeavor in that it entails a more "human science approach to social science" (Rennie, 2002, p. 117) in which the lived experience of each participant is used to develop a model of wisdom. It is the hopes of this researcher that taking a qualitative assessment of this complex phenomenon will generate suggestions for the practice and teaching of psychotherapy, as well as future directions for empirical exploration of this construct.

Method

Participants

Researcher. The researcher of this study is a 28-year-old, Caucasian, female doctoral student in clinical psychology at the University of Memphis. Her undergraduate studies in psychology were completed at Mississippi State University. The researcher served as a guidance counselor for three inner-city schools and also worked with emotionally disturbed and at-risk youth at several Youth Villages group homes in Memphis. The researcher is primarily interested in humanistic and constructivist therapies, but uses integrative modalities in her practice as a student-therapist. Before the completion of this qualitative study, the researcher did not have specific ideas on how wisdom processes are utilized by wise therapists, but believed that this quality was important in facilitating an optimally meaningful and successful psychotherapy experience for clients.

Interviewees. The 17 interviewees in this study (see Table 1) were psychotherapists nominated multiple times by other professionals in their field times as

being “wise”. In all, approximately 400 individual leaders of national, state and city psychology organizations were contacted by e-mail and asked to nominate psychotherapists whom they believe embodied wise qualities and use wisdom in their practice, with the request that they send on our call to their members. Nominations were also sought from approximately 140 psychotherapy-related organizations (and the request for them to forward our call to their members) as well as approximately 20 psychology groups with minority interests (e.g., Society for the Psychological Study of Lesbian, Gay and Bisexual Issues, Association for Women in Psychology). Approximately 10 APA psychotherapy related journal editors were contacted, as were 64 counseling psychology and 178 clinical psychology doctoral programs. Thus, the researcher sought variety in her sample with regards to age, race/ethnicity, gender and psychotherapy orientation, yielding approximately 300 nominations. The following letter/e-mail was used in the recruitment process:

Dear [Professional],

I am a doctoral student in clinical psychology at The University of Memphis. I am working under my psychology professor, Heidi Levitt, Ph.D., in conducting a project funded by a grant from The University of Chicago Arete Initiative to study how wisdom is enacted within psychology. To accomplish this end, I am trying to identify psychologists who are thought to enact wisdom within the practice of psychotherapy. Because of your position as an officer of [professional organization], I was hoping that you might assist me in identifying psychologists who you think demonstrate professional wisdom or who are known for enacting wisdom in psychotherapy. The practice of professional wisdom is quite broad and nominations are not meant to be confined to any

one demographic group (e.g., age, gender or race/ethnicity). If you could let me know the names and professional affiliations of any such individuals, I would be most grateful. Individuals who are nominated most frequently will be invited to participate in this study and to be interviewed. The results of this study are meant to further knowledge of how wisdom takes form within psychotherapy and I'd be glad to send you a copy of the findings, if you are interested. I appreciate any suggestions you have and thank you earnestly for your consideration.

Sincerely,

Elizabeth Piazza-Bonin, B.S.

Heidi M. Levitt, Ph.D.

All 19 of the psychotherapists who received multiple nominations were invited to participate in an interview, with 17 therapists accepting our request. The following e-mail/letter was used contact potential interviewees:

Dear [Professional],

I am a doctoral student in clinical psychology at the University of Memphis. I am working under my psychology professor, Heidi Levitt, Ph.D., in conducting a project to study how wisdom is enacted within psychology funded by a grant from The University of Chicago and the John Templeton Foundation Arete Initiative. To accomplish this end, I have asked your peers in [professional organizations] to help me identify psychologists who are thought to exemplify wisdom within the practice of psychotherapy by making nominations of wise psychologists. Your name was one of the names nominated most frequently as someone who exemplifies professional wisdom. At this point, I would like to invite you to participate in an interview as one of approximately 20 participants in your

field who exemplify wisdom in psychotherapy. I would be very honored to speak with you and to hear your thoughts about bringing wisdom to bear upon psychotherapy and about the potential to train other psychotherapists to do so. Your ideas, along with those of other nominees, would contribute towards furthering the knowledge of how wisdom takes form within psychology. The interview should take approximately one hour. I would be glad if you would be willing to have your name used in conjunction with your interview, but am willing to have your interview be anonymous if you would prefer. I am very interested in speaking with you and listening to your thoughts on the role of wisdom within psychology. I would be glad to answer any questions you might have or to arrange a [phone] discussion to provide additional information on the interview. If you could provide a time or two that might work and a phone and fax number, I would be pleased to schedule to call you at your convenience and send a consent form with additional information about the study. In any case, I am glad to communicate to you the respect of your peers who have nominated you as a psychologist who epitomizes wisdom.

Sincerely,

Elizabeth Piazza-Bonin, B.S.

Heidi M. Levitt, Ph.D.

The researcher gathered participants' demographic information by collecting data via a brief questionnaire asking about qualities such as age, race, gender, professional specializations, years of professional practice, psychotherapy orientation, and professional organizations they are involved in (see Appendix B). All of the 17 psychotherapists who agreed to participate were interviewed. The data reached saturation

at interview 15, meaning that subsequent interviews did not add any novel information to the hierarchy, signaling a comprehensive analysis.

Procedure

Recruitment. Leaders and professionals in the field of psychology were asked to identify those psychotherapists who enact wisdom in their practice. Individuals who were nominated multiple times were contacted via email or telephone to be invited to participate in the interviewing process.

Interviews. Interviews were conducted by phone, with the exception of one local participant who was interviewed at his office. The interviews were approximately one hour in duration and a definition of wisdom was not provided by the interviewer. The goal, instead, was for the interviewees to reflect upon their own concepts of wisdom and explore the ways wisdom is present in their work as psychotherapy professionals. The focus question provided in each semi-structured interview was "How do you enact wisdom within your profession and how do you think professionals in your profession can become wise?" Additional questions were asked to help clarify the role of factors (personal, interpersonal and systemic) that could influence wisdom. The interview protocol served as a guide to generate questions during the interview (see Interview Protocol, Appendix A).

The interview questions were generated in light of present research on wisdom as it relates to psychology and psychotherapy. These studies have examined the relationship between wisdom and various constructs such as age, personality, intelligence, and emotion. Due to the scarcity of research on wisdom in psychotherapy, some of the questions included in the interview protocol were designed to explore professionalization

factors (e.g., systemic factors) that had not been empirically studied in relation to wisdom and how these could hinder or promote clinical wisdom.

Qualitative Method

Grounded Theory Analysis. Grounded theory analysis (Glaser & Strauss, 1967) is a methodology that utilizes inductive analysis to explore subjective experiences (e.g., Rennie, 2000). It is used to develop a model of a phenomenon by identifying patterns or commonalities in a dataset without limitations from predetermined hypotheses. The rigorous nature of this method makes it one of the most respected and widely used qualitative methods in the field of psychology (Fassinger, 2005).

The approach to grounded theory used in this project was developed by David Rennie (e.g., Rennie, Philips, & Quartaro, 1988). After transcribing each interview, the Nvivo 8 software program was used to aid in organizing the information throughout the analysis of the data. Each interview was examined, first dividing the text into singular units of text containing one meaning--that is, *meaning units* (Giorgi, 1970)--relevant to the topic of wisdom. These meaning units then underwent constant comparison and were subsequently organized into categories based on similar meanings of text. In turn, the categories generated were analyzed and, based upon commonalities therein, organized into more abstract, higher-order categories. This process was repeated with further interviews until *saturation* was reached at interview 15, and no incoming interview data seemed to add new meaning to the categories. The hierarchical structure ultimately produced a core category that represents the lived experiences of the interviewees.

In order to limit the researcher bias on the data, any personal beliefs or assumptions about the data were recorded by memo writing throughout the research

process. This form of documentation aided in limiting any potential biases, guiding the researcher to become aware of the ways her ideas might influence the data and to think through how to limit this influence. As well, memos were used to keep a detailed record of the analytic process and theory development.

Credibility checks. The researcher implemented three credibility checks to assess the accuracy of the data. First, participants were given the opportunity at the end of each interview to provide any further information that seemed relevant to the interview. These questions (i.e., "Was there anything that we didn't discuss that you feel is relevant to share?" "Do you feel that you would have answered the questions differently if I were your peer?" "Are there any ways in which you think I could improve this interviewing process in the future?") helped the researcher to address any topics that were initially omitted.

The second credibility check used was the review of the research analysis and process of with a co-investigator who is knowledgeable in the grounded theory method and who conducted the majority of the interviews. This step provided an opportunity for the perspectives of other research team members to contribute their understandings of the complex nature of the data and to demonstrate that researchers with unique perspectives can share an interpretation of the data (Hill, et al., 2005).

The third credibility check utilized participant feedback to review the proposed model of wisdom. All of the interviewees consented to being contacted following the initial analysis, and were provided a written summary of the findings and asked to provide feedback, with 6 responding to our request. The feedback was positive overall, with some suggestions for slight modifications (which will be further discussed in the

results section). Participant Paul Leonard commented on the results saying, "Your work is very important. I wish these issues were addressed earlier in my training. Hopefully, your work will help future therapists, although as we know, they must struggle to grow, much like our clients" (personal communication, October 2010). Christine Courtois also remarked, "I appreciate your findings…. I will seek to use your information in some of my training, hoping to pass on the wisdom of colleagues" (personal communication, October 2010). The positive feedback was received from participants across orientations, which helped to increase our confidence in our results.

Results

Participant interviews were transcribed and then divided into 742 meaning units (775 when counting meaning units that were duplicated in the process of analysis). A hierarchy was developed containing 7 levels. The core category that emerged from this analysis contained four clusters. These clusters subsumed 11 categories, which encompassed themes from 27 subcategories. This section will review each cluster in turn followed by a description of the core category. Similar to Hill's categorization system (Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996) the words "few" will refer to 1-3 therapists, "some" to 4-8 therapists, "many" to 9-11 therapists, "most" to 12-16 therapists, and "all" to 17 therapists.

Cluster 1: Overcoming a Fear of the Dark and the Intimate: The Need to Move Beyond Intelligence Towards Wisdom Via Introspection and Lived Experience of Struggle

All the participants contributed to this cluster, describing the dynamic interplay between wisdom and intelligence, and the qualities that divide the two. Intelligence was

thought to facilitate the ability to learn theory and techniques, while wisdom guided the application of that knowledge in therapy. Participants described this guidance as based within emotional and social intelligence – a sensitivity to the emotional experience of clients and the ability to communicate powerfully given that context.

Category 1: Intelligence is not enough: Wise therapists need emotional intelligence grounded in difficult life experiences to better understand experiencing and working through pain in order to help clients learn from powerful emotions.

While many therapists (6 of 17) viewed intelligence as separate from wisdom, others (11 of 17) expressed that intelligence was a necessary, but insufficient, underpinning of wisdom in psychotherapy. Most therapists (13 of 17) explained that to develop clinical wisdom, therapists needed not only intelligence but emotional intelligence. One participant said:

> I don't think you have to be genius level, but… you have to have a certain degree of intellectual capacity … but also emotional intelligence is critical… because you're… able to get into, um, sharing an affect state with them or maybe registering something that they're not registering and being able to feed it back to them…(Christine Courtois)

Another participant described the need to guide clients to explore intense emotion:

> You need the capacity to be in the presence of strong emotion and not go "Eek!" … to just be there… to be at home with somebody sobbing or raging or shaking in your office and say, "Alright.… You're having very intense feelings…. What are your intense feelings telling you? How can you notice that, pay attention to that? How can that give you information?" (Laura Brown)

The participants thought wise therapists would have the ability to not only tolerate strong emotion but the interpersonal sensitivity to guide clients who might be overwhelmed or threatened by these feelings to stay in contact with them in order to recognize their meaning.

The capacity for emotional intelligence was thought to be enhanced by therapists' personal experiences of loss and pain, helping therapists draw from their own struggles to understand the complexity within their clients' emotions. One therapist explained this, saying that therapists need

> An empathic ability to see it [a situation] from both sides…. [to have] emotional experiences with the fundamentals of life… birth, death, joy, grief, loss… [so] there's an emotional counterpoint, and it needs to be grounded… within sufficient emotional experiences. (John Norcross)

Another participant commented on attending to a wide range of personal emotional experiences to better understand clients' emotions:

> I don't think you can do it [learn about emotions] didactically… by sitting in a classroom… no more than you can sit in a classroom and learn about music and expect to be a musician…. You have to wind up playing the horn. You have to play the instrument…. It has to wind up being something that you allow to happen… and you're willing to explore, and revel in. And, that includes every kind of emotion from the most wonderful emotions… to the most horrible ones, because ultimately we're dealing with people's emotions, and we darn well better know what we're doing. (Frank Froman)

Therapists thought that connecting to the spectrum of their own emotional experiences, especially those grounded in life struggles, could help them guide clients in utilizing and understanding their own emotions more effectively.

Category 2: Wise therapist needs social intelligence: Intelligence alone can get in the way of wisdom because it lacks tolerance for the ambiguity and unpredictability of human beings.

The majority of participants (16 of 17) expressed that though a broad intellectual knowledge base was important -- especially for researchers and academics – it was even more valuable for therapists to have relational and social intelligence derived from their own life experience. Participants (2 of 17) even raised concerns that intelligence alone could impede wisdom when therapists are taught to provide quick answers rather than to tolerate and explore ambiguity in therapy. One interviewee described how this way of working with clients could interfere with the therapy process:

> I think that some of the really best researchers are really smart… [but they don't] quite get human beings… that you can't do procedures…. We [therapists] have plans for what *we're* gonna talk about when they come in for session… [but clients have] had a life! They have plans!.... They, uh, don't tell us stuff…. They actively lie to us… and I really love that about humans…. That's part about what I like about being a therapist is we're so juicily messy. And, for a lot of people that's like… "Please let's screen you out of my study. Let's make sure that there's nothing comorbid here!" (Laura Brown)

Exploration of clients' ambiguities and complexities was thought to help therapists adjust interventions so that clients might accept them and find them to be useful. In contrast, too

strong a drive for certainty and knowledge could close explorations and impair relational development if clients are not ready to accept the therapist's solutions.

Participants described that to develop wisdom as psychotherapists, it was important to extend beyond intelligence and the acquisition of knowledge towards developing social intelligence. One participant described how this skill could be useful in therapy:

> I did tremendous work in terms of my neuropsychology classes… understand[ing] why somebody is, um, experiencing these memory problems…. However, that knowledge I don't think is going to be, or that intelligence is going to be, useful unless I can convey some way to the individual I'm working with… what that knowledge means in terms of being more effective in their own life or dealing with [their] problems…. [An] understanding of people and why they act the way they do and feel the way they do is probably more important than informational knowledge… or the knowledge of different theories. (Mary Beth Kenkle)

Therapists described that social intelligence in therapy allowed for more effective communication with clients and also allowed therapists to apply their knowledge and intelligence in a way that is flexible enough to work with the complexities of human beings.

One therapist emphasized that experiencing being completely vulnerable in a relationship and negotiating states of conflict and feelings of rejection were prerequisites to the development of social intelligence. He explained:

> I can't see people having wisdom if they… haven't really lived an intimate relationship… [an] attachment relationship…. Having struggled to be intimate

with another… gives you an understanding of… life in a relationship… what they feel, or what they need, and what relationships are all about. (Leslie Greenberg)

Social intelligence was thought to provide a deeper understanding of how clients might negotiate both their personal relationship challenges as well as the dynamics within the therapist-client relationship.

Category 3: We must strive to know ourselves before we can know our clients: Pushing ourselves to be vulnerable and authentic about our own inner turmoil allows us to appreciate the human experience we all share.

Most therapists (14 of 17) expressed that their clinical wisdom was developed by going beyond textbook knowledge and pushing themselves to be vulnerable and authentic about their inner experiences, especially those that felt dark and uncomfortable to explore. This candid introspection was thought to aid therapists in connecting to their clients on a basic level of humanity. A therapist described finding this inherent commonality with clients by "show[ing] some willingness to be accessible, reachable, approachable. I am a flawed person like you are. The difference between you and me – the only difference that I'm really aware of right now – is that you're diagnosed and I'm not" (Stuart Krause). Another therapist articulated this need, saying that therapists should acknowledge that in everyone there is "an odious rage… that there is spite and vengeance and hate and jealously… [by] recognizing the darker part… helping people to integrate that rather than to deny it… to understand that that's what it is to be human" (Leslie Greenberg). Participants thought that being reflexive about their internal experiences, helped them go beyond an objective, intellectual appraisal of clients' difficulties to a joined understanding of clients' suffering and anguish.

Participants (12 of 17) suggested that self-reflection could come in many forms, with personal therapy being mentioned most often. Interviewees thought that both individual and group therapy could help facilitate therapists' process of introspection while also providing a firsthand look into the experience of being a client. One therapist explained how this novel perspective helped him gain a better appreciation for the client role:

> My understanding of how slow that process is… how, um, difficult, emotionally, it can be to introspect… I gained a lot of that, not from an intellectually distant study of therapy, but that state of being a patient… the affective progression of sloshing through that is very laborious… (Paul Leonard).

Another participant spoke of the value of becoming a client as a therapist:

> You have to be willing to constantly require yourself to do the same kinds of difficult tasks that your clients are doing with you… be open to change, take the risks that are necessary for growth, to feel feelings that you don't want to feel, to face challenges with courage and honesty. We ask our clients to do that every day. We have to be willing to do that ourselves. (Laura Brown)

Therapists expressed the value of trying on the client role, both gaining insight to their clients' experiences in therapy, and also connecting with their clients on the most basic level of human pain and struggle.

While therapists thought it important to develop an understanding of clients' difficulties, a few participants (2 of 17) highlighted the need to balance being empathic while maintaining a sense of boundaries when identifying with clients' stories. Beverly Greene, an African American psychotherapist, described how therapists from

marginalized groups might have an inherent capacity to develop this skill:

> When you're at the margin... you have an opportunity to see the center from a distance.... what we call *therapeutic distance* is that capacity to be emotionally present and available in the present…and to take a step back and sort of be able to look at the interaction as its taking place…even though you're participating in it…. Stepping back and forth between those two positions with a client at any given time … we're sort of sitting both within the margin and the inner circle and the outside at the same time …having to be attuned to what's going on with a patient, but you have to have enough distance that while you can understand what the person is feeling.

Shifting back and forth in this manner requires not only the ability to intellectually assess the interaction between client and therapist, but the capacity for experiencing emotional contact with a client while reserving the distance to continue to guide the client forward – a capacity that was a result of wisdom.

The following principles were developed from cluster 1:

Principle 1.1: To develop clinical wisdom, therapists should learn to become comfortable with the ambiguous parts of themselves that they find most threatening so that they can better understand and relate to these aspects in their clients.

Principle 1.2: To develop clinical wisdom, therapists should learn about how the ways they relate to and are seen by others -- especially in long-term relationships. By becoming aware of and dealing with their own fears and struggles in intimate, vulnerable, and dependency-based relationships, they can better navigate their therapist-client relationships and understand their clients' relationship patterns.

One participant suggested a slight modification to the principles to emphasize ambiguity, which we agreed was helpful and changed, though this participant said he agreed with the overall theme.

Cluster 2: Staying with Vulnerability and Ambiguity Helps Therapists to work from within the Clients' Value Framework and Facilitate Openings for Either Acceptance or Change

Seventeen participants contributed to this cluster and described how they sought to create change in their clients while working from within clients' values and perspectives. Therapists described acting as a guide in the approach, encouraging clients to come to their own insights rather than attempting to foist solutions upon them.

Category 1: Therapists' valuing clients' authority begets clients' empowerment: Creating agency by advocating with, not for, clients, while utilizing their own values, preferences, and experiential wisdom in therapy.

Many participants (7 of 17) expressed adopting a more collaborative stance with clients to foster client empowerment in therapy. One therapist described how the clinically wise therapist navigates therapy in this manner:

> It's about being able to co-construct. I think I'm much less likely to go from A to Z with my patients than I used to be. I'm much more, "Let's figure this out together, and I'll help you to take the next step"…. I used to get more into making, you know, interesting interpretations…. [but] it was like "Ok, well, that might be right, but it's not helpful…. [instead we should] end up doing it together. (Nadine Kaslow)

Therapists who enacted a more collaborative stance with clients explained that when trying to facilitating change or acceptance, it was best for insights and solutions to unfold from clients. One participant said:

> There are two Latin verbs I use.... There's docere… related to a deficit model, that "I have what you need and I'm going to impart it to you"…. Then there's ducere... "to call forth from"… "to pull out of"…. A verb used to draw water from a well… [the latter is related to wisdom because] it's using the client's wisdom… taking advantage of a rather vast store of knowledge and experience that the person has. (William Miller)

Guiding clients to come to their own insights and meaning was thought to empower clients by helping them develop the ability and confidence to rely upon their own wisdom when confronted with problems outside of therapy.

Participants described helping clients tap into their internal wisdom by using experiential exercises in therapy. One therapist said:

> You can't say to people, "cheer up" if they're depressed, and you know, give them a book about … how to cheer up. The world is filled with a myriad of self-help books …. Still, people get caught up in affective states. So, if you want to do something that helps people to change, uh, a state, an emotion, you have to rely on methods that are more artistic... rather than using didactics. (Jeff Zeig)

He later described these artistic methods as coming from "lots of little experiential gains or moments you create in experiences by using… metaphors… allusion... anecdotes… poems…. The art of psychotherapy is how to make simple ideas come alive." Using creative methods that connect clients with their experiences in a vivid way was thought to

make them more memorable and accessible when clients needed to draw from these lessons outside of the therapy room.

A few participants (3 of 17) also thought that stimulating and sometimes challenging clients' thinking by posing novel, provocative questions could generate new ways of conceptualizing their struggles and their needs. One interviewee explained that therapists should encourage clients to "not just uncritically accept whatever it is they're told about themselves or the world. But, to use their own experiences and their own intuitions to… guide, supplement and evaluate that information" (Beverly Greene). This type of inquiry was thought to be especially important for clients from marginalized groups, helping them to articulate needs and feelings that might be disenfranchised.

Some therapists (6 of 17) said that working within clients' unique perspectives and values would not only make change in therapy seem less threatening to clients, but also prevent resistance when implementing change strategies. One participant explained, "Being wise is…. knowing how to say things in a way that other people can hear and… being able to adapt it so that they will hear" (Leslie Greenberg). By honoring instead of neglecting clients' values and preferences in therapy, clients would be more invested in the change process because solutions would fit within the complexities of their own cultures, social relationships, and pragmatic limitations.

While working with clients in this collaborative, egalitarian manner, some interviewees (4 of 17) described adopting transparency about issues that might be difficult to talk about but are important in the therapeutic relationship (e.g., rifts in the alliance, value differences). Being honest and upfront with clients, no matter how

challenging, was thought to create a more equal and respectful partnership that could further client agency.

Category 2: Shifting perspectives by exploring threat and uncertainty: A valuing of relational attunement over decontextualized intervention enactment.

Therapists described exploring clients' ambiguities and vulnerabilities for long enough to integrate new aspects of their experience into their understanding. Most therapists (14 of 17) described the wise therapist as lacking preconceived notions about clients, allowing them to explore these uncertainties and threats with respectful interest and unending curiosity. One participant said:

> Wisdom is knowing what you don't know…. Being able to trust that what's really important is what's happening in the relationship, and that you're not in charge of that…. You cannot know what's going to happen…. You have to be willing to trust the process rather than impose some kind of, um, presuppositions on it. (Laura Brown)

Therapists valued this relational attunement, humbly acknowledging clients as the owners and teachers of their experiences. A participant explained that therapists need to "be able to see it [the experience] from their [the client's] perspective…. Otherwise, you're not able to provide the kind of intervention that would… effect behavior change… and [generate] meaning for the client" (Jean Lau Chin). Another therapist said that the clinically wise therapist knows

> when to shut up…. The patient is going to inform you about what they are… which is not the same as acquiescing to whatever a patient wants you to do, but,

> you have to listen in order to understand. And, you shouldn't be acting on anything you really don't understand. (Beverly Greene)

Therapists thought that using their respectful curiosity and intrigue as guides in therapy would increase their attunement to each client's circumstances.

Therapists (6 of 17) also described forming meaningful connections with clients by taking time in therapy to hone in on what clients are communicating within session, attending to cues beyond the clients' words. One therapist articulated the value of this attunement, saying:

> Being able to slow them [clients] down…. [makes] the relationship become special. It's not just, um, "Here's what happened, here's my problem, nuh-duh-duh." It's more like, "Hold on. You just had a look on your face that didn't look happy. Can you tell me about that?" And then it becomes more real and genuine and deeper. (Paul Leonard)

Therapists thought that attending to clients in this manner could make clients feel genuinely cared for while also giving an opportunity to uncover important topics needing further exploration that might have been missed if the therapist were too focused on enacting a specific intervention. They said to do this work, it was important to focus on the alliance, valuing relational attunement above the drive to implement specific interventions.

Therapists (8 of 17) also described attentively responding to clients' hardships through an optimistic lens, even utilizing humor in the face of pain to provide new perspectives, hope, and perhaps acceptance, for clients. One therapist said that using humor with clients

> … gives them something which is unique and special to look back on… and… gives them a sense of hope…. When people are laughing… when they find humor in their situation… they learn to look at things in different ways…. It [therapy] should be extraordinarily memorable. (Frank Froman)

Therapists described using humor and optimism within the therapist-client relationship as an effective way of shifting clients' perspectives towards hope, outside of any particular interventions.

Category 3: Wise psychotherapists do not cling to standardized approaches to eliminate uncertainty because they understand that not having all the answers is often scary but necessary for attunement.

Most participants (13 of 17) discussed the value of humility in the wise practice of psychotherapy, acknowledging that clients are complex -- often beyond apprehension. Though participants valued being empirically informed, they tended to emphasize a greater need to be flexible with interventions and to use standardized approaches in more dynamic forms. One participant said of evidence-based therapy:

> It [evidence-based therapy] can have a lot of rigorous, black and white, methodological stuff going on. Well, I applaud that. I think it's a necessary, but insufficient condition, for real therapy…. There are some problems that evidence-based therapies don't touch anyway…. Not everything that a client walks in the door with, you can flip through your evidence-based manual and, "Aha! Here it is!" (Stuart Krause)

Participants (9 of 17) confessed that not having clear-cut answers could invoke fear in therapists, but that wisdom entails the ability to remain calm and adaptable in the face of

uncertainty (4 of 17). Therapists (5 of 17) described mitigating this fear by looking to their professional and personal ethics, morals, and values. One interviewee said, "I think wisdom comes with a kind of flexibility and creativity… and I can only be creative and flexible if I am confident that I can do that ethically [and] with integrity" (Nadine Kaslow). Participants thought that having solid moral and ethical groundings gave them a sense of direction when ambiguity arose in therapy, allowing them to be more adaptive with their interventions.

The following principles were developed from cluster 2:

Principle 2.1: Wise clinical practice entails staying with and exploring vulnerable aspects and ambiguous understandings of clients yet having optimism that new understandings and acceptances can best arise when the clients are able to wrestle with the difficult and uncertain within a safe relationship and work through these states.

Principle 2.2: Wise clinical practice entails coming to each client with curiosity and humility – accepting that you may not have any preconceived answers and being open to tailoring your practice to each client.

Principle 2.3: Wise clinical practice entails knowing that sometimes the answer may be facilitating acceptance of experience instead of change. The aid may be relational in which clients can develop self-acceptance as much or more than intervention-focused change.

Principle 2.4: Wise clinical practice is informed by empirical support but interventions are adapted creatively and flexibly to each client.

Principle 2.5: The psychotherapy relationship is a necessary component of treatment and so developing self-awareness of how one forms and engages in

relationships is crucial for therapists.

One participant provided feedback suggesting that we explicitly include mention of therapist's personal therapy in one of the principles. There were different perspectives about this idea in the data, however. Although the participants agreed that therapy was helpful, participants described many methods of learning to be self-aware (e.g., travel, reading literature, multi-cultural awareness, feedback from others) and some expressed concerns about the idea of mandating psychotherapy. Another participant suggested a principle stating more clearly "the first and necessary and often sufficient component of all psychotherapy treatment must be the therapist-client relationship, apart from any specified treatments that are implemented later" (personal communication, October, 2010). This feedback was consistent with the data in the hierarchy and led to the formation of principle 2.5.

Cluster 3: The Isolation of the Wise in the Psychotherapy Culture: Political and Personal Disincentives to Wisdom

This cluster included two categories that described the participants' (17 of 17) descriptions of difficulties that can arise, both politically and personally, from the increased valuing of intelligence in the psychotherapy culture, where ambiguity and uncertainty are frowned upon.

Category 1: Empirically-supported treatments and managed care have created a culture where medical-like interventions are valued over wisdom-informed approaches to therapeutic relationship, despite the latter having evidence of producing change.

When asked about ways the psychotherapy field influences wise clinical practice, many therapists (9 of 17) spontaneously commented upon the empirically-supported therapy movement, with all (17 of 17) participants expressing reservations in some form. Although the participants were in favor of seeking empirical support for therapy practices, there were concerns about the narrow understanding of empiricism as well as the role of interventions in therapy. Participants worried that this movement might encourage psychotherapists to become technicians, with standardized interventions being the focus of therapy at the cost of the relationship between client and therapist. An interviewee provided a firsthand account:

> If you're paying more attention to the manual than the client, you aren't doing it right. And, I wrote such a manual… that had a zero effect…. We did it in our clinic with therapists I personally trained… and we got absolutely no effect of motivational interviewing with the drug abuse population where other studies have found such an effect. And, I think the manual is the problem…. So if you write a manual I think it has to be done in a way that leaves enormous flexibility and emphasizes the interpersonal dance… responding immediately to what the client is telling you… not "In session 1 you do this"… and… "In session 2 you do this and this"… but rather, "Here's the style and here are the tools and pay very close attention to what your client is telling you" because that's what tells you where to go next. (William Miller)

Another participant highlighted the limitations of science, saying of the empirically supported movement:

It's an important movement. We need to try to figure out through research what works, but it's not the only way. We're not going to be able to study in my lifetime, or yours, enough detail about everything that is effective in terms of psychotherapy…. So I think it's really good to do the studies, it's really good to pay attention to them, and… it's not going to be everything. (Susan McDaniel)

Interviewees emphasized using the empirical literature to inform their treatments in combination with their own creativity and flexibility, especially for cases in which scientific data is limited.

Therapists (11of 17) raised concerns that standardized treatments might be used by clinicians in a wholesale manner, potentially making treatments less effective when they are applied without attention to client individuality or the therapeutic relationship. A participant expressed her fears that "[we are] in a world that just wants cookie cutter solutions to problems… reducing people to dollars and cents…" (Beverly Greene). She later said:

> Things that don't get talked about in the evidence based literature very often is the repository of literature that says regardless of your theoretical orientation, your relationship with the client is the factor that most affects outcome…. It gets convenient from time to time to sort of ignore it because that's not necessarily consistent with making money.

Participants spoke of the culture of managed care where motives are often profit-oriented, not client-oriented -- perhaps increasing the drive for researchers to produce manualized treatments. Participants described the deleterious effect that this culture has had on the profession, creating a division between researchers and practitioners. The

schism between psychotherapy cultures reflects differences in understandings of empiricism and the role of science within the therapy relationship. Instead of further dividing the field, it was suggested that psychotherapists embrace a wide range of practices and doctoral programs with different emphases. While these issues have been of increasing dispute in psychology, these participants emphasized the value of scientists and practitioners informing and supporting one another.

Category 2: Wise practice can be heavy and burdensome: Therapists must stay connected to professional community and maintain personal support systems to replenish that which they give to clients.

Many participants (9 of 17) described a greater exertion of time, energy, and emotion entailed in being a wise therapist. One participant stated:

> I've gotten feedback [from other therapists] that I have too much or try to do too much and I don't mean that in necessarily a rescuing way, but, I put a lot of myself into what I'm doing, and a couple of times therapists in groups have said to me, "You don't have to work that hard." (Christine Courtois)

Participants thought that practicing in a wise fashion entailed emotional contact and vulnerability with clients and so necessitated upholding boundaries with clients and finding activities and supports to meet their own needs. One therapist said that wise practice can feel "sacrificial", and needs to be balanced with seeking personal outlets for self-expression:

> [You] need some place in your life where you're also known…. It's possible to hide behind empathy if you get very good at listening. You don't have to do anything else. I mean, on the train to work or any place you are, if you listen to

> people they will talk to you and talk to you and tell you what a good conversationalist you are and you haven't told them a thing about yourself. So, it's important, I think, to have balance in your life somewhere where you make meaning, and where you have intimate connection and where people listen to you, and give you the same gift that you're giving to your clients. (William Miller)

On a professional level, interviewees (3 of 17) emphasized the need to find balance by staying connected to a larger community of therapists with whom consultation could take place. One participant thought a therapist struggling with a clinical case should " overcome his or her shame about… what they're doing or what their failures might be… and really need to seek out consultation" (Christine Courtois). Another therapist expressed concern for those who do not utilize consultation, saying, "Isolation means that you're only talking to yourself and you start to think you are smarter than you are…. You get overconfident, and therefore, you're not wise" (Laura Brown). Staying connected to both personal and professional ties were seen as crucial to practicing in a wise fashion because therapists then could provide optimal support for their clients.

The following principles were developed from cluster 3:

Principle 3.1: Wise therapists act as advocates for their clients with insurance companies and educators of these companies.

Principle 3.2: Wise therapists learn to set boundaries, and seek personal support and peer supervision so that they can put creative energy and emotional connection into therapy without becoming depleted or disenfranchised by a therapy culture with different values.

One participant commented on this cluster, suggesting more neutral language such as

"Beyond the Conventional" or "Beyond Convention" as opposed to this more politicized framing (personal communication, August 2010). Another participant said that this cluster was "spot on" (personal communication, October 2010) and the interpretation seemed to fit with other respondents' responses. However, no other specific feedback was provided about this cluster.

Cluster 4: Rewarding Questioning Rather Than Answering: A Radical Approach to Admitting, Assessing, and Training Therapists

Participants raised concerns that our current training processes emphasize intellectual achievement rather than the wide spectrum of processes that might be associated with wise clinical practice. This final cluster was organized into three categories, and represented the amalgamation of wise therapists' (17 or 17) views on how training programs could admit, assess, and train therapists to better promote the beginnings of wisdom in burgeoning psychotherapy professionals.

Category 1: The intellectual, social, and emotional functioning of student applicants should be considered to ensure that they will be both good therapists and researchers.

Therapists nominated for their wisdom (13 of 17) expressed the importance of admitting students into training programs who are not only intelligent, but who also have the capacity for emotional intelligence. One participant articulated this notion by saying:

> If I were looking to train therapists, I would look for somebody who was able to talk both the language of thoughts and the language of feelings. And if the person could not talk both languages, I would probably not be interested in training them…. People have to have a set of tools, um, to deal with the complexities of

> the human being, and one of them is a deep, deep willingness to go on an emotional journey with people, and if you're not aware of your own emotions and what's going on inside of you, I don't know how you could possibly be a guide to anybody else who's going through an emotional experience. (Frank Froman)

Participants suggested that the current process of admitting applicants based on test scores and grades might be sufficient for those training for a research career, but do not signal the capacity for emotional intelligence, which students need to develop as psychotherapists. Participants described dismay at a trend for trainees to be resistant to personal reflection as part of their training. Instead of viewing introspection as a way to evolve as developing psychotherapists, it was described that some trainees resisted this work, claiming it was invasive rather than developmentally important.

However, participants (9 of 17) emphasized that trainees should become comfortable and adept with their emotions, which could be facilitated by providing opportunities for structured self-reflection (e.g., role plays, personal therapy) to aid in the development of these skills. Participants suggested that in conjunction, trainees could benefit from instructor and peer feedback on how they are interacting within the program and with their clients. This feedback could provide multiple perspectives to help trainees gauge their progress in this area, and signal any areas that need attention.

Therapists (9 of 17) also described the importance of psychotherapy training to prepare students to form a strong therapeutic relationship, which participants feared was sometimes overlooked in academic environments. A therapist articulated this saying:

> On internship [we have] a million services that need to be provided. In graduate school, [we have] a million things we need to teach them. And I think the process

of just being with people isn't something we take enough time to teach. (Nadine Kaslow)

Therapists said faculty should not only talk explicitly about values such as empathy, respect, and compassion within the practice of psychotherapy, but should model these values for trainees. Participants indicated that because these skills were so fundamental, it was necessary for students to be assessed for mastery of these skills before moving ahead in their training as psychotherapists.

Category 2: Looking beyond disorder to the order: Encouraging students to actively seek knowledge outside their own worldviews in order to appreciate clients' uniqueness instead of pathologizing them.

Participants (10 of 17) emphasized the need to encourage trainees to learn about other cultures, beliefs, and worldviews. One participant spoke of approaching clients within a more contextualized perspective, trying to understand the nuances of clients' lives "and not just about their phobias or mood disorder…. You learn about their culture, you try to embed yourself, your knowledge…. And if you have a knowledge lacking, go fix that. Work on it" (Paul Leonard). This active development of cultural awareness was thought to help trainees learn varied ways to solve problems from a nonjudgmental stance and to appreciate (instead of pathologize) the different values held by others. Working with clients from different backgrounds, reading literature, and having immersion experiences were seen as helpful. One interviewee spoke of his approach to teaching multicultural appreciation:

We do a couple week immersion program in Mexico…. Without fail, students come back enriched with an understanding of how there are a lot of different ways

> to look at the world…. When they see that people do things differently in another country and it works that it gives them the idea that maybe there's more than one right way to be… which is what I think is kind of a hallmark of wisdom in our students. (Monte Bobele)

Exposing students to perspectives outside their own could help them understand how cultural differences can influence people's awareness and prioritizing of their needs. This awareness could be particularly important when oppressive systems made marginalized people's needs less visible.

Repeatedly, participants (9 of 17) talked about the need for therapists to view clients outside of a particular category of disorder. One participant said, "It's frequently more important to know the person that has a disorder than the disorder the person has" (John Norcross). Another participant spoke of the consequences of not attending to clients in this way:

> Just labeling them [clients] as in denial or difficult, or… waiting for… neurosis to develop…. There's just too much space between you as the therapist and the client. The client is now a patient… somebody that you do something to…. You work on them… You are able to walk away from them, and you're still immaculate. (Stuart Krause)

Therapists thought that focusing on clients' difficulties within the context of their specific cultures and life circumstances could help therapists attend to clients with more care and compassion than they would if viewing clients strictly through a lens to find clients' pathologies.

Category 3: Fostering autonomy and collaboration without fear: Faculty must put aside theoretical differences and hierarchical power structures to give students the liberty to follow their own curiosities.

All of the participants (17 of 17) contributed to this category, emphasizing the powerful role that training programs have in the development of wisdom in new therapists. Interviewees (6 of 17) expressed concern for training programs where discord exists amongst faculty, specifically when divisions are made in regards to differences in therapeutic orientation. This type of environment was thought to create incoherent training programs and breed unhealthy competition amongst students. Wisdom was thought to be stunted in such programs, where students were not encouraged to learn from multiple perspectives, and to hinder their development of, and appreciation for, collaborative professionalism. Similarly, wise therapists raised concerns about training programs that were strongly hierarchic in nature, placing students in a position of dependence and generating a fear of questioning and innovating. Instead, they thought programs should encourage students to develop their own curiosities and think independently.

In contrast, participants (16 of 17) thought that wisdom could be nurtured and developed in programs that fostered students' professional autonomy. By exposing students to a variety of psychotherapy orientations and theories (not only learning about theory, but also watching high quality therapy in action and receiving supervision) students could understand psychotherapy from many angles. One participant spoke of this, saying:

> As students learn, they sometimes get prematurely stuck on you know either a particular method, orientation, or otherwise. I think that, uh, does not do students a service…. I think exposure to multiple methods and orientations is important, you know, in terms of enabling students to develop their skills and understanding otherwise, and there are some… programs that are more narrow in focus. (Jean Lau Chin)

A breadth of understanding was thought to help students work with the diversity amongst their clients and conceptualize cases in a more comprehensive way.

> Participants also thought that wisdom could be better developed when students were aided by the support of mentors and faculty who provided a safe environment for wrestling with ambiguity and where not having all the answers was expected. One participant said, "I think the way we train folks is we often don't give them permission to not know…. Sometimes the academic pressure… detracts from the skill training…" (Christine Courtois)

Similarly, interviewees talked about giving students the opportunity to develop an experimental spirit where they are encouraged to try new things and question old ideas without constant fear of failure. A participant articulated this in saying, "It's a little bit like raising kids… [they've] got to have all the support they need so that when they fall down it's not fatal…. They also have to have the chance to fall down so they aren't fearful" (Laura Brown). Therapists thought that because tolerating ambiguity was thought to be a central trait of wisdom, the current emphasis on giving correct answers in training programs should be augmented with an emphasis on developing wise questions to be asked within both research and clinical practice.

The following principles were developed from cluster 4:

Principle 4.1: Training programs that wish to foster wise clinical practice in therapists could admit students by assessing their relational skills, ability to handle ambiguity, and self and cultural awareness as well as their intellectual skills.

Principle 4.2: Training programs that wish to foster wise clinical practice in therapists encourage independent thought in their trainees and model and talk explicitly about good relational and collaborative skills across perspectives.

Principle 4.3: Training programs that wish to foster wise clinical practice in therapists train therapists to value different types of psychotherapy theory, research, and practice traditions and encourage them to value the strengths in each tradition.

Principle 4.4: Training programs that wish to foster wise clinical practice in therapists encourage students to develop knowledge about themselves and their relationships with others by engaging in practices such as personal therapy, seeking out feedback from others, learning about other cultures and valuing differences, and learning to understand the workings of oppression from both majority and minority cultural perspectives.

One participant provided a narrative of specific positive feedback about this cluster, but no changes were suggested.

Core Category: Clinical Wisdom is Taking the Risk Not To Know: Using Your Experiences of Pain and Struggle as Guides in Exploring your Clients' Ambiguity and Vulnerability While Allowing Their Values and Context to Tailor your Interventions

Wise practice was thought to be associated with gains for clients across the interviews. Therapists described wise clinical practice as rooted in an in-depth exploration of clients' *individual* experiences within a framework of their own values and social/cultural contexts. Although most of the therapist-participants were advocates of empirical research on clinical treatments, they emphasized the humility needed to recognize the limits of their knowledge of clients' experiences and to deliberately tailor treatments for each client. Therapists talked about the profound challenge entailed in stepping into and working within a clients' internal world and value system– and in particular their experiences of uncertainty and threat. Their experiences of personal pain and struggle and their experience with others' emotions –including their clients – can guide them to notice what aspects of clients' issues are tender, are most needing integration, and are in need of exploration and understanding. They repeatedly emphasized the need for self-awareness, interpersonal sensitivity, and the ability to tolerate ambiguity and develop comfort with *not knowing* while engaged in this difficult exploration.

In contrast, the profession of psychology has been influenced strongly by a foundation in intelligence testing (Rose, 1998), and the trait of intelligence and having ready answers is highly prized in our profession and academia broadly. As well, limited session numbers push therapists to seek out packaged treatments that can assist therapists in being effective quickly with a range of clients. Within this context, it can be hard for developing therapists to accept how little they know about a given experience and to move slowly with clients to develop a nuanced understanding of a painful experience. Therapists described, however, taking risks to allow themselves to be emotionally open

with clients and to use what they have learned about pain and relationship through their own life experience, the literature and research, and professional work to guide their clients' explorations. This focus upon clients' ambiguity and vulnerability helped therapists identify opportunities for change by noticing material that has yet to be integrated into the client's framework of understanding (e.g., discrepancies in clients' experiences or conflicting needs). An awareness of these fragmented experiences could lead clients' to more awareness of one's needs and more comfort with oneself. These explorations were thought to foster transformative therapeutic relationships, clients' acceptance of threatening aspects of themselves, and insights that were context-sensitive and more relevant to or adaptive within their realities. This approach encouraged therapists to apply techniques from across orientations in a highly individualized manner.

The participants thought that wise clinical practice emphasized relational connection and weighing empirical evidence critically and then shaping interventions to fit clients' individual needs. Therapists worried that graduate schools tended to admit and train students based solely upon markers of intelligence and certainty (e.g., knowing answers, scores on exams) and did not emphasize values such as compassion, respect for differences, potential for intimacy, coping with ambiguity, or relational understanding.

Obstacles to wise practice were thought to increase when psychologists communicated intelligence/certainty-valuing modes of practice (e.g., rigidly standardized interventions, session-limited practice, uncritical perspectives on efforts to seek empirical support for therapy approaches) to training accreditation bodies, insurance companies, other professionals, or consumers. The interviewees thought that to aid in the development of wise therapists-to-be, training programs should place an emphasis on the

development of self-knowledge, relational understanding, and the appreciation of cultural differences and systems of oppression. This emphasis could best come about via creating graduate school environments that are structured to model and reward these traits and foster students' independence, curiosity, and collaborative approaches to practice and research.

In the development of this core category, we received specific feedback from three participants. The first participant asked for us to use more "neutral" language and "less jargony terms" (personal communication, August 2010). Another participant commented that the category was a bit "too global" (personal communication, August 2010). The researcher took this information into account, and developed the core category presented here in the results. A participant who provided feedback on this overarching theme provided positive feedback and had no suggestions for changes. The other participants approved all of the findings without suggesting any alterations.

Discussion

In this study, wise practice was understood as dependent upon a tolerance for ambiguity and anxiety. It may seem incongruous then for the authors to be offering principles for wise psychotherapy practice based on the expertise of eminent psychotherapists in our study, because they might appear to reduce ambiguity. As a result, the author wishes to stress the differences between rules and principles. It has been argued that is more useful to conceptualize psychotherapy as guided by principles instead of rules because they allow for flexibility in application and therapy is a complex task that is continually changing and being reinterpreted (Levitt, Neimeyer, & Williams, 2004). Based upon this understanding, the principles described herein are not to be used

as prescriptive rules to be applied without regard to context, but as heuristics that increase clinicians' awareness of choices to consider.

The findings in our study have differentiated a wisdom-based model of psychotherapy from an intelligence-based model. Both models work to increase clients' self-awareness, but there are profound differences in the ways psychotherapy is conceptualized and researched. Within an intelligence-based model, the goal of psychotherapy is to educate clients and to help them develop a new cognitive understanding of themselves. Since the model of healthy psychological functioning is logic-based, outcomes for different clients appear similar. The associated psychotherapy research paradigm emphasizes manualized interventions that are easily replicated across patients and amenable to experimental research (see Baker, McFall, & Shoham, 1999). This view stems from definitions of psychotherapy in terms of orientations that are defined in turn by interventions. An intelligence-based model of psychotherapy is not surprising in the context of a field which has its roots in intelligence testing (Rose, 1998) and which is shaped within academic contexts which value intellectual achievement. In contrast, the wisdom-based model of therapy works to develop an understanding of the interconnection between emotion, social and cognitive functioning. This view understands psychotherapy as primarily a relational act, emphasizing the relationship and the complexities involved in psychotherapy relationships. These perspectives value research that explores the complexities in psychotherapy process in relation to outcome. Eminent psychotherapists in our study worried about the growing schism that this divide is causing in our field as we grapple with how to understand and study psychotherapy as a wise endeavor.

Psychologists who are primarily cognitive-behavioral in their orientations often place great emphasis on clinical trials of specific factors and empirically supported treatment efforts in which change is measured on a symptom or cognitive level without as much analysis of moment-by moment process variables. On the other hand, psychologists who ascribe to humanistic, family systems, interpersonal and psychodynamic orientations tend to place more value on the relationship as central and conduct more qualitative and process research without as extensive a tradition of experimental research (Hill & Corbett, 1993). The divide is evident in the differing psychotherapy orientations between clinical and counseling psychologists. Orientation differences have been found among members of APA division 12 (clinical psychology) and division 17 (counseling psychology). Specifically, when asked about their dominant psychotherapy orientation, counseling psychologists were more likely than their clinical psychology counterparts to ascribe to client-centered/humanistic traditions (11% versus 5% respectively), and clinical psychologists to behavioral (12% versus 4%) and psychodynamic (13% versus 11%) orientations (Bechtoldt, Wyckoff, Pokrywa, Campbell, & Norcross, 2000). Differences in orientations also have been found amongst faculty in APA accredited counseling and clinical psychology doctoral programs. These divides are most prominent between the programs in terms of ascribing to humanistic versus cognitive behavioral traditions. Counseling psychology PhD faculty have been shown to ascribe more often to humanistic orientations than their clinical psychology PhD counterparts (28% versus 10% respectively). Clinical psychology faculty more often ascribe to cognitive-behavioral traditions than counseling psychology faculty (51% versus 43% respectively) (Oliver, Norcross, Sayette, Griffin, & Mayne, 2005). Another divide can be found amongst

research and practice oriented programs (Mayne, Norcross, Sayette, 1994). Specifically, research oriented PhD programs ascribe more often to cognitive-behavioral traditions than do the practice oriented PsyD programs (64% versus 33%), with practice oriented PsyD programs ascribing more often to psychodynamic orientations than do research oriented PhD programs (29% versus 12%) (Sayette, Mayne, & Norcross, 2010). While there is convergence between psychologists in terms of being eclectic/integrationists (e.g., 29% of Division 17 and Division 12 members were self-identified as eclectic/integrationists) (Bechtoldt et al., 2000), the divergence in traditions suggests that these groups hold differing values. It might be that psychotherapy orientations and programs of training have traditions that rely upon intelligence- or wisdom-based models to different degrees or in different ways and so the process of incorporating wise practice might need to be tailored for each context.

The following sections will address the need for a shift towards wisdom-based approaches in psychotherapy and review related empirical findings. They also will address the ways in which our professional culture thwarts this shift from occurring within a political climate that prizes ready-made answers and standardization. As well, suggestions of how to incorporate wisdom-based approaches in psychotherapy practice and training will be explored.

Merging Intelligence and Wisdom in Psychotherapy Culture

Clinical wisdom was described as a process rooted in helping clients stay with their vulnerabilities and ambiguities within a supportive relationship and construct new meanings. Eminent therapists in the current study emphasized that to work with clients in this manner, it was necessary to welcome uncertainty in therapy, and be willing to

flexibly adapt to the needs presented by clients' specific contexts and values. While there are many psychotherapy cultures, the participants described ways in which the dominant culture in psychotherapy does not support such understandings of psychotherapy that would promote wisdom.

Although all the participants in the current study were in favor of being empirically informed in their clinical practices, their concerns included: (1) The EST rhetoric recommends an automatization of thought and processes in psychotherapy at the expense of flexibility and context-based interventions; (2) Different research questions and approaches require differing methodologies; and (3) ESTs emphasize specific interventions instead of common factors, despite empirical evidence indicating the importance of the latter.

Automatization of psychotherapy. As Sternberg (2004) postulated, intelligent people are not necessarily wise. While an intelligent person embraces automatization of thought within a particular context to increase efficiency, the wise person resists automatization and tries to understand the limits of a given context. Also, he proposed that people who are high in intelligence are more likely to engage in egocentrism (feeling that they are the center of the world), omniscience (thinking they know everything), omnipotence (believing they can do anything they want), and invulnerability (thinking they are infallible and can get away with anything). The current study highlighted how these patterns in thinking can contradict the aims of wisdom in therapy. Participants indicated that therapists utilizing wisdom in therapy have to be comfortable with their own pain and relationship struggles. This comfort can help them to: (1) learn from their struggles so they can more sensitively guide clients as they explore their own difficult

experiences; (2) demonstrate a comfort and optimism in the face of distress; and (3) be humble in approaching client's experiences and be motivated to understand their clients' experiences within their own set of values and preferences.

Participants emphasized that the dominant perspective in psychotherapy is more invested in developing approaches based upon therapist certainty and knowledge rather than processes of contemplation and questioning. For instance, manualized treatments with promises of ready-made insights, such as empirically supported treatments (ESTs), are becoming the standard of practice in our field. This effort at standardization originated to help psychotherapy assimilate into the medical-model system (Task Force, 1995) and position psychotherapy as a profession that could compete with medicine. The leader of the NIMH in the 1980's, Dr. Gerald Klerman, encouraged psychologists to "view psychotherapy as we do aspirin"—and introduced randomized controlled trials (RCTs) to study psychotherapy in the NIMH-supported Treatment of Depression Collaborative Program (Beutler, 2009, p. 308). Psychotherapy became analogous to a drug in which the "inert" and active ingredients could be identified and the combination maximized to create positive outcomes (Beutler, 2009; Stiles & Shapiro, 1994, p. 946).

Stiles and Shapiro labeled this drug metaphor as "misleading" (Stiles, 1999, p. 5). Stiles argued that psychotherapy is "systematically appropriately responsive." He refers to responsiveness as "behavior that is affected by emerging context, particularly including client requirements" (p. 6). Thus, appropriate responsiveness means "responding to emerging context in a way that advances the goals of treatment" (p.7). When therapists adjust their interventions "to the inclusion of client's changing requirements, outcome is reciprocally affecting process" (p. 7). Therefore, "any

appropriate responsiveness tends to defeat the process-outcome correlation" and "it is unlikely that correlations or related statistics… will adequately assess relationships between process and outcome" and so these relationships "may be unanswerable within a conventional linear framework" (pp. 946-947). Despite these limitations, our field adopted the medical model which spawned the proliferation of standardized treatments for discrete diagnostic categories.

Participants also worried that the proliferation of manualized ESTs in practice and training might lead clinicians to use these interventions in an inflexible manner. Empirical studies have found that adherence to EST protocols can be detrimental to treatment in some cases (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996) and that treatments usually found to be effective can be problematic when used rigidly and without regard to other important factors such as proper timing (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010). There may be different ways of writing and using manuals, however. Some treatment developers have explicitly advised against therapists using their treatments in a rigid manner (Beck, Rush, Shaw, & Emery, 1979). Others have proposed ways to use maualized treatments as guides where the manual is "flexible, vibrant and alive, requiring creativity and clinical skill to be optimally successful" (Kendall, Chu, Gifford, Hayes, & Nauta, 1998, p. 179). Kendall and colleagues highlight that although many manuals do not overtly address process factors or the role of the therapy relationship, that these factors are of "major importance in manualized treatment, just as with any other" (p. 180). Participants in the current study also expressed that manuals should be used flexibly with room for creativity and adaptation. However, they

emphasized that this work must be done in the context of developing a foundation based on a strong therapy relationship.

The gold standard. Participants acknowledged the value that experimental studies provide in furthering an empirical understanding of therapy. However, they also raised concerns that this methodology has been prized to the exclusion of others because of the dominant culture's allegiance to the medical model. Such "methodolatry" (see Bakan, 1967) could stunt our understanding of psychotherapy, as investigating human science requires the use of many methods because one method alone cannot provide a complete understanding of such complex interpersonal exchanges (see Slife & Williams, 1995). The dominant culture, however, follows precedence used in natural sciences and the medical model tradition, labeling the randomized controlled trial as the "gold standard" of psychotherapy research for deeming a treatment as being "empirically supported" (Chambless & Hollon, 1998). Placing experimental design at the top of the methodology hierarchy implicitly disregards the valuable information gleaned from quasi-experimental, process, and qualitative research. Beutler (2009) argues that "A cardinal value of science is openness within a discovery based system that is guided by the questions asked rather than by the method used to answer them. By automatically excluding certain scientifically respectable methods [that are most adept at answering types of questions] in favor of a single 'gold standard,' scientists of this ilk have merely transferred the mantle of authority from a person to a method" (p. 302). The methodologies for scientific inquiry are varied, and by narrowly defining how we study psychotherapy and the questions we ask might not only stunt our understanding of this complex work, but also favor only those therapies amenable to experimental inquiry (e.g.,

therapies that are focused on symptom reduction). Subsequently, psychotherapy traditions with non-dominant values (e.g., humanistic, psychodynamic and experiential approaches) are marginalized (Bohart, Leitner, & O'Hara, 1998) as are the research methodologies that they utilize (e.g., qualitative studies, process research). Participants in the current study emphasized the need to recognize the limitations of experimental designs and more broadly, the limitations of science. They also suggested that wise clinical researchers responded to the fallible nature of science by seeking diversity in research methodology to foster a multi-faceted understanding of psychotherapy.

Participants also suggested utilizing research to investigate other important therapy factors (e.g., client values, cultural beliefs) in a comprehensive way to increase a wiser and deeper understanding of psychotherapy. They emphasized that the drive for knowledge in our field, however, can lead to the exclusion of relational and other such factors in preference for clean, sterile standardization. One research participant, John Norcross (2001), wrote, "The EST lists and most practice guidelines depict disembodied therapists performing procedures on Axis I disorders. This stands in marked contrast to the clinician's experience of psychotherapy as an intensely interpersonal and deeply emotional experience" (p. 346). Duncan and Miller (1999) suggest that the psychotherapy profession would be better served by "identifying empirically validated treat*ers* rather than empirically validated treat*ments*" (p. 439, italics preserved). Citing the work of Castonguay and Beutler (2006) and Duncan and Miller (2006), Beutler (2009) asserts that because EST results have "failed to be terribly impressive …. Many EST scholars are… coming to recognize that such weak results may indicate that the real influences in psychotherapy include effects that are associated with variables that are nonrandomly

distributed aspects of the therapist, the relationship, and the patient" (p. 310). Participants in the current study echoed this notion and suggested that more focus be placed on the development of relational and interpersonal skills as well as developing the person of the therapist to better foster wise clinical practice.

Common factors versus proliferation of interventions. The advocacy of ESTs continues to gain support in our field despite scientific evidence showing that common factors across orientations account for the majority of the variance in therapy outcome studies (Wampold, 2001) and despite criticisms about the theoretical flaws (e.g., comparing approaches that aren't compatible with experimental models of research, ignoring the forms of change valued in humanistic, existential and psychodynamic approaches) (e.g., Bohart et al., 1998). Findings suggest that the person of client (Lambert, 1992) and therapist (Crits-Christoph et al., 1991; Project MATCH Research Group, 1998) as well as the power of the therapy relationship (Wampold, 2001), account for the largest portion of the variance (40%, 5-9% and 7% respectively) (Norcross, 2001) and estimate that specific ingredients in therapy only account for between less than one percent and eight percent of the variance in outcome studies (Garfield, 1992; Wampold, 2001). The psychotherapy culture majority has supported the movement towards standardization in spite of these scientific findings.

Further evidence for this cultural trend is found in the accreditation standards of The American Psychological Association (APA) and The Association for Psychological Science (APS). Both of these professional bodies have made efforts to privilege the psychotherapy training and practice of ESTs. APA currently requires accredited doctoral programs to "provide a wide range of training and educational experiences through

applications of empirically supported intervention procedures" (APA Commission on Accreditation, 2011). APS has taken this standard to a more stringent level, creating their own accreditation system that aims to "stigmatize ascientific training programs and practitioners" who do not limit their scope to ESTs, with efforts to "enhance the generation, application, and dissemination of experimentally supported interventions, thereby improving clinical and public health" (Baker, McFall, & Shoham, 2009, p. 67). Participants worried about the growing divide in the field that these movements are causing, and felt strongly about being empirically informed, but with a diverse focus that allows room for a variety of research and practice traditions.

Further debate exists between members of APA's Division 12 (clinical psychology) and Division 29 (psychotherapy) tasks forces. Division 12 championed the search for EST's which was heavily criticized by leaders of Division 29. This rift became the catalyst for the development of a new task force to identify "empirically supported relationships" (Castonguay & Beutler, 2006). The field "remains divided on how best to establish the scientific bases of practice…. These two divisional initiatives exaggerate the schism between the relative value of objective and subjective experience that exists in the field, rather than healing it" (p. 4). In efforts to eliminate the implicit "either-or" dialectic that these two groups suggest, their work attempts to integrate the meaningful research from both camps to identify principles of change that could guide therapists across theoretical orientations. The participants of this study thought that both types of interventions were valuable so long as the answers were understood as flexible suggestions that should be adapted creatively by clinicians for their clients.

Attending to the complex nature of therapist and client factors, and the dynamics of the therapy alliance, while also finding ways to integrate this information into the use of specific techniques requires psychotherapy researchers and practitioners to become comfortable with ambiguity and uncertainty in the face of a drive for certainty and knowledge in an intelligence-valuing profession. Research on common factors (e.g., the therapy relationship, the person of the client and therapist) is in-line with our field's valuing of empirical research on therapy outcome but could move science in a direction that informs therapists' practices across psychotherapy orientations and focus on the aspects of therapy that appear to be most responsible for client outcome.

Vulnerability, Ambiguity and Acceptance in Psychotherapy

Themes tied to the use of ambiguity and vulnerability in the psychotherapy process emerged in the current study. Because the literature is sparse on the nature of these constructs, the author reviewed this study's interviews and isolated examples where therapists described vulnerability or ambiguity being used in their therapy practice to shed light on these constructs. This exploration yielded six examples of in-session clinical wisdom entailing vulnerability and nine examples of ambiguity that could generate hypotheses for future studies, in addition to other less concrete descriptions of these qualities.

Vulnerability. In discussing these experiences, participants in the current study described the value of therapists' vulnerability. Therapists became comfortable with vulnerability by continuously introspecting about their relationships with significant others, becoming comfortable with the threatening parts of themselves, and reflecting upon their interactions with their clients. Accessing their own vulnerabilities in this way

informed the ways they act in therapy, as well helped them understand their clients' relational and behavioral patterns. When therapists willingly immersed themselves in understanding the ambiguous nature of their own internal and social experiences, they appreciated the gains that can be made by exploring ambiguity with clients – how slowly this process toward clarity might proceed and why patience is important in reaching an accurate understanding.

Moments of vulnerability have been defined as those "brief periods when a person risks exposing and experiencing parts of the self that are habitually hidden from others or even from the self" (Livingston, 2003, p. 649). Livingston described how the therapist's "empathic immersion in the patient's subjective experience" is central in allowing a client's vulnerability to unfold, and is in-line with research that suggests the positive influence therapist empathy, genuineness and warmth has on aiding client change (Truax & Mitchell, 1971). This pivotal role of the therapeutic relationship was echoed in the current study, and suggests that the therapy relationship and alliance can either promote or divert this process. Trends found in the current study suggest that a strong therapy relationship and alliance is necessary to help move from identifying ambiguity towards exploration. The quality of the therapy alliance consistently has been associated with positive therapy outcome (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000) with weakened outcomes being linked to therapy termination (Samstag, Batchelder, Muran, Safran, & Winston, 1998). Though clients can leave therapy for many reasons, one could be the "result of a therapist's or client's becoming closed in response to the intimacy of relating and being vulnerable together" (Leroux, Sperlinger, & Worrell, 2007). Learning to navigate therapy in the midst of clients unveiling their vulnerabilities

might aid in the progression of therapy. Yet, practicing in a way that is not sensitive to the delicate nature of clients' being vulnerable could stop therapy in its tracks.

Ambiguity. Participants suggested that by carefully and slowly attending to what clients are saying in therapy, ambiguous content was clarified and signaled new areas that needed further exploration. These moments were thought to help guide the direction of therapy in a responsive way. The use of this process element can be seen across orientations (e.g., helping clients attend to difficult or incongruent thoughts in cognitive-behavioral therapy (CBT), fragmented experiences and emotions in emotion-focused therapy (EFT), and ambiguous motives in patterns of relationships in psychodynamic therapy). Participants approached clients without preconceived notions, and instead used their curiosity as a tool to facilitate exploration of inchoate thoughts and emotions.

Patterns in the current dataset suggest the importance of not only noticing the signals of ambiguity in therapy, but heightening clients' ability to stay focused upon, contemplate and resolve confusing issues. This progression is being researched in the literature on the assimilation scale. Honos-Webb and Stiles (2002) identified the importance of increasing awareness in the first stages of their Assimilation of Problematic Experiences Scale (APES). This scale outlines a "developmental sequence though which problematic experiences pass on their way to being assimilated in successful psychotherapy" (p. 85) and has been linked to good therapy outcome (Rudkin, Llewelyn, Hardy, Stiles, & Barkham, 2007). Techniques from across theoretical orientations can be used to help clients move through these stages. Within this the initial stages, after helping clients increase their awareness, therapists facilitate an experiential understanding of this new awareness so that the client can eventually clarify the

problem/difficulty and gain insight. This type of exploration might require clients to engage in experiences of emotional pain or distressing thoughts. In other words, clients would have to be willing to become vulnerable in session.

Acceptance. If therapists and clients are able to navigate this fragile terrain of ambiguity and vulnerability together effectively, the therapeutic focus can shift towards making meaning of these experiences. The participants suggested that clinically wise therapists would not solely focus on changing clients' emotions and thoughts, but also facilitate acceptance when needed. Thus, explorations of ambiguity and vulnerability might suggest that the clients make changes in their lives or accept their lives as they are. This form of exploration and meaning-making has been utilized across different therapies (e.g., emotion focused therapy, mindfulness-based therapies) to allow room for the experience of troubling emotions and thoughts as opposed to actively avoiding and changing them (see Greenberg, 2002; Linehan, 1993). Mindfulness-based therapies such as Dialectical Behavior Therapy (Linehan, 1993), Acceptance Based Behavioral Therapy (Roemer & Orsillo, 2005), Mindfulness Based Cognitive Therapy (Segal, Williams, & Teasdale, 2002), and Acceptance and Commitment therapy (Blackledge & Hayes, 2001) are structured to help clients stay in the present with distressing thoughts and emotions. These therapies integrate themes present across orientations (e.g., psychodynamic, experiential, cognitive, and behavioral) (Martin, 1997). Therapies that provide a forum for clients to attend to, instead of flee from, difficult emotional states with aims of self-acceptance might allow for a broader range of solutions than only focus upon interventions that require change.

Implications for Training Clinicians to be Wise

Participants thought the development of clinical wisdom occurred after acquiring years of personal and professional experiences, but that the training environment plays a crucial role in placing novice psychotherapists on this path. They raised questions about the criteria that are used to judge applicants to doctoral programs because of their heavy emphasis on intellectual achievement rather than the many factors that could foster wise clinical practice. While admitting students based largely on their intellectual capabilities might be sufficient for research or academic training, it was not seen as adequate for the interpersonal work they would undertake as psychotherapists. Skovholt and Ronnestad (2003) asserted that "Many students are admitted to graduate school in the counseling and therapy professions because they excel at mastering the intellectual content in academic classes. However, this skill set does not translate directly to the complexity of practice..." (p. 47). Participants suggested that training programs should therefore admit students not only based on their academic abilities, but also for their capacities for emotional and social intelligence. They recommended applicants be assessed on their abilities to be empathic, form alliances, and work collaboratively. Norcross (2002) described a variety of measures to assess empathy from both the perspective of an outside rater (for example, Watson, 1999) as well as the from client perspective (Barrett-Lennard, 1981). Measures such as these could be used in conjunction with other forms of assessment (e.g., letters of recommendation) to gauge applicants' capacities to develop the core relational skills they would need as therapists.

Once students are admitted, training programs could provide an environment that supports the ongoing development of emotional and social intelligence. Participants were

strongly in favor of helping trainees develop these qualities by encouraging them to experience the psychotherapy process as clients. Undergoing a personal therapy journey can be helpful in increasing empathic ability and decreasing dislike of clients (Wogan & Norcross, 1985) and can increase therapists' emphasis on the therapy relationship (Macran & Shapiro, 1998). Orlinsky and Ronnestad (2005) studied the self-generated rankings of over 4,000 psychotherapists and found that personal therapy was viewed as one of the top three experiences of professional development, with direct client contact and case supervision being the only experiences that were ranked higher. Personal therapy consistently was ranked as providing superior learning experiences to taking courses or reading psychotherapy journals, highlighting the need to augment didactic education with opportunities for personal exploration via trainees' own personal therapy. While most European countries designate that emerging psychotherapists must undergo a specified number of personal therapy hours to become licensed (Orlinsky, Ronnestad, Willutzki, Wiseman, & Botermans, 2005), training programs in the United States do not ordinarily require personal therapy for students (Norcross, 2005),

Applicants also could be evaluated on their respect for diversity issues and their openness to working with people who have different values and cultural backgrounds. Once admitted, wisdom could be fostered in trainees by providing opportunities to become aware of the ways in which their own cultures influence their perception of clients, and how to use this awareness to better work with clients with differing values. Participants in the current study suggested that multicultural competency could be fostered by exposing students to diversity-focused coursework, immersion and/or study-abroad experiences, psychotherapy training in community-based clinics with different

client populations, reading various sources of literature, and engaging in an analysis of their own cultural backgrounds and origins. Training students in this area also was thought to help new clinicians better understand themselves and to appreciate differences that might otherwise be pathologized.

APA requires that multicultural competence be woven into training of psychotherapists, and meta-analyses have found that multicultural training in education yields positive outcomes -- especially when students take courses or more in depth training based on theory and research (Smith, Constantine, Dunn, Dinehart, & Montoya, 2006). However, concerns have been raised that some of this training has been more focused on knowledge acquisition than teaching students interpersonal skills related to multicultural issues (Carter, 2001). Evidence shows that experiential methods of learning (e.g., practicum experiences with diverse groups) can make students more competent to work with multicultural clients (Allison, Echemendia, Crawford, & Robinson, 1996; Arthur & Januszkowski, 2001). Also, students have rated these experiential learning opportunities as the most useful component of multicultural training (Heppner & O'Brien, 1994), and so perhaps giving students experience a variety of cultural growth opportunities would best help them to understand the complexity of culture in clients' lives and tailor interventions more meaningfully to their specific values and needs.

In terms of their psychotherapy training broadly, interviewees emphasized that finding supportive mentorship was a key. They expressed that mentors were most helpful to students when they encouraged an experimental spirit in students while also providing the guidance and support to learn a variety of therapy approaches and voice novel ideas. An integrative framework could provide this type of model and would allow mentors and

mentees to work with a breadth of orientations and techniques. Supervision could focus on helping students identify change processes they need to facilitate with individual clients, while guiding them towards the most useful interventions for the identified process (Boswell, Nelson, Nordberg, McAleavey, & Castonguay, 2010). Participants in the current study thought it was important for mentors to demonstrate respect for diversity in therapeutic orientations and research methodologies, which could help trainees tolerate ambiguity better as they discover that there are many approaches to therapy and research. This respect for diversity also could foster in students an appreciation of differences and collaborative research across divisions and orientations.

The relationship between mentor and mentee also can teach developing clinicians how to build a strong therapeutic alliance, which participants identified as an important skill for wise clinical practice. Angus and Kagan (2007) promote a strong supervisory relationship so that trainees can transfer this sense of connection to their alliances with clients. They noted that "the ability to form a strong bond with others seems to be a transferrable skill that is learned in the context of significant relationships and then generalized to subsequent relationships" (p. 373). This relational security could allow them to develop the skills needed for clinical wisdom, and model for students a productive working alliance in therapy.

Limitations and Strengths

Readers should be mindful that this study focused on doctoral-level psychotherapists who were trained as psychologists, and did not look at professionals with master's degrees, novice therapists, or those trained in other professions. Furthermore, we asked participants about their perceptions of what they do in therapy to

enact wise practice, and we did not collect data to analyze how close their descriptions match the interventions they actually provide in their sessions. Also, our sample included therapists whose main focus was on conducting adult and individual therapy. Future studies could focus on therapists who specialize in group, family, and other forms of psychotherapy.

The current study used a grounded theory analysis, and therefore, the results represent only one interpretation of the data. The researcher carefully examined participant's interviews over a series of months, however, and utilized several credibility checks, such as consensual understandings of the data between researchers, interview checks, and participant feedback. The researchers utilized a memoing process to aid in the recognition of personal biases, as well as to track shifts in the interpretation of the data, and to document the developing theory. Lastly, the sample included diversity in terms of ethnicity, gender, and theoretical orientation, and so was based upon a range of perspectives. The data analysis reached the level of saturation at interview 15 and new categories did not develop in the last two interviews, suggesting that the analysis was comprehensive in scope.

As psychotherapy research and practice moves forward, integrating a wisdom-based model of therapy can transform the contemporary practice and research cultures in a number of ways. Conceptualizing psychotherapy as having a goal of promoting wisdom and wise solutions in turn promotes research and practice that is attuned to the therapy relationship, and that challenges psychologists to become more comfortable with ambiguity and uncertainty. It teaches lessons of humility and guides us to examine the barriers to wisdom within the professional systems we have created.

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Appendix A

Interview Protocol

Prelude

The focus of this study is on the place and function of wisdom within your professional practice. Because I am looking to develop an understanding of what wisdom is through the interviews, I'm not beginning with a set definition of wisdom, so please use your own understanding of what wisdom means as we discuss this topic and help me to understand that meaning as it applies to (your professional group). It is not concerned with formal theories of wisdom that might exist within your profession as much as how you think wisdom can have a place or effect within the daily practice of (profession). As someone who has been nominated as a wise (profession), I'm particularly interested in how you might enact wisdom within your practice. The main question in each interview is "*How do you enact wisdom within your profession and how do you think professionals in your profession can become wise?*" I am interested in hearing any thoughts you think are relevant to this question.

Sub-questions

1. How would you define **what it means to be a wise** (Psychotherapist)?
2. Is your understanding of **wisdom in your profession** the same or different than your understanding of wisdom on whole? (How so?)
3. Do you think that wisdom has a place within the **functioning of (profession**)?
4. Can you provide a description of an **experience or story** of someone within your profession demonstrating professional wisdom?
5. Does **intelligence** have a role in wisdom? If so, what?
6. Does **emotion** have a role in wisdom? If so, what?
7. Are there types of **communication or interpersonal styles** that you think facilitate being wise within your profession? If so, what are they?
8. Are there personal or **personality characteristics** that you think facilitate being wise within your profession? If so, what are they?
9. Is there a typical set of **consequences of wise action** as compared with unwise action within your profession?
10. Are there **advantages** to practicing in a wise fashion? If yes, what are they? **Disadvantages**?
11. Are there **challenges** do wise people face when working within unwise systems? If yes, what are they? How could they best **cope** with these challenges? Are there **obstacles** do they face in coping? If yes, how can they best deal with these obstacles?
12. Are there **constraints** on the practice of wisdom within your profession? If yes, what are they?
13. Are there **systemic factors**, such as someone's **position or relationships**, that might facilitate being wise? If so, what are they? **Finances or resources**?
14. What would distinguish a wise versus **unwise system** within your profession?
15. Do you think **emerging professionals** within your profession can be trained to practice of wisdom? If so, how?
16. If so, how? Influences your **clients**? Does it influence their own sense of wisdom?
17. Do you think the practice of wisdom within your profession **influences perspectives** in your profession? (e.g., empirically validated therapy/ restorative justice?)
18. Do you think the practice of wisdom within your profession **influences the public**? If so, how?
19. If you were going to articulate a **brief definition of wisdom** now at the end of our interview, what would that be?

Appendix A

Credibility Questions

1. Are there any questions that have **not been asked** that seem relevant?
2. Do you feel that you would have answered these questions differently if I was someone within your own professional group? (If not) Or your own
3. Do you have **advice** about how I might proceed with these interviews? **Suggest other nominees**?

Appendix B

The Psychotherapeutic Wisdom Project Psychotherapist Nomination Form

Please identify any psychologist(s) who you think enact wisdom within the practice of psychotherapy.

1. Name of Nominee 1:_____

Can you briefly describe how this person demonstrates professional wisdom within his or her practice of psychotherapy?

_____

(please feel free to elaborate as much as you wish)

2. Is this nomination based upon (check all that apply):

__Having seen this person perform therapy in a video or in person

__Having read transcripts of this person's therapy

__Having read this person's descriptions of his or her therapy process

__Having received therapy supervision from this person or conducted co-supervision

__Other (Please describe): _____

3. We are interested in seeking interviewees who can share many different perspectives with us. Can you describe your nominee?

Sex: _____ Race: _____

Psychotherapy orientation (if known): _____

Population they work with (if known):_____

4. Can you give us any information to help us to locate this person, such as their professional affiliation, city, or any contact information? _____

Appendix B

Please copy and paste the questions #1-4 here if you would like to nominate more than one psychologist. We are happy to receive multiple nominations.

Please complete the following questions about your own demographic information:

Sex:_____ Race:_____

Your Professional Degree: _____PhD_____PsyD____MA_____MS_____BA____BS

_____Other: Please describe:_____

Your Psychotherapy Orientation:_____

Years in Psychotherapy Practice: _____

Once completed, please e-mail this form to:

psychotherapyresearch@mail.psyc.memphis.edu If you would like to receive a copy of our findings once the study of wisdom is completed please provide your e-mail address here: _____

Thank you for your participation in our study!

Table 1

Participants' Demographic Information

Name	Sex	Race	Highest Degree	Years as Therapist	Therapy Orientation	Primary Professional Setting
Monte Bobele	Male	Caucasian	Counseling Psychology Ph.D., ABPP	30+ years	Brief Solution Focused	University (and 25 years in practice)
Laura Brown	Female	Caucasian	Clinical Psychology Ph.D.	32 years	Feminist Therapy	Private Practice
Jean Lau Chin	Female	Asian American	School Psychology, Ed.D.	40 years	Electic-Psychodynamic, Systemic, Multicultural, Feminist	University/Private Practice/Community Mental Health Center
Christine Courtois	Female	Caucasian	Counseling Psychology, Ph.D.	30 + years	Integrative	Private Practice
Frank Froman	Male	Caucasian	Counseling Psychology, Ph.D.	37 years	Eclectic	Private Practice
Les Greenberg	Male	Caucasian	Clinical/ Counseling Psychologist, Ph.D.	35 years	Humanistic/Existential	University/ Private Practice
Beverly Greene	Female	African-American	Clinical Psychologist, Ph.D.	26 years	Feminist Psychodynamic	University/ Private Practice
Nadine Kaslow	Female	Caucasian	Clinical Psychologist, Ph.D., ABPP	31 years	Integrative	University/ Hospital/Private Practice
Mary Beth Kenkel	Female	Caucasian	Clinical Psychology, Ph.D.	20 years	Cognitive Behavioral	Retired from Private Practice
Stuart Krause	Male	Caucasian	Clinical Psychology, Ph.D.	19 years	Cognitive, Existential	Hospital/Comm. Mental Health Center
Paul Leonard	Male	Caucasian	Clinical Psychology, Ph.D.	17 years	Cognitive-Behavioral, Systems, Solution-Focused	Private Practice
Susan McDaniel	Female	Caucasian	Clinical Psychology, Ph.D.	30 years	Family Systems	University

Table 1

Participants' Demographic Information

Name	Sex	Race	Highest Degree	Years as Therapist	Therapy Orientation	Primary Professional Setting
William R. Miller	Male	Caucasian	Clinical Psychology, Ph.D.	37 years	Humanistic-Behavioral	Retired, University
John Norcross	Male	Caucasian	Clinical Psychology, Ph.D.	27 years	Integrative/Eclectic	University and Private Practice
Roger Peterson	Male	Caucasian	Clinical Psychology, Ph.D., ABPP	38 years	Cognitive-Interpersonal-Constructionist	University /Private Practice
Melba Vasquez	Female	Hispanic	Counseling Psychology, Ph.D., ABPP	30+years	Eclectic with focus on multicultural/feminist theory	Private Practice
Jeff Zeig	Male	Caucasian	Clinical Psychology, Ph.D.	36 years	Symbolic Experiential (Humanistic/Existential)	Private Practice

Table 2

Clusters and Categories, With Number of Participants Who Contributed Units to Each

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Cluster, category and subcategory titles

Cluster 1: Overcoming a Fear of the Dark and the Intimate: The Need to Move Beyond Intelligence Towards Wisdom Via Introspection and Lived Experience of Struggle. (17)

- 1.1 Intelligence Is Not Enough: Wise Therapists Need Emotional Intelligence Grounded in Difficult Life Experiences to Better Understand Experiencing and Working Through Pain in order to Help Clients Learn from Powerful Emotions. (16)
  - 1.1a Intelligence is necessary but insufficient to be wise. (11)
  - 1.1b Intelligence is separate from wisdom: Intelligent people are not always wise, as they can be too busy trying to be smart, while oblivious to understanding human beings. (7)
  - 1.1c Wise therapist has emotional intelligence grounded in own difficult life experiences, attending to own emotions in order to empathically guide clients into understanding and utilizing their emotions. (13)
- 1.2 Wise therapist needs social intelligence: Intelligence alone can get in the way of wisdom because it lacks tolerance for the ambiguity and unpredictability of human beings. (16)
  - 1.2a Wise psychotherapist has intelligence and broad knowledge base, but an even greater sense of knowledge about people, relationships, and personality, with life experience to draw from. (16)
  - 1.2b Intel alone can impede wisdom. (2)
  - 1.2c Need to have experienced intimate relationships to be able to understand the needs, feelings and dynamics of a relationship with clients. (1)
- 1.3 We Must Strive to Know Ourselves Before We Can Know Our Clients: Pushing Ourselves to Be Vulnerable and Authentic About Our Own Inner Turmoil allows us to Appreciate the Human Experience We All Share. (14)
  - 1.3a Therapists must engage in introspection to know their own emotions in order to empathize with clients. (12)
  - 1.3b We must be willing to be vulnerable and authentic about our own pain and suffering, and the darker parts of our selves, helping us to relate to clients as equals struggling through the same journey of being human beings. (9)

Cluster 2: Staying with Vulnerability and Ambiguity Helps Therapists to work from within the Clients' Value Framework and Facilitate Openings for Either Acceptance or Change. (17)

- 2.1 Therapists' Relinquishing of Power Begets Clients' Empowerment: Creating Agency by Advocating With, Not for, Clients, while Utilizing Their Own Values, Preferences, and Experiential Wisdom in Therapy. (11)
  - 2.1a Avoiding resistance: Soliciting client preferences while being perceptive to client values and differences. (6)

Table 2

Clusters and Categories, With Number of Participants Who Contributed Units to Each

2.1b Wise psychotherapists are collaborative and equal partners with clients while utilizing clients values, preferences, and experiential wisdom in therapy, helping clients to generate their own insights. (7)

2.1c Wise PT raises difficult questions about self and the world that clients might have never considered, especially important for clients from marginalized groups. (3)

2.2 Category 2: Shifting Perspectives by Exploring Threat and Uncertainty: A Valuing of Relational Attunement over Decontextualized Intervention Enactment. (15)

2.2a Must be willing to develop a relationship by being ignorant about your client and curious without imposing your own categories, because we never know who is sitting in front of us. (14)

2.2b Wise psychotherapist is optimistic and enthusiastic, often with appreciation for humor in therapy, looking for client strengths, providing hope that clients can survive and move past their pain. (8)

2.2c Wise psychotherapist fosters understanding, connection and insight by slowing down and genuinely empathizing with clients in session. (6)

2.3 Wise Psychotherapists Do Not Cling to Standardized Approaches to Eliminate Uncertainty because They Understand That Not Having All the Answers Is Often Scary but Necessary for Attunement. (13)

2.3a Wise psychotherapist is able to remain calm when facing uncertainty, crisis, and ambiguity in therapy. (4)

2.3b Wise PT has a strong moral, ethical and value related compass to rely on. (5)

2.3c Wise PT sits with humility, being aware of what they don't know, and accepting that this understanding is uncomfortable and scary. (9)

Cluster 3: The Isolation of the Wise Regarding the Dominance of Intelligence in our Culture: Political and Personal Disincentives to Wisdom. (17)

3.1 Empirically-Supported Treatments and Managed Care Have Created a Culture where Medical-Like Interventions are Valued over Wisdom-Informed Approaches to Therapeutic Relationship, Despite the Latter Having Evidence of Producing Change. (17)

3.1a Wise therapist is the whole ball of wax, able to contextualize standardized approaches, integrating the uniqueness of clients, with own personality, creativity, innovation and research. (13)

3.1b Wise therapists try to learn from other therapy perspectives and without power struggles, but avoid becoming surgeons doing procedures on clients, instead focusing on individualizing their approach to their wonderfully messy, unpredictable clients. (16)

3.2 Wise Practice Can be Heavy and Burdensome: We Must Stay Connected to Professional Community and Maintain Personal Support Systems to Replenish That Which We Give to Clients. (10)

Table 2

Clusters and Categories, With Number of Participants Who Contributed Units to Each

3.2a Wise therapist does not try to do it all alone like a single parent, must stay connected to professional community or you risk having false sense of confidence. (3)

3.2b Wise therapists are aware of the great responsibilities they have, and put in more time and energy, sometimes to the point of self-sacrifice, so must allow yourself permission to back off and find personal supports to give to you what you give to your clients. (9)

Cluster 4: Rewarding Questioning Rather Than Answering: A Radical Approach to Admitting, Assessing and Training Therapists. (17)

4.1 The Intellectual, Social, and Emotional Functioning of Student Applicants should be Considered to Ensure that they will be both Good Therapists and Researchers. (13)

4.1a Programs should be explicit in values re self reflection and being comfortable in own skin—emotions and self awareness are just as important as cognitions, if can't access them, need to be in therapy yourself. (9)

4.1b Teaching students how to just be with clients sometimes gets overlooked -- need to teach and assess mastery of respect, empathy, listening and collaboration while emphasizing trainees experiential learning and self reflection process as well. (9)

4.2 Looking Beyond Disorder To the Order: Encouraging Students to Actively Seek Knowledge Outside Their Own Worldviews In Order To Appreciate Clients' Uniqueness Instead of Pathologizing Them. (12)

4.2a Wisdom is enhanced by exposure to other cultures, beliefs and worldviews: Need to be exposed to things outside psychology to relate to variety of clients, and must be open to the experiences that will provide this knowledge. (10)

4.2b Pay more attention to the client than the disorder, or s/he becomes a patient you do something to, something to work on, and you're still immaculate. (9)

4.3 Fostering Autonomy and Collaboration Without Fear: Faculty Must Put Aside Theoretical Differences and Hierarchical Power Structures to Give Students the Liberty to Follow Their Own Curiosities. (17)

4.3aTraining programs can encourage the development of wisdom by providing supportive environments where students are able to cultivate and experiment with their own interests, not just that of faculty, while being allowed to grow, stumble, and occasionally fall. (16)

4.3b Training programs can hinder the development of wisdom due to internal politics regarding theory and orientation, and hierarchical structures that place students in positions as inferior dependents. (6)

Core Category: Clinical wisdom is taking the risk not to know: Using your life experiences of pain and struggle as guides in exploring your clients' ambiguity and vulnerability while allowing their values, and context to tailor your interventions.